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FOUR OAKS SENIOR LIVING	**565 BOYETTE ROAD FOUR OAKS, NC 27524**

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on November 28, 2023 through December 1, 2023.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the special care unit environment was clean, orderly, and free of hazards including cleaning chemicals, sharp objects, and personal care products. The findings are: Review of the facility's policy and procedure for Special Care Unit (SCU) Safety Measures for Accidental Ingestion dated September 2021 revealed: -Personal items that could be ingested were maintained by staff (including all liquid personal items, and aerosols ...) in a secure location until needed for resident use. -Resident and responsible party were notified of policy on admission. -Resident rooms and care areas were inspected regularly for unsafe items that could be	D 079		

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accidentally ingested or harmful.
-Staff routinely monitored residents for possible hoarding of substances that could be ingested.
-All utility closets and laundry areas were locked unless under direct supervision.
-All toxic substances remained in original containers and were secured in a locked area unless being used under direct supervision.

Review of the facility's census report dated 11/28/23 revealed there were 34 residents in the SCU.

Observations of the SCU soiled utility room on 11/28/23 at 9:43am revealed:
-The door to the soiled utility room was unlocked.
-There were 3 male residents sitting in chairs near the soiled utility room in the small hallway leading to an enclosed outside area.
-There was an unopened 33.8 ounce bag of antibacterial hand soap and an aerosol can of stainless steel cleaner and polish on the shelf inside the soiled utility room.
-The labels on both containers had warnings to keep out of reach of children and to contact a physician or poison control center if swallowed.
-There was an approximately half full container of neutral cleaner concentrate with a warning on the label to keep out of reach of children and that the concentrate was an eye irritant.
-There was an approximately half full container of disinfectant concentrate with a warning on the label that concentrate was hazardous to humans.
-It was corrosive, caused irreversible eye damage and skin burns.
-The disinfectant concentrate could be fatal if inhaled and was harmful if swallowed or absorbed through the skin.
-There was a commode with brown water inside the bowl and covered with a clear plastic bag.

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Observations of the SCU housekeeping closet and electrical room on 11/28/23 at 10:30am revealed:
-The door to the housekeeping closet was unlocked.
-There was a full bottle of chlorinated cleaner and disinfectant on the shelf in the housekeeping closet.
-There was a precautionary statement on the label to wear protective gloves, protective clothing, and eye and face protection with handling and use of the chlorinated cleaner and disinfectant.
-The label instructed to call the poison control center or physician if swallowed and fresh air when inhaled.
-There was a bottle of fabric softener on the shelf in the housekeeping closet.
-There were two 33.8 ounce bags of the antibacterial hand soap on the shelf in the housekeeping closet.
-There were 17 additional 27 ounce bags of hair and body shampoo on the shelf in the housekeeping closet.
-There was a kitchen steak knife on the shelf in the housekeeping closet.
-There was an aerosol can of glass cleaner with a warning label that instructed to keep out of reach of children and call poison control if swallowed.
-There was a gallon container approximately half full of odor counteractant on the shelf with a warning label to keep out of reach of children.
-The odor counteractant was flammable and caused eye and skin irritation.
-There was a full gallon container of the odor counteractant, neutral cleaner and multi-surface glass cleaner on a wheeled cart between the entrance door of the housekeeping closet and the electrical room.

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D 079	Continued From page 3 -The door to the electrical room was inside the housekeeping closet and was unlocked and propped open with a cleaning cart. -The electrical room was cluttered with carts, vacuums, and boxes in front of 3 electrical panels on the wall and there was a large hot water heater in the corner. Observations during the initial tour on the SCU on 11/28/23 from 9:43am until 10:51am revealed: -There was no cover on the toilet tank in the bathroom in resident room 611. -There was no toilet paper holder on the wall in the bathroom in resident room 612. -There were holes in the wall where the toilet paper holder had been. -The toilet paper holder was resting on the towel rack near the handwashing sink with the 2 screws in the upright position. -There was a torn piece of linoleum with a raised edge causing a tripping hazard at the entrance of the bathroom in resident room 602. -There was also an approximately 1 inch wide rip in the linoleum with raised edges in the shape a "T" approximately 18 inches in length in front of the toilet causing a trip hazard. -There was a brown substance smeared on the sink counter, faucet handle, mirror, wall around sink, light switch, and toilet seat in the bathroom in resident room 502. -The toilet had feces and brown water with a dark blue ring around the edge of the water. -The floor in resident room 502 had an accumulation of dirt, food particles, and smudges. -There was a 16.9 ounce bottle of antiseptic mouthwash that was 2/3 full on the dresser in resident room 501. Observations of the SCU kitchen on 11/28/23 10:34am revealed:	D 079		

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-There was a drawer next to the sink containing a shaving razor, electric razors, electric hair flat iron, and a blow dryer.
-There were two partially full containers of laundry soap in the unlocked under sink cabinet.

Interview with a personal care aide (PCA) on 11/28/23 at 10:36am revealed:
-The doors to the soiled utility room and housekeeping closet were supposed to be kept closed and locked.
-The facility did not have any housekeepers.
-There were 2 housekeepers from a sister facility cleaning the facility.
-The housekeepers might have left the doors unlocked since they did not work at the facility.
-Things like razors and laundry soap were not supposed to be kept in the kitchen area.
-She did not know how they got there.
-There was no process to routinely check areas of the SCU for hazards in areas accessible to residents.
-The maintenance person was told about the plugged-up toilet in room 502, the toilet tank cover in room 611 and the broken toilet paper holder in room 612.
-The maintenance person was not able to work on repairs because he was the housekeeper on the assisted living (AL) side.

Interview with the housekeeper on 11/28/23 at 10:42am revealed:
-They were scheduled to clean at the facility for 2 days (11/28/23 and 11/29/23).
-She reported all housekeeping concerns and repairs needed to staff working on the SCU.
-She did not know the names of the staff.
-She did not know anything about the soiled utility room or housekeeping closet being locked or unlocked.

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D 079	Continued From page 5 Interview with a medication aide (MA)/ PCA on 11/28/23 at 10:52am revealed: -The soiled utility room and housekeeping closet were supposed to be kept closed and locked. -There was no one responsible for routinely checking that the clean utility room and housekeeping closet doors were locked. -The facility did not have any housekeepers for approximately one month (November 2023). -She had not been in resident rooms like 502, so she did not know the condition of the rooms. Observation on the SCU on 11/28/23 from 2:29pm until 2:39pm revealed: -The door to the soiled utility remained unlocked and with none of the cleaning chemicals removed. -The door to the housekeeping closet and electrical room remained unlocked and with none of the cleaning chemicals, sharp objects or personal care products removed. Interview with the maintenance person on 11/28/23 at 2:25pm revealed: -He knew repairs and maintenance were needed on the SCU. -He did not know everything that needed to be repaired because he was not always at the facility. -Staff usually told him what repairs needed to be done. -He had been working at the facility for 3 months but had been pulled away for 3 weeks to help at a sister facility and another 2 weeks at a second sister facility. -When he returned to the facility, he was behind on repairs and maintenance. -He was also working as the housekeeper 3 days per week and maintenance 2 days per week.	D 079		

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-The soiled utility room and housekeeping closet were usually locked.

Interview with the Special Care Coordinator (SCC) on 11/28/23 at 3:06pm revealed:
-The soiled utility room and housekeeping closet were supposed to always be locked because there were chemicals and household cleaning products stored in there.
-It was a SCU and residents should not have access to chemicals and cleaning products that could be harmful if ingested.
-The doors may have been left unlocked for 3rd shift to have access since the facility did not have housekeepers for the last month (November 2023).
-A family member might have brought the mouthwash in for the resident in room 501.
-There was no process in place to periodically check the doors and resident rooms for hazards.

Interview with the Administrator on 11/28/23 at 3:28pm revealed:
-The soiled utility room and housekeeping closet were to be kept locked at all times to keep residents out.
-A former housekeeper left one week ago without turning in her key to the soiled utility room and housekeeping closet.
-Staff on the SCU did not know she had a spare key until today (11/28/23).
-She was not at the facility that morning and neither was the maintenance person.
-Housekeeping staff, maintenance, the MCC and one MA on the SCU had a key to the soiled utility room and housekeeping closet.
-There was a key on the MA key ring so that 3rd shift had access to clean up any housekeeping incidents.
-Staff on the SCU on duty on 11/28/23 did not

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D 079	Continued From page 7 realize they had a key to the soiled utility room and housekeeping closet. -She did not know whether the soiled utility room and housekeeping closet were unlocked since the housekeeper left. -Staff using the soiled utility room and housekeeping closet were responsible for making sure the doors were closed and locked after use. -No one was responsible for periodically checking that the soiled utility room and housekeeping closet were locked. -Those areas were kept locked because there were chemicals stored in there. -Residents with advanced stages of dementia might not see or know those were chemicals and accidentally ingest it. -There were no incidents of residents accidentally ingesting any hazards or being in the soiled utility room or housekeeping closet. -There were 3 residents that she could think of that had wandering behaviors on the SCU but they mostly wandered in and out of other residents' rooms. -Staff were responsible for completing a work order for repairs concerns and putting it in the box outside the administrative offices. -Work orders were reviewed daily at the morning meeting. -The maintenance person completed any repairs, signed the work order, and turned it in to her. -She verified the repair was completed and signed the work order. ________________________________ The facility failed to ensure the special care unit environment was clean, orderly, and free of hazards including caustic cleaning chemicals, sharp objects, and personal care products resulting in unmonitored access to hazards on the SCU which had residents with cognitive impairment and wandering behaviors. This failure	D 079		

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D 079	Continued From page 8 was detrimental to the health, safety, and welfare of 34 residents on the SCU and constitutes a Type B Violation. ________________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/28/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 15, 2024.	D 079		
D 106	10A NCAC 13F .0311(b) Other Requirements 10A NCAC 13F .0311Other Requirements (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. This rule apply to new & existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure a reliable heating system sufficient to maintain 75 degrees Fahrenheit under winter conditions in one room on the Assisted Living (AL) and one room on the Special Care Units (SCU). The findings are: Review of the website www.weather.com revealed: -The weather forecast in the Four Oaks, North Carolina area on 11/28/23 at 4:50 pm was 44	D 106		

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degrees outside.
-The weather forecast in the Four Oaks, North Carolina area on 11/28/23 at 4:49 pm showed a weather review of a high of 51 degrees and a low of 28 degrees on 11/29/23.

a. Observation of resident room #315 in the Assisted Living on 11/28/23 at 9:34 am revealed:
-There were two residents that resided in this room.
-Upon entering the room there was a perceivable decrease in the temperature in the room as compared with the hallway.
-Both roommates were lying in their beds with a comforter and a blanket over them.
-Room #315 central HVAC vent did not produce cold or hot air.

Interview with the first resident in room #315 on 11/28/23 at 9:34 am revealed:
-The room was very cold.
-She told the medication aide (MA) that the room was cold, and the Administrator said she would look into it a month ago.

Interview the second resident in room #315 on 11/28/23 at 9:34 am revealed:
-It was worse at night; "we can't hardly stand it at night."
-She said when the MA gave her medicine, the MA said it was cold, and she responded, "It is extra cold at night."

Second observation of Room #315 on 11/28/23 at 2:14 pm revealed the room temperature thermometer showed 61.6° F.

Third observation of Room #315 on 11/28/23 at 4:07 pm revealed the room temperature thermometer showed 62.5° F.

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Interview with the Maintenance Person on 11/28/23 at 3:49 pm revealed:
-The motor of the heating unit in room #315's heating unit ran, but no heat came out of the vent.
-The HVAC company fixed the system about a month and a half ago because air was not coming out, the HVAC replaced an instrument panel.
-The HVAC company came out last week for the annual service, and he was unsure what was found when the units were checked.

Interview with the Administrator on 11/28/23 at 4:56 pm revealed:
-The staff had not mentioned anything about coldness in the resident's room.
-The residents did not say anything about it being cold in their room.
-There were no reports of any issues from the HVAC company when they came out for the annual inspection.
-Maintenance, she, or the MA could control the thermostats.
-When something was wrong with the heating system, she contacted the in-house maintenance technician to find out if there was a problem with the unit; if the system could not be fixed, then she contacted the facility's regional maintenance supervisor, who contacted the HVAC company.
-The residents could be relocated to another room if needed during this process.

Fourth observation of the first resident in room #315 on 11/30/23 at 11:51am revealed the resident lying in bed with one comforter and blanket over her head.

Second interview with the first resident in room #315 on 11/30/2023 at 11:51 am revealed:

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-She was not feeling well and had a sore throat and a cold, but she did not mention her symptoms to anyone.
-She had felt this way for about a month.
-She stayed in her room last night and was offered an extra blanket.
-The 2nd shift MA mentioned to her that she could sleep next door if she would like.
-This was the first person to mention moving due to her cold room.
-Although cold, she preferred sleeping in her room because "things get stolen."

Interview with the personal care aide (PCA) on 11/30/23 at 12:04 pm revealed:
-She was aware the heat was not getting to room #315.
-The resident mentioned to her that they did not have heat.
-She did not mention it to anyone because she was busy.

Second interview with the second resident in room #315 on 11/30/23 at 12:09 pm revealed:
-The Administrator came to her last night and said she could stay in another room at night if she wanted.
-She did not want to do that because it seemed like a lot of trouble.
-She was offered an extra blanket.

Interview with medication aide (MA) on the AL hall on 11/30/23 at 12:54 pm revealed:
-She walked into the room, felt cold air, and asked the residents in room #315 if they wanted to move, and the first resident in room #315 said, "It is always cold in here," and the second resident said no.
-The MA would inform the Resident Care Coordinator (RCC) or the Administrator about the

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cold room issue.

Interview with the Resident Care Coordinator (RCC) on 11/30/23 at 1:23 pm revealed:
-The rooms on the end of the building tend to be colder, but if the door was open, the room would warm up.
-When a resident complained about the cold, the process was to offer extra blankets or suggest leaving the door open so air could circulate.
-The next step was to move to a warmer room and speak with maintenance about the issue.
-The RCC was unaware if the HVAC company knew of any issues.

Observation of the facility on 12/10/23 at 2:45 pm revealed the HVAC staff were working on the heating units.

Interview with the HVAC company maintenance technician on 12/10/23 at 2:48 pm revealed:
-The heating system breaker tripped and needed a reset.
-His company was in the facility for annual maintenance service the prior week.

b. Observation of resident room #503 on the Special Care Unit (SCU) on 11/28/23 at 10:34 am revealed:
-Upon entering the room there was a perceivable decrease in the temperature in the room as compared with the hallway.
-The resident was sitting in a chair in his room with his coat on and a blanket over his lap.

Interview with the resident in room #503 on 11/28/23 at 10:34 am revealed:
-He would like to have more heat.
-He told the personal care aide (PCA) and medication aide (MA) two weeks ago about

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needing heat.
-He asked the MA if he could use an electric blanket in the room and was told no.

Second interview with the resident in room #503 on 11/28/23 at 4:11 pm revealed that he asked the MA for another blanket for later when it got cold, and she brought him an extra blanket.

Interview with a PCA on the SCU on 11/28/23 at 4:14 pm.
-There was always a constant draft of cold air.
-She would adjust the heat thermostat as needed, and it became warmer.
-Many residents said that they were cold.
-She had not seen anyone come out to check the thermometer or the heating system.
-She had not mentioned the issue with the RCC or the Administrator.

Interview with the MA on 11/28/23 at 4:20 pm revealed
one resident said they were cold, and the MA turned up the thermostat from 69 to 72.

Second observation of the resident in room #503 on 11/28/23 at 4:11 pm revealed the room temperature thermometer showed 67.8 degrees F.

Second interview with the resident in room #503 on 11/30/23 at 12:17 pm revealed:
-He slept well and was warm last night.
-He got an extra blanket and felt a difference with the heat turned up.
-He kept his coat on through the night to stay warm.

Second interview with a MA on 11/30/23 at 12:20 am revealed:

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-The thermostat was controlled by staff.
-Staff would get hot after assisting with resident care and would keep the temperature at a level comfortable for themselves.
-The Administrator had it where only the MAs controlled the thermometer; however, the PCA would walk into the room and turn the thermometer to their comfort.
-She came in on first shift, the unit was "ice cold."

Observation of the locked room where the thermostats were located on 11/30/23 at 12:25 pm revealed that several thermostats were set on cool, and the MA turned the dial to heat.

Interview with the Special Care Coordinator (SCC) on 11:30 at 12:34 pm revealed:
-No one told her that residents were cold.
-The thermostat was normally set between 74 to 75 on cool or heat.
-She did not check each room to check the room temperature.
-There was no process of checking room temperature in each resident's room.
-She was unaware if anyone had followed up with maintenance regarding the cold temperature on the unit.

Third observation of the resident in room #503 on 12/01/23 at 9:15 am revealed the resident was asleep in bed with two blankets and wearing his coat.

Second interview with the Maintenance Person on 12/01/23 at 4:01 pm revealed the thermostat on the SCU hall must be replaced for unit 21 (room #503) because the thermostat was inoperable.

____

The facility failed to ensure the heating system

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D 106	Continued From page 15 was sufficient to maintain 75 degrees Fahrenheit (F) under winter conditions in the Assisted Living (AL) and Special Care Units (SCU), where temperatures were observed and reported to fluctuate from 61.6 to 67.8, and the temperature was recorded at 44 degrees outside. This resulted in at least three residents having to sleep with their coats on and/or blankets over their heads. This failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation. ______________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/22/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 15, 2024.	D 106		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure water temperatures on the Special Care Unit and	D 113		

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D 113	Continued From page 16 Assisted Living were consistently maintained between 100 and 116 degrees Fahrenheit (F). The findings are: Review of the facility's county environmental health inspection report dated 06/27/23 revealed: -The facility's score was 97.5 with a total of 2.5 deductions. -There was a 1.5 deduction for hot water. -Comments for hot water included hot water ranged 102 to 124 degrees Fahrenheit (F) throughout the facility. -The front (assisted living) left hall was 124 degrees F and the front right hall was 118 degrees F. -The Special Care Unit right hall was 102 degrees F and the left hall was 123 degrees F. -The report was signed by the Administrator. Review of the North Carolina Division of Health Service Regulation Construction Section Hot Water Safety Guide revealed: -A water temperature of 127.4 degrees F could result in a first degree burn in 30 seconds and a second degree (full thickness injury) burn in 60 seconds. -A water temperature of 131 degrees F could result in a first degree burn in 17 seconds and a second degree burn in 30 seconds. Review of the facility's census report dated 11/28/23 revealed there were 34 residents in the Special Care Unit (SCU). Review of weekly water temperature checks dated 09/08/23 through 11/28/23 revealed: -There was documentation of weekly water temperature checks from fixtures on the 300 (assisted living - AL), 400 (AL), 500 (SCU), and	D 113		

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600 (SCU) halls and the kitchen.
-The temperature in resident rooms 413-415 was 89.1 degrees F on 09/29/23.
-The temperature in resident rooms 418-420 was 88.3 degrees F on 09/29/23.
-The temperature in resident rooms 413-415 was 90.1 degrees F on 10/01/23.
-The temperature in resident rooms 418-420 was 89.6 degrees F on 10/01/23.
-The temperature in resident rooms 413-415 was 90.0 degrees F on 10/06/23.
-The temperature in resident rooms 418-420 was 90.1 degrees F on 10/06/23.
-The temperature in resident rooms 415-417 was 91.0 degrees F on 10/13/23.
-The temperature in resident rooms 418-420 was 90.0 degrees F on 10/13/23.
-Temperatures ranged from 97 to 114 degrees F on 10/20/23.
-The temperature in resident rooms 308-310 was 93.2 degrees F on 11/08/23.
-The temperature in resident rooms 312-314 was 92.3 degrees F on 11/08/23.
-The temperature in resident room 313 was 93.6 degrees F on 11/08/23.
-The temperature in resident room 415 was 92.0 degrees F on 11/08/23.
-The temperature in resident room 510 was 92.0 degrees F on 11/08/23.
-Temperatures ranged from 97 to 114 degrees F on 11/14/23, 11/19/23 and 11/27/23.

Upon request on 11/28/23, 11/29/23 and 11/30/23, weekly water temperature checks from 06/01/23 through 08/31/23, were not provided for review.

Observation of hot water temperatures on the SCU on 11/28/23 from 9:37am until 9:57am revealed:

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-Hot water from the sink in the bathroom of resident room 601 was 127 degrees F.
-Hot water from the sink in the bathroom of resident room 611 was 120 degrees F.
-Hot water from the sink in the bathroom of resident room 613 was 63 degrees F.

Interview with a resident on 11/28/23 at 9:58am revealed:
-The hot water system was old.
-Hot water temperatures varied; sometimes it was too hot and sometimes it was too cold.

Interview with a personal care aide (PCA) on 11/28/23 at 10:36am revealed:
-The hot water temperatures fluctuated between too hot and too cold.
-The first room on the hall (601) was "so hot sometimes you could cook an egg on a table with it."
-The last room on the hall (619) was "sometimes as cold as ice" (measured at 114 degrees F).
-The temperatures fluctuated from room to room on both the 500 and 600 halls.
-The maintenance person was told about the hot water temperatures.
-The maintenance person was responsible for routinely checking hot water temperatures.
-The maintenance person was not able to make adjustments because he was also the housekeeper on the assisted living (AL) side.

Interviews with the maintenance person on 11/28/23 at 2:25pm and 3:35pm revealed:
-Hot water temperatures had been fluctuating from 90 to 120 degrees F when he checked that day (11/28/23).
-He was adjusting the hot water heater temperatures.
-He did not know before 11/28/23 that hot water

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temperatures were fluctuating.
-At 3:35pm he got the water temperatures down to 117 and 120 degrees F in rooms 601 and 611.
-He was working to get water temperatures between 100 and 116 degrees F.
-It was hard to properly adjust hot water heater thermostat for rooms out of range because there were multiple thermostats and no labels as to which went to what rooms.
-The low temperature in room 613 was because the faucet needed replacement.

Interview with the Special Care Coordinator (SCC) on 11/28/23 at 3:06pm revealed she did not know of any issues with the hot water fluctuating between cold and hot on the SCU.

Observation of hot water temperatures on the SCU on 11/28/23 from 2:29pm until 2:39pm revealed:
-Hot water from the sink in the bathroom of resident room 601 was 130 degrees F.
-Hot water from the sink in the bathroom of resident room 611 was 130 degrees F.
-Hot water from the sink in the bathroom of resident room 613 was 65 degrees F.
-There were no signs posted to alert residents, staff and visitors of fluctuating hot water temperatures.

Observation of hot water temperatures on the assisted living side on 11/29/23 at 10:45am revealed:
-The sink in the community bathroom near the front desk had a temperature of 123 degrees F.
-There was no sign posted to alert residents, staff and visitors of fluctuating hot water temperatures.

Second interview with the maintenance person on 11/30/23 at 11:56am revealed:

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D 113	Continued From page 20 -When hot water temperatures were outside the range of 100 to 116 degrees F, he adjusted the thermostats and rechecked the temperatures. -There were 6 thermostats on one hot water heater for the 300 and 400 halls (assisted living). -There were 2 hot water heaters for the 500 and 600 halls (SCU). Interview with the Administrator on 11/28/23 at 3:28pm revealed: -No one had reported any issues with the hot water on the SCU prior to 11/28/23. -The maintenance person was responsible for completing weekly water temperature checks. -The maintenance person was responsible for reporting any concerns with hot water temperatures. -Staff were responsible for completing a work order for concerns related to fluctuating hot water temperatures and putting it in the box outside the administrative offices. -Work orders were reviewed daily at the morning meeting. -The maintenance person completed any repairs, signed the work order, and turned it in to her. -She verified the repair was completed and signed the work order. ______________________________ The facility failed to ensure hot water temperatures on the Special Care Unit (SCU) were consistently maintained between 100 and 116 degrees Fahrenheit (F) where temperatures were observed and reported to fluctuate from 63 to 130 degrees. A water temperature of 127.4 degrees could result in a first degree burn in 30 seconds and a second degree burn (full thickness injury in 60 seconds. This failure placed residents with cognitive impairments and wandering behaviors at risk for burns which was detrimental to the health, safety and welfare of residents on	D 113		

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D 113	Continued From page 21 the SCU and constitutes a Type B Violation. ________________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/28/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 15, 2024.	D 113		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II,	D 255		

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which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher;
(I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes;
(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed;
(K) new onset of impaired decision-making;
(L) continence to incontinence or indwelling catheter; or
(M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to complete an assessment and care plan for 1 of 1 sampled resident (#1) with significant change in mobility, repeated falls, and pressure wounds.

The findings are:

Review of Resident #1's current FL-2 dated 08/30/23 revealed:
-Diagnoses included neurocognitive disorder, atrial fibrillation, and hypertension.
-Resident #1 was constantly disoriented.
-Resident #1 was ambulatory.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 08/30/23.

Review of Resident #1's primary care provider

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D 255	Continued From page 23 (PCP) order dated 11/07/23 revealed an order wound care nurse for multiple wounds to Resident #1's buttocks. Review of Resident #1's current care plan dated 09/12/23 revealed: -Resident #1 was sometimes disoriented, forgetful, and needed reminders. -Resident #1 had wandering behaviors, was confused to his whereabouts, and resisted care at times. -Resident #1 was ambulatory and his skin was intact. -Resident #1 required limited staff assistance with toileting, bathing, dressing, and grooming. -There was no documentation Resident #1 used a wheelchair for mobility. -There was no documentation of wounds and skin prevention intervention such as repositioning. -There was no documentation of fall prevention interventions such as a fall mat, bed/chair alarm, and increased supervision. Review of Resident #1's licensed health professional support (LHPS) assessment and evaluation dated 09/11/23 revealed: -Resident #1 did not have any LHPS tasks. -Resident #1 was able to transfer independently and ambulated without an assistive device. Review of Resident #1's current Special Care Unit (SCU) quarterly profile and care plan dated 11/28/23 revealed: -Staff redirected Resident #1 with any instance of behavioral concern. -Resident #1 used a wheelchair and required staff assistance. -Resident #1 required staff assistance with incontinence care.	D 255		

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-Resident #1 required limited staff assistance with hygiene and transfers.
-There was no documentation of wounds and skin prevention intervention such as repositioning.
-There was no documentation of fall prevention interventions such as a fall mat, bed/chair alarm, and increased supervision.

Observation of Resident #1 on 11/29/23 at 10:09am revealed:
-A PCA and the Physical Therapist (PT) assisted Resident #1 to stand from being seated in his wheelchair.
-Resident #1 was unsteady and unable to stand without assistance.
-There was a cushioned dressing on Resident #1's left buttock.
-There was generalized deep redness to both buttocks and a foul odor.
-There were 3 open wounds that were not covered with a dressing.
-The PT encouraged staff to assist the resident with changing his position every 1 and 1 half to 2 hours as previously mentioned.
-Changing the resident's position could be done by shifting side to side in the wheelchair, rising from being seated using handrails in the hallway as tolerated and transferring to lying on his side in his bed.

Telephone interviews with Resident #1's Guardian on 11/29/23 at 12:58pm and 2:51pm revealed:
-She was Resident #1's Guardian since August 2023.
-Resident #1 had a fast decline since he was admitted to the facility (08/30/23).
-The resident had been in the wheelchair for a while; she could not remember exactly how long.
-She met with the Special Care Coordinator

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(SCC) on 11/09/23
-She was told by the SCC that Resident #1 developed wounds on his buttocks.
-She was told the wounds developed because they were trying to keep Resident #1 seated to prevent falls while the PCP re-evaluated the resident's medication regimen.
-Staff moved him closer to the front desk to watch him more closely.
-She was told Resident #1 had 6 falls: a fall after a resident-to-resident altercation on 09/17/23, two falls on 10/12/23, and one fall on 10/17/23, 10/18/23 and 10/19/23.

Interview with a medication aide (MA)/personal care aide (PCA) on 11/28/23 at 9:30am revealed Resident #1 required more than 1 staff to assist with personal care including transfers and toileting.

Second interview with the MA/PCA on 11/29/23 at 10:29am revealed:
-Resident #1 was ambulatory when he first came to the facility (08/30/23).
-He had been using a wheelchair for mobility for approximately one month.

Third interview with the MA/PCA on 11/30/23 at 12:27pm revealed:
-MAs did not have anything to do with resident assessments and care plans.
-If she noticed a change in a resident, she reported it to the SCC and primary care provider (PCP).
-When there were changes in a resident's care needs, the SCC told the staff working.
-Staff were responsible for telling the oncoming shift at each shift change.
-Changes in care needs were not documented anywhere for staff reference.

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Interview with the SCC on 11/30/23 at 12:34pm revealed:
-She was responsible for completing resident assessments and care plans.
-She had not had a chance to update Resident #1's assessment and care plan due to significant changes in his mobility, multiple falls, and wounds.
-The Regional Nurse was responsible for licensed health professional support (LHPS) assessments and evaluations.
-She was not sure if the Regional Nurse was aware of Resident #1's significant changes and new LHPS tasks.
-She did not know if she had to notify the Regional Nurse or if the Regional Nurse knew because she had access to the electronic charting system.

Interview with the Regional Nurse on 11/30/23 at 1:30pm revealed:
-She was at the facility once a week.
-She completed LHPS assessments and evaluations when she was there.
-She did not know when a resident had significant changes and new LHPS tasks from the electronic charting system.
-MAs were responsible for telling her about significant changes and new LHPS tasks.
-When she was notified, she completed the LHPS assessment and evaluation which included recommendations for the care plan and validating staffs' skills on tasks such as assistive devices, transfers, and wounds.

Interview with the Administrator on 12/01/23 at 4:15pm revealed:
-The SCC was responsible for completing resident assessments and care plans annually

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D 255	Continued From page 27 and with a significant change. -Resident #1 was ambulatory on admission to the facility (08/30/23). -It was sometime in October 2023 after his falls that he had a change in mobility and started using the wheelchair. -She thought the previous SCC had completed a significant change assessment and care plan for Resident #1's. [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care & Supervision] [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care & Supervision]	D 255		
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 observations, interviews and record reviews, the facility failed to provide personal care assistance for 3 of 5 sampled residents (#1, #2 and #4) who required staff assistance with transfers and mobility (#1), had a history of diabetes and required staff assistance with cleaning fingernails and bathing (#2), and required staff assistance with incontinence care (#4).	D 269		

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The findings are:

1. Review of Resident #1's current FL-2 dated 08/30/23 revealed:
-Diagnoses included neurocognitive disorder, atrial fibrillation, and hypertension.
-The recommended level of care for Resident #1 was a Special Care Unit (SCU).
-Resident #1 was constantly disoriented.
-Resident #1 was ambulatory and continent of bowel and bladder.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 08/30/23.

Review of Resident #1's current care plan dated 09/12/23 revealed:
-Resident #1 was sometimes disoriented, forgetful, and needed reminders.
-Resident #1 had wandering behaviors, was confused to his whereabouts, and resisted care at times.
-Resident #1 was ambulatory and his skin was intact.
-Resident #1 required limited staff assistance with toileting, bathing, dressing, and grooming.
-There was no documentation Resident #1 used a wheelchair for mobility.
-There was no documentation of wounds and skin prevention interventions such as repositioning.

Review of Resident #1's primary care provider (PCP) order dated 11/07/23 revealed an order wound care nurse for multiple wounds to Resident #1's buttocks.

Review of Resident #1's home health nurse

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(HHN) visit note dated 11/27/23 revealed:
-Resident #1 was seen twice weekly for wound care starting on 11/07/23.
-Resident #1 was forgetful and had fatigue, weakness, and activity intolerance.
-Resident #1 took an anticoagulant (blood thinning) medication.
-Resident #1 had 3 wounds on his right buttock with 25-50% granulation tissue (healthy tissue) and minimal (less than 25%) drainage.
-The date of onset for the 3 wounds on the right buttock was 11/07/23.
-Resident #1's wounds were improving.

Review of Resident #1's home HHN visit note dated 11/29/23 revealed:
-There were two new wounds and existing wounds showed more slough (dead cells and debris) than granulation.
-The HHN contacted Resident #1's PCP and received new wound care orders.
-Staff were educated to call the HHN if the dressing came off.
-There was a new stage II pressure ulcer on Resident #1's left lower buttock with date of onset on 11/29/23.
-The three existing right buttock wounds had 10% granulation tissue and moderate (wet 25-75%) drainage.
-There were no documented details of the second new wound.

Interview with a medication aide (MA)/personal care aide (PCA) on 11/28/23 at 9:25am revealed:
-She was working as a PCA on 11/28/23.
-Staff rounded every two hours; residents were checked for toileting and incontinence care needs.
-Resident #1 resisted care at times.
-Resident #1 had a wound on his bottom.

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Interview with a second MA/PCA on 11/28/23 at 9:30am revealed:
-She was working as the MA on 11/28/23.
-There were no residents with open wounds on the SCU.
-Resident #1 required more than 1 staff to assist with personal care including transfers and toileting.

Observation of Resident #1 on 11/29/23 at 10:09am revealed:
-A PCA and the Physical Therapist (PT) assisted Resident #1 to stand from being seated in his wheelchair.
-Resident #1 was unsteady and unable to stand without assistance.
-There was a cushioned dressing on Resident #1's left buttock.
-There was generalized deep redness to both buttocks and a foul odor.
-There were 3 open wounds that were not covered with a dressing.
-All 3 wounds had smooth, macerated (softening due to extended exposure to moisture) edges and moist yellow tissue inside the wounds.
-The wound at the top of the buttock was approximately the size of a quarter.
-The wound at the middle of the buttock was approximately the size of a nickel.
-The wound at the bottom of the buttock near the thigh was approximately the size of a dime (new according to the HHN's 11/29/23 visit note) .
-The PT encouraged staff to assist the resident with changing his position every 1 and 1 half to 2 hours as previously mentioned.
-Changing the resident's position could be done by shifting side to side in the wheelchair, rising from being seated using handrails in the hallway as tolerated and transferring to lying on his side in

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his bed.

Observation of Resident #1 on 11/30/23 at 11:46am revealed:
-There was a cushioned dressing on Resident #1's right buttock.
-There was a large purple and yellow bruise on the resident's left buttock.
-There was an open wound approximately the size of a dime at the bottom of Resident #1's left buttock near the thigh (new according to the 12/01/23 interview with the HHN).
-There was yellow tissue inside the wound, no odor and less general redness than on the right buttock seen 11/29/23.

Interview with a PCA on 11/30/23 at 11:43am revealed:
-Third shift staff usually got Resident #1 up before 7:00am and he was usually up in his wheelchair until after lunch.
-Today (11/30/23) she got Resident #1 up before breakfast (7:30am).
-Sometimes how long Resident #1 was up in his chair or lying in his bed depended on his preference.
-Sometimes he told staff he wanted to be in his chair or be in his bed.

Second interview with a PCA on 11/30/23 at 12:18pm revealed:
-When the wounds were first discovered staff were told to keep Resident #1 in the bed.
-Approximately two weeks ago (11/16/23) staff just started getting him up.
-She did not know how it started, she came in one morning and he was up and staff continued getting him up.
-Resident #1 started having a lot of falls and the former SCC told staff to keep him in the

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wheelchair.
-They watched Resident #1 by keeping him in the living room in his wheelchair.

Interview with a MA/PCA on 11/30/23 at 11:35am revealed:
-When the wounds were first found (11/07/23), the SCC told staff to lay the resident in his bed after meals.
-She had not seen his wounds since the HHN started managing them.

Telephone interview with Resident #1's Guardian on 11/29/23 at 12:58pm and 2:51pm revealed:
-She was Resident #1's Guardian since August 2023.
-Resident #1 had a fast decline since he was admitted to the facility (08/30/23).
-Resident #1 was ambulatory when he was admitted to the facility.
-The resident had been in the wheelchair for a while; she could not remember exactly how long.
-She met with the Special Care Coordinator (SCC) on 11/09/23
-She was told by the SCC that Resident #1 developed wounds on his buttocks.
-She was told by the SCC the wounds developed because they were trying to keep Resident #1 seated to prevent falls while the PCP re-evaluated the resident's medication regimen.

Interview with the SCC on 11/30/23 at 12:34pm revealed:
-Staff told her they had not seen the wounds on Resident #1 before third shift 11/06/23-11/07/23.
-The wounds were open when she first saw them on 11/07/23.
-She was not given any instructions on changing Resident #1's position.
-She was not aware of a facility standard or

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procedure for assisting with position changes when a resident had a decline in mobility.
-Resident #1 was kept in his wheelchair to keep from falling.
-After the wounds were found, Resident #1 was kept in his bed.
-The PCP had told her a couple of weeks ago to get Resident #1 up because it was not good for him to just sit.
-The PCP did not say how often to get him up out of bed.
-She thought staff should try to help Resident #1 to stand every 2 hours and turn side to side if he was lying down.

Telephone interview with the HHN on 12/01/23 at 10:51am revealed:
-She saw Resident #1 regularly for wound care.
-The wounds on Resident #1's buttocks started as boils that were hard and angry looking with a significant amount of hot redness.
-The wounds opened, and the redness decreased.
-There was some improvement of Resident #1's buttocks wounds when she saw him on Monday (11/27/23), but the wounds had worsened when she saw him on Wednesday (11/29/23).
-She found two new open wounds on Wednesday (11/29/23).
-The new wounds were located on the lower buttocks bilaterally near the thigh.
-The existing wounds had pink granulation tissue on Monday (11/27/23) and on Wednesday (11/29/23) the existing wounds had yellow slough.

Telephone interview with Resident #1's PCP on 11/30/23 at 4:21pm revealed:
-She saw Resident #1's wounds on 11/07/23.
-There was an infection to the wounds and she treated Resident #1 with oral and topical

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antibiotics and had home health see him for wound care.
-The wounds had improved since 11/07/23, with decreased redness and the infection was cleared when she saw the wounds on 11/28/23.
-She had spoken to staff several times since 11/07/23 to change Resident #1's position every hour, provide rest periods from the wheelchair and turn side to side while lying down every 1-2 hours.
-Resident #1 could not sit or lie on his buttocks for long periods.
-Not repositioning Resident #1 every 1-2 hours increased pressure on his buttocks and increased moisture which would cause further skin breakdown.

Interview with the Administrator on 12/01/23 at 4:15pm revealed:
-If a resident was kept sitting for safety reasons, she expected staff to offer a pillow to sit on, check the resident buttocks with incontinence care, and report any redness or changes immediately to the SCC.
-Staff were responsible to assist with position changes for residents with limited mobility every 2 hours.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

2. Review of Resident #4's current FL-2 dated 09/19/23 revealed:
-Diagnoses included dementia, hypertension, and chronic kidney disease.
-The recommended level of care for Resident #4 was a Special Care Unit (SCU).
-Resident #4 was constantly disoriented.
-Resident #4 was non-ambulatory and had bowel

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and bladder incontinence.

Review of Resident #4's current care plan dated 11/28/23 revealed:
-Resident #4 was always disoriented and had significant memory loss.
-Resident #4 had wandering and verbally abusive behaviors.
-Resident #4 resisted care at times.
-Resident #4 was ambulatory with a wheelchair and used a seatbelt restraint.
-Resident #4 was a fall risk and remained on increased supervision (unspecified frequency).
-Resident #4 had bowel and bladder incontinence and required extensive assistance with toileting and incontinence care.
-Resident #4 required limited assistance with ambulation and transfers.

Interview with a medication aide (MA)/personal care aide (PCA) on 11/28/23 at 9:25am revealed Resident #4 was resistant with staff when they tried to assist her with personal care needs such as toileting.

Observation of Resident #4 on 11/29/23 at 10:23am revealed:
-The PCA assisted Resident #4 with standing from her wheelchair and lowering her pants.
-Resident #4 yelled at the PCA (nonsensical words) and pushed against the PCA until she was seated on the toilet.
-Resident #4 was wearing 2 incontinence briefs.
-The PCA removed one incontinence brief and left the second one on the resident.

Interview with the PCA on 11/29/23 at 10:23am revealed:
-She put 2 incontinence briefs of Resident #4 because the resident usually had diarrhea when

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she drank milk and ate eggs for breakfast.
-Putting 2 incontinence briefs on Resident #4 minimized accidental leakage.
-Resident #4 had diarrhea, but most of it went into the toilet.
-She removed one incontinence brief and left the other on because only one was soiled.
-Resident #4 had mild pink/red skin in her gluteal fold.
-There were no open areas on Resident #4's buttocks.

Telephone interview with Resident #4's primary care provider (PCP) on 11/30/23 at 4:21pm revealed:
-She did not know staff were using 2 incontinence briefs on Resident #4.
-Resident #4 should not be wearing 2 incontinence briefs because she would not be changed as frequently which increased the risk of skin breakdown (wounds).

Interview with the Special Care Coordinator (SCC) on 12/01/23 at 3:00pm revealed:
-She did not know staff were using two incontinence briefs on Resident #4 on 11/29/23.
-She knew it had been a problem in the facility before because it was discussed in staff meeting not to "double brief".
-Using two briefs implied staff were not trying to keep up with their duties and increased the risk of the resident developing skin break down (wounds).

Interview with the Administrator on 12/01/23 at 4:15pm revealed:
-Staff were not to use 2 incontinence briefs on a resident for dignity and to prevent skin breakdown.
-Staff had been educated on not using 2

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incontinence briefs previously.

Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.

3. Review of Resident #2's current FL-2 dated 08/15/23 revealed:
-Diagnoses included vascular dementia without disturbance, type 2 diabetes mellitus with specified complications, chronic diastolic congestive heart failure, chronic anemia without bleeding, hypoxia, aspiration pneumonia of right lower lobe, bacteremia, and history of gout.
-The resident was constantly disoriented.
-The resident was semi-ambulatory.
-The resident was incontinent of bowel and bladder.
-The resident required assistance with bathing, dressing, and feeding.
-The resident was documented as having wandering behavior.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 02/05/19.

Review of Resident #2's special care unit (SCU) resident profile and care plan dated 10/04/23 revealed:
-The resident was incontinent and required staff assistance for toileting needs and hygiene.
-Staff would provide hands-on assistance to perform hygiene and cleaning up after incontinent episodes.
-The resident used a walker, requiring staff assistance.
-Staff would monitor ambulation through the facility and report any changes.
-The resident required limited assistance with

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bathing.
-Staff would provide showers and sponge bath to ensure the resident was clean and report any skin changes.
-The resident required limited assistance with dressing.
-Staff would get the resident dressed in clean and tidy clothes daily.
-The resident required limited assistance with grooming and hygiene.
-Staff would provide grooming including nail and hair care every shift.
-The resident required limited assistance with transferring.
-Staff would provide stand by assist to transfer to/from bed and chair.

Review of Resident #2's current assessment and care plan dated 10/24/23 revealed:
-The resident was documented as being physically abusive (injurious to others), resisted care, and had disruptive/socially inappropriate behavior.
-The resident wandered in the SCU and in other's rooms.
-The resident could be verbally aggressive towards staff at times.
-The resident was ambulatory and used a walker.
-The resident was documented as always disoriented.
-The resident required limited assistance by staff with eating, toileting, ambulation, bathing, dressing, grooming, and transferring.

Observation of Resident #2 during tour of the facility on 11/28/23 at 2:20pm revealed:
-Resident #2 was sitting in a chair.
-The resident's fingernails on both hands were ¼ - ½ inches long, jagged with sharp edges, and yellow.

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-There was a substance with some brown debris underneath all the resident's fingernails.

A second observation of Resident #2 on 11/30/23 at 12:36pm revealed:
-Resident #2 was lying in bed on his back.
-The resident was wearing a green sweatshirt with dried, dark yellow, crusty substances on the right front of the shirt and in the lower middle portion of the sweatshirt.
-The resident was wearing gray sweatpants with dried, dark yellow, crusty substances on the upper right leg of the sweatpants.
-The resident's fingernails on both hands were ¼ - ½ inches long, jagged with sharp edges, and yellow.
-There was a substance with some brown debris underneath all of the resident's fingernails.

Interview with the personal care aide (PCA) on 11/30/23 at 12:38pm revealed:
-She came to assist Resident #2 to the dining room for lunch.
-She was not sure when the resident last had a shower because he was usually bathed by second shift staff.
-Whichever staff gave the resident a shower was supposed to document a skin assessment in the computer each time they bathed the resident.
-The resident's fingernails should be cleaned when he was bathed.
-She was not sure what was underneath the resident's fingernails.

A third observation of Resident #2 on 11/30/23 at 12:40pm revealed:
-The PCA did not offer to change the resident's clothes or clean his fingernails.
-The PCA assisted the resident with ambulating to the dining room with his walker.

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-The PCA assisted the resident in sitting down at the dining room table to eat lunch.

Review of a shower list/bathing schedule for the SCU residents revealed:
-Resident #2 was scheduled for bathing/showers on second shift.
-The resident's name was under the column labeled "Monday and Thursday" and a second column labeled "Tuesday and Friday".

Interview with the Special Care Coordinator (SCC) on 11/30/23 at 12:45pm revealed:
-Residents were supposed to get bathed/showered 3 times a week, including cleaning fingernails.
-If a resident's name was listed under 2 columns, that meant they were bathed 2 days listed in one column and 1 day listed in the other column.
-The third day should be noted beside the resident's name in the second column.
-She was working on updating the shower schedules.

A fourth observation of Resident #2 on 11/30/23 from 12:49pm - 12:53pm revealed the resident was in the dining room feeding himself lunch, using his utensils at times and at other times using his hands with fingernails with debris underneath them.

Review of Resident #2's shower skin assessments for September 2023 - November 2023 revealed:
-There was a shower skin assessment dated 09/04/23 at 2:16pm noted "no shower".
-The resident was noted to have bruising, discoloration, and swelling to the left eye.
-There was a shower skin assessment dated 10/27/23 at 9:33pm.

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-Staff documented there was nothing new to report.
-There was a shower skin assessment dated 11/28/23 at 10:06pm noted "shower day".
-Staff documented the resident had a scar on the back of his head from a fall.
-There were no other shower skin assessment sheets for Resident #2 from 09/01/23 - 11/30/23.

Interview with a medication aide (MA) on 11/30/23 at 1:15pm revealed:
-The PCAs on second shift were assigned to bathe the resident.
-The PCAs were responsible for cleaning Resident #2's fingernails and filing them.
-Resident #2's fingernails needed to be cleaned and filed.

A second interview with the PCA on 11/30/23 at 3:03pm revealed she had not cleaned Resident #2's fingernails today, 11/30/23, because she had not had a chance to do it.

Interview on 11/30/23 at 5:37pm with the PCA who documented the shower assessment for Resident #2 on 11/29/23 revealed:
-She did not realize until recently that she was supposed to fill out a shower assessment form when she bathed residents.
-She was still learning how to fill out the shower assessment form.
-She had noticed Resident #2's fingernails were long and dirty but the resident would not let her clean them.
-She did not document the resident refused to let her clean his fingernails because she did not know she had to document it.
-She had not notified anyone about the resident's long, dirty fingernails.
-She did not know why she did not report the

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condition of the resident's fingernails to anyone.

A second interview with the SCC on 11/30/23 at 3:30pm revealed:
-The PCAs were responsible for doing shower assessments with each shower.
-The PCAs should be checking the resident's skin each time the resident was bathed.
-The PCAs should be cleaning the resident's fingernails when the resident was bathed and anytime the fingernails were visibly soiled.
-The PCA should have cleaned Resident #2's fingernails today, 11/30/23, before taking the resident to the dining room to eat lunch.
-The resident put his hands down his pants at times and used his fingers to feed himself so it was important that his hands and fingernails were kept clean.

A third interview with the SCC on 11/30/23 at 5:18pm revealed:
-She did not know why staff had only documented 3 shower skin assessments for Resident #2 since September 2023.
-The PCAs were supposed to document the shower skin assessments each time a resident was bathed.
-She checked the shower skin assessments, "less than I should".
-When a resident had dried food or other substances on their clothing, the PCAs or MAs should change the resident's clothing at that time.

A fifth observation of Resident #2 on 11/30/23 at 5:27pm revealed:
-The resident was lying in bed.
-The resident was still wearing the same soiled green sweatshirt and gray sweatpants that he was wearing prior to lunch today, 11/30/23.
-The resident's fingernails on both hands were

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shorter than observed today, 11/30/23, at 12:36pm.
-There was still some debris underneath the resident's fingernails.

A fourth interview with the SCC on 11/30/23 at 5:30pm revealed:
-She had a PCA clean Resident #2's fingernails today, 11/30/23.
-The resident's soiled clothing should have already been changed by the PCA.

Interview on 11/30/23 at 5:31pm with the PCA who was instructed to clean Resident #2's fingernails on 11/30/23 revealed:
-She did not clean the resident's fingernails; she just clipped them.
-She had no explanation for not cleaning the resident's fingernails.

Interview with the Administrator on 11/30/23 at 5:50pm revealed:
-A shower skin assessment should be documented for each shower a resident was given.
-The PCAs were responsible for documenting the shower skin assessments in the computer.
-The PCA should have cleaned Resident #2's fingernails as instructed today, 11/30/23.
-The PCAs or MAs should change a resident's clothing anytime it was visibly soiled or dirty.

Telephone interview with Resident #2's primary care provider (PCP) on 11/30/23 at 4:34pm revealed:
-Staff needed to make sure they were cleaning Resident #2's fingernails.
-The number one rule to help prevent the spread of germs was to sanitize or wash hands before meals.

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-The facility's PCAs and MAs should be keeping the resident's fingernails clean.

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

____

The facility failed to provide personal care assistance including repositioning, nail care, bathing, and toileting for 3 of 5 sampled residents (#1, #2 and #4) which resulted in the development and worsening of pressure wounds and an infection on Resident #1's buttocks, unclean fingernails during meals and increased risk of spreading germs for Resident #2, who used his fingers to eat at times, and other residents in the Special Care Unit (SCU) dining room, and increased risk of skin breakdown for using double incontinence briefs for Resident #4. The facility's failure 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 12/01/23 for this violation.

THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 31, 2023.

D 270	10A NCAC 13F .0901(b) Personal Care and Supervision	D 270		

10A NCAC 13F .0901 Personal Care and Supervision
(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.

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

Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (#1, and #4) who required increased supervision for repeated falls with injuries (#1, #4).

The findings are:

Review of the facility's policy and procedure for Safety Measures for Fall Reduction dated September 2021 revealed:
-Residents were evaluated by management on admission or readmission for fall risk.
-Residents were evaluated at each fall, and appropriate reports were completed with documentation of each new intervention.
-When a fall or fall related accident or incident occurred a fall related accident/incident report was completed by the Resident Care Coordinator (RCC) or designee in the electronic charting system at which time the 72 Hour Fall Management Follow Up was added in the electronic charting system.
-Vital signs and observations for any changes were completed every shift by medication aides (MAs) post fall and documented in the shift electronic progress note.
-Within 24-48 hours of each fall a manager completed the Post Fall Care Plan Evaluation for Interventions.
-A new intervention must be added for each additional fall.
-The RCC or designee added the Fall Risk

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Banner to the face sheet in the electronic charting system.
-The RCC or designee added the Fall Risk emblem to the door name plate.

Interview with the Memory Care Coordinator (MCC) on 12/01/23 at 3:00pm revealed:
-Any incident involving a resident was an automatic 3 days of increased supervision (fall monitoring).
-Medication aides (MAs) were responsible for checking the resident's vital signs every shift for the 3 days (fall monitoring) and documenting the results on the resident's electronic medication administration record (eMAR).
-Personal care aides (PCAs) visually checked the residents on fall monitoring for their safety and location every 15 minutes.
-PCAs documented the resident's location at the time of 15 minute check on the Increased Supervision & Accountability Checklist sheets (15 minute check sheets).
-MAs were responsible for initiating the 3 days of fall monitoring when they completed accident/incident reports.
-She was responsible for implementing interventions documented on the eMAR.
-Accident/incident reports came to electronic charting system alert screen prompting her to review and initiate interventions.
-Interventions were chosen from computer generated questions related to what happened around the incident.
-She verbally communicated any new interventions to staff on duty.
-Staff were expected to communicate updates verbally at shift change until all staff were aware.
-Staff were expected to do what they documented they did on check sheets and the eMAR

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1. Review of Resident #1's current FL-2 dated 08/30/23 revealed:
-Diagnoses included neurocognitive disorder, atrial fibrillation, and hypertension.
-Resident #1 was constantly disoriented.
-Resident #1 was ambulatory.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 08/30/23.

Review of Resident #1's current care plan dated 09/12/23 revealed:
-Resident #1 was sometimes disoriented, forgetful, and needed reminders.
-Resident #1 had wandering behaviors, was confused to his whereabouts, and resisted care at times.
-Resident #1 was ambulatory and his skin was intact.
-Resident #1 required limited staff assistance with toileting, bathing, dressing, and grooming.
-There was no documentation Resident #1 used a wheelchair for mobility.
-There was no documentation of fall prevention interventions.

Review of Resident #1's home health nurse (HHN) visit notes dated 11/27/23 and 11/29/23 revealed:
-Resident #1 was a high risk for falls.
-Resident #1 had joint stiffness, muscle weakness, poor balance, and an unsteady gait.
-Resident #1 took an anticoagulant (blood thinning) medication.

Telephone interview with Resident #1's Guardian on 11/29/23 at 12:58pm and 2:51pm revealed:
-She was Resident #1's Guardian since August 2023.

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-Resident #1 had a fast decline since he was admitted to the facility (08/30/23).
-He was initially ambulatory without a device.
-The resident had been in the wheelchair for a while; she could not remember exactly how long.
-She met with the Special Care Coordinator (SCC) on 11/09/23.
-The SCC told her Resident #1 was moved closer to the front desk to watch him more closely.
-She was told Resident #1 had 6 falls: a fall after a resident-to-resident altercation on 09/17/23, two falls on 10/12/23, and one fall on 10/17/23, 10/18/23 and 10/19/23.
-She was not made aware of falls on 10/28/23, 11/09/23 and 11/16/23.

Observation of Resident #1 on 11/29/23 at 10:09am revealed:
-A personal care aide (PCA) and the Physical Therapist (PT) assisted Resident #1 to stand from being seated in his wheelchair.
-There was an alarm box on the back of Resident #1's wheelchair that was attached to his shirt.
-The PCA disconnected the alarm from Resident #1.
-Resident #1 was unsteady and unable to stand without assistance.

Review of Resident #1's accident/incident report dated 09/17/23 revealed:
-Resident #1 fell due to an altercation with another resident at 4:10pm on 09/17/23 in the hallway.
-Resident #1 had a skin tear on his left elbow.
-Resident #1 was sent to the emergency room (ER) at 4:40pm on 09/17/23 via emergency medical services (EMS).
-Fall monitoring with increased supervision was implemented for 09/17/23 through 09/20/23.

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Review of Resident #1's ER visit notes dated 09/17/23 revealed:
-Staff reported Resident #1 fell after an altercation with another resident.
-Resident #1 went into the other resident's room and took an electronic device.
-Resident #1 had a skin tear on his left elbow and complained of left knee pain.
-Diagnoses included left elbow skin tear, injury due to altercation and fall.
-Resident #1 was discharged from the ER on 09/17/23.

Review of Resident #1's September 2023 eMAR revealed staff documented administering 8:00pm medications on 09/17/23.

Request for Resident #1's Increased Supervision & Accountability Checklist on 11/28/23 and 11/29/23, dated 09/17/23, was not provided.

Review of Resident #1's Increased Supervision & Accountability Checklist dated 09/18/23 revealed:
-The sheet had an abbreviation key for locations with 3 columns per page for staff to document location and their initials in 15 minute intervals.
-Staff documented every 15 minute checks starting at 7:00am on 09/18/23.

Based on review of Resident #1's 09/17/23 accident/incident report, eMAR documentation, and 15 minute check sheets, there were no 15 minute checks completed for the resident from his return from the ER on 09/17/23 until 7:00am on 09/18/23.

Review of Resident #1's accident/incident report dated 10/12/23 revealed:
-Resident #1 had an unwitnessed fall at 6:54pm in the dining room.

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-Resident #1 was sitting on the floor in the dining room.
-Resident #1 did not have any injury.
-Resident #1 was sent to the ER at 6:50pm on 10/12/23.
-Fall monitoring every shift was implemented for 10/12/23 through 10/15/23.
-Staff were to ensure Resident #1 had on the proper footwear.

Review of Resident #1's ER discharge instructions dated 10/12/23 revealed:
-The resident was seen for a fall and diagnosis included a closed head injury.
-Blood and urine tests, electrocardiogram and head and spine computed topography (CT) scans were done in the ER.
-Results of the testing were not included on the ER discharge instructions.

Interview with the Special Care Coordinator (SCC) on 12/01/23 at 3:00pm revealed:
-Resident #1 had two falls on 10/12/23, one at 3:10pm and one at 6:45pm.
-There was no documentation of 15 minute checks initiated after the first fall on 10/12/23 at 3:10pm.

Review of Resident #1's October 2023 eMAR revealed staff documented administering 8:00am and 8:00pm medications on 10/13/23.

Request for Resident #1's accident/incident report on 11/28/23 and 11/29/23, dated 10/12/23 at 3:10pm, was not provided

Request for Resident #1's Increased Supervision & Accountability Checklist on 11/28/23 and 11/29/23, dated 10/13/23, was not provided.

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D 270	Continued From page 51 Review of Resident #1's Increased Supervision & Accountability Checklist dated 10/14/23 revealed staff documented 15 minute checks starting at 7:00am on 10/14/23. Based on review of Resident #1's 10/12/23 accident/incident report, eMAR documentation, interviews with Guardian and SCC, and 15 minute check sheets, there were no every 15 minute checks completed for the resident after the first fall on 10/12/23 at 3:10pm through 7:00am on 10/14/23. Review of Resident #1's accident/incident report dated 10/18/23 revealed: -Resident #1 had an unwitnessed fall in his bedroom. -Resident #1 was found sitting on the floor at 10:35am on 10/17/23. -Resident #1 did not have any injury. -Fall monitoring every shift was implemented for 10/18/23 through 10/21/23. -An order for a call bell (pendant) was going to be requested. Request for Resident #1's Increased Supervision & Accountability Checklist on 11/28/23 and 11/29/23, dated 10/17/23 was not provided. Review of Resident #1's accident/incident report dated 10/18/23 revealed: -Resident #1 had an unwitnessed fall in the dining room. -He was lying on his right side on the dining room floor at 10:30am on 10/18/23. -Resident #1 did not have any injury. -Resident #1 was sent to the ER at 1:00pm on 10/18/23. -Fall monitoring every shift was implemented for 10/18/23 through 10/21/23.	D 270		

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-A chair alarm was implemented.

Interview with the Special Care Coordinator (SCC) on 11/30/23 at 12:34pm revealed:
-On 10/18/23, Resident #1 fell in the kitchen.
-At first staff did not know he hit his head, then staff saw swelling coming on the right side of his head.

Review of Resident #1's ER discharge instructions dated 10/18/23 revealed:
-The resident was seen and diagnoses included a fall and traumatic head injury.
-Blood tests and head and spine CT scans were done in the ER.
-Results of the testing were not included on the ER discharge instructions.

Review of Resident #1's Increased Supervision & Accountability Checklist dated 10/18/23 revealed:
-Staff documented Resident #1 was in the dining room from 7:00am until 10:30am.
-Staff documented Resident #1 was in the bathroom at 10:45am, and then in the living room from 11:00am until 12:15pm.
-Staff documented Resident #1 was in the living room at 1:00pm and the hospital at 1:15pm.

Based on review of Resident #1's 10/18/23 accident/incident report, eMAR documentation, and 15 minute check sheets, there were no 15 minute checks completed for the resident after the fall on 10/17/23 through 7:00am on 10/18/23.

Review of Resident #1's accident/incident report dated 10/19/23 revealed:
-Resident #1 fell in the dining room without injury at 12:50pm on 10/19/23.
-Resident #1 was on the floor on his right side.
-There was no documentation of injury or

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complaint of pain.
-Resident #1 was sent to the ER via EMS at 1:24pm on 10/19/23.
-Resident #1 was placed on fall monitoring and increased supervision for 10/19/23 - 10/22/23.

Review of Resident #1's ER visit notes dated 10/19/23 revealed:
-Resident #1 presented after being found sitting on the floor, slipping out of his wheelchair.
-Resident #1 complained of mild dizziness and low back pain.
-CT scan of Resident #1's spine showed two fractures along Resident #1's spine.
-Resident #1 was to follow up as an outpatient with orthopedics for a lumbar brace as needed for comfort.

Review of Resident #1's Increased Supervision & Accountability Checklist dated 10/19/23-10/20/23 revealed staff documented 15 minute checks from 7:00am on 10/19/23 until 6:45am on 10/20/23.

Request for Resident #1's Increased Supervision & Accountability Checklist on 11/28/23 and 11/29/23, dated 10/20/23 and 10/21/23, were not provided.

Review of Resident #1's progress note dated 10/28/23 at 6:25am revealed:
-There was a TeleTriage visit note documenting a call from staff.
-Staff reported Resident #1 was found on the kitchen floor without injury.
-The time of the fall was not documented.

Review of Resident #1's progress note dated 10/28/23 at 6:55pm revealed:
-Resident #1 fell at 2:00pm.

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-There were no details of the fall such as location and evidence of injury included.

Request for Resident #1's accident/incident reports on 11/28/23 and 11/29/23, dated for 10/28/23, were not provided.

Review of Resident #1's Increased Supervision & Accountability Checklist dated 10/29/23 revealed staff documented 15 minute checks beginning at 7:00am on 10/29/23.

Second interview with the SCC on 12/01/23 at 3:00pm revealed:
-She could not confirm how many falls Resident #1 had on 10/28/23 because the documentation was not clear.
-There was no documentation of 15 minute checks initiated on 10/28/23 after the fall documented at 6:25am or after the second fall at 2:00pm.
-She did not know if staff checked Resident #1 every 15 minutes on 10/28/23 after the first fall (prior to the second fall) or immediately following the second fall.

Review of Resident #1's primary care provider (PCP) visit note dated 10/31/23 revealed:
-Resident #1 was a high fall risk, in a wheelchair, taking blood thinning medication and required close monitoring.
-Resident #1 would benefit from a higher level of care/skilled nursing due to declining health, high fall risk and recurrent falls resulting in injuries.
-Resident #1 had a fall on 10/19/23 resulting in a closed spinal fracture and ER visit with a pending orthopedic referral appointment.
-Resident #1 had another fall on 10/28/23.

Review of Resident #1's accident/incident report

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dated 11/09/23 revealed:
-Resident #1 had an unwitnessed fall in his bedroom.
-Resident #1 was found sitting on the floor at 6:30am on 11/09/23.
-Resident #1 did not have an injury.
-Fall monitoring was implemented from 11/09/23 - 11/12/23.
-A bed alarm was implemented.

Review of Resident #1's Increased Supervision & Accountability Checklist dated 11/08/23 - 11/09/23 revealed:
-Staff documented Resident #1 was in his bedroom from 11:00pm on 11/08/23 until 5:45am on 11/09/23.
-Staff documented Resident #1 was in the living room from 6:00am until 6:45am.
-Staff documented Resident #1 was in his bedroom from 7:00am until 2:00pm on 11/09/23.

Based on review of Resident #1's 11/09/23 accident/incident report and 15 minute check sheet, there was a discrepancy in the resident's documented location (bedroom verses living room) at 6:30am.

Review of Resident #1's accident/incident report dated 11/16/23 revealed:
-Resident #1 had a witnessed fall in the living room.
-Resident #1 was sitting on the floor in front of his wheelchair at 9:50am on 11/16/23.
-Resident #1 did not have an injury.
-There was no documentation of the details on how the resident got from his wheelchair to sitting on the floor.
-Fall monitoring was implemented from 11/16/23 - 11/19/23.
-A snack was to be offered at high-risk times.

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Review of Resident #1's Increased Supervision & Accountability Checklist dated 11/16/23 revealed:
-Staff documented Resident #1 was in his bedroom from 7:00am until 11:15am.
-Staff documented Resident #1 was in the living room from 11:30am until 12:15pm.

Based on review of Resident #1's 11/16/23 accident/incident report and 15 minute check sheet, there was a discrepancy in the resident's documented location (bedroom verses living room) at 9:50am.

Review of Resident #1's accident/incident report dated 11/24/23 revealed:
-Resident #1 was unresponsive while sitting at a table in the dining room at 1:00pm on 11/24/23.
-Resident #1 was sent to the ER at 1:03pm on 11/24/23 via EMS.
-Monitoring every shift from 11/24/23 through 11/27/23 was implemented.

Review of Resident #1's Increased Supervision & Accountability Checklist dated 11/24/23 revealed:
-Staff documented Resident #1 in the dining room from 12:45pm until 1:15pm.
-Staff documented Resident #1 was in the living room at 1:30pm and 1:45pm.
-Staff documented Resident #1 was in the bathroom from 2:00pm until 2:30pm.
-Staff documented Resident #1 was in the living room from 2:45pm until 4:15pm.
-There was no documentation Resident #1 was sent to the hospital.

Based on review of Resident #1's 11/24/23 accident/incident report and 15 minute check sheet, there was a discrepancy in the resident's documented location (facility verses hospital)

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from 1:30pm until 4:15pm.

Interview with Resident #1 on 11/30/23 at 1:20pm revealed:
-He sometimes felt dizzy.
-He was very tired.

Interview with the Special Care Coordinator (SCC) on 11/28/23 at 2:54pm revealed Resident #1 was moved from room 615 to room 603 one month ago to be closer to the desk because he had a lot falls.

Interview with a personal care aide (PCA) on 11/30/23 at 11:30am revealed:
-Resident #1 was able to stand from his wheelchair.
-She had not seen him walk since he started using the wheelchair about a month ago.
-She was not sure if Resident #1 was able to walk.

Second interview with a PCA on 11/30/23 at 12:18pm revealed:
-Resident #1 started having a lot of falls and the former SCC told staff to keep him in the wheelchair.
-They watched Resident #1 by keeping him in the living room seated in his wheelchair.

Interview with a medication aide (MA)/PCA on 11/29/23 at 2:31pm revealed:
-Normally residents were placed on every 15-minute checks after a fall or if they were on antibiotics.
-She thought Resident #1 was placed on 15-minute checks indefinitely around 11/22/23.
-She did not know how there were discrepancies documented on accident/incident reports and 15 minute check sheets for Resident #1.

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Telephone interview with Resident #1's primary care provider (PCP) on 11/30/23 at 4:21pm revealed:
-Staff should document care in accordance with care provided.
-Not documenting the 15-minute checks was a serious concern.
-Staff were responsible for checking Resident #1 every 15 minutes and ensuring his bed/chair alarm was properly attached.
-The alarm should sound as soon as Resident #1 got up for staff to respond.
-She had talked to the staff on 11/28/23 and reinforced all fall prevention measures for Resident #1.
-She had mentioned to staff that Resident #1 needed to be monitored more closely.
-It was not safe for Resident #1 to fall so frequently.
-She thought Resident #1 still needed a higher level of care because he was a high fall risk, on a blood thinner for atrial fibrillation and had decreased mobility requiring a wheelchair.

Second telephone interview with Resident #1's Guardian on 11/30/23 at 11:06am revealed:
-She was not notified of the primary care provider's (PCP's) recommendation for a higher level of care on 10/31/23.
-As Resident #1's Guardian, she should have been notified.

Interview with the Special Care Coordinator (SCC) on 11/30/23 at 12:34pm revealed:
-The PCP said medications could be contributing to Resident #1's falls by causing a low blood pressure.
-Resident #1 would stand up and fall, bend forward in his chair and fall.

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D 270	Continued From page 59 -She thought Resident #1 could have been dizzy or lightheaded when he fell. -Resident #1 was moved closer to the front desk because of the increased falls. -She was aware of the PCP's recommendation for a higher level of care. -Nothing had been done to evaluate Resident #1's level of care needs. -It was the Administrator's responsibility to follow up on that. -The PCP told the Administrator and her about the evaluation for a higher level care for Resident #1 on the same day (10/31/23) that she saw the resident. Interview with the Administrator on 12/01/23 at 4:15pm revealed: -Staff were responsible for checking residents as assigned and when needed for safety and location. -Staff were responsible for documenting accurately on monitoring sheets. -Increased supervision was implemented after each fall for Resident #1 which was the facility's policy for fall prevention. -She did not know there were discrepancies in documented the location of falls between accident/incident reports and every 15 minute check sheets. 2. Review of Resident #4's current FL-2 dated 09/19/23 revealed: -Diagnoses included dementia, hypertension, and chronic kidney disease. -Resident #4 was constantly disoriented. -Resident #4 was non-ambulatory and had bowel and bladder incontinence. -There was an order to check the bed/chair alarm and seatbelt placement and functioning every shift.	D 270		

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Review of Resident #4's current care plan dated 12/08/22 revealed:
-Resident #4 was always disoriented and had significant memory loss.
-Resident #4 had wandering and verbally abusive behaviors.
-Resident #4 resisted care at times.
-Resident #4 was ambulatory with a wheelchair and had a seatbelt restraint and chair alarm.
-Resident #4 was a fall risk and remained on increased supervision (unspecified frequency).
-Resident #4 required extensive assistance with toileting and incontinence care.
-Resident #4 required limited assistance with ambulation and transfers.

Review of Resident #4's quarterly special care unit (SCU) profile dated 10/03/23 revealed:
-Resident #4 had behaviors including verbal abuse, screaming, aggression and uncooperative.
-Resident #4 was ambulatory with a wheelchair and required staff assistance.
-Resident #4 required staff assistance with transfers in and out of her wheelchair.

Review of Resident #4's restraint consent, care plan and order dated 10/30/23 revealed:
-There was an order for a wheelchair belt while up in the wheelchair.
-The wheelchair belt was to be checked every 30 minutes and released every 2 hours.
-Alternatives tried before implementing the wheelchair belt was increased supervision.

Observation of Resident #4 on 11/28/23 at 9:12am revealed she was seated in her wheelchair with a seatbelt secured around her waist in the living room.

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Observation of Resident #4 on 11/28/23 at 2:48pm revealed she was in the living room seated in her wheelchair with a seatbelt secured around her waist and an alarm box on the chair and attached to her shirt.

Interview with a personal care aide (PCA) on 11/28/23 at 2:48pm revealed Resident #4 had a seatbelt to keep her from falling.

Observation of Resident #4 on 12/01/23 at 2:55pm revealed:
-She was propelling her wheelchair with her feet in the hallway near the front desk.
-Her seatbelt was on.

Review of Resident #4's accident/incident report dated 09/14/23 revealed:
-Resident #4 had an unwitnessed fall.
-Resident #4 was laying on the floor beside her bed at 6:00am on 09/14/23.
-Resident #4 had a scratch on her forehead.
-Monitoring every shift from 09/14/23 through 09/17/23 was implemented.
-Staff were informed to ensure Resident #4 was positioned safely in bed and the bed alarm was attached.

Review of Resident #4's Increased Supervision & Accountability Checklist sheet dated 09/13/23-09/14/23 revealed:
-There was no documentation from 1:30am on 09/14/23 to 2:45am on 09/14/23.
-Staff documented Resident #4 was in her bedroom from 3:00am until 5:30am.
-Staff documented Resident #4 was in the hallway from 5:45am to 6:45am.

Review of Resident #4's Increased Supervision &

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Accountability Checklist sheet dated 09/14/23 revealed there was no documentation from 3:15pm to 10:45pm.

Review of Resident #4's Increased Supervision & Accountability Checklist sheet dated 09/15/23 revealed there was no documentation from 3:30pm to 5:00pm.

Based on review of Resident #4's 09/13/23 - 09/15/23 accident/incident report and 15 minute check sheets, there was a discrepancy in the resident's documented location (bedroom verses hallway) at 6:00am and no documentation of 15 minute checks for 7.5 hours on 09/14/23 and 1.5 hours on 09/15/23.

Review of Resident #4's accident/incident report dated 10/28/23 revealed:
-Resident #4 had an unwitnessed fall in the hallway.
-Resident #4 was laying on her left side on the floor at 11:50am on 10/28/23.
-Resident #4 had no injury.
-Monitoring every shift from 10/28/23 through 10/31/23 was implemented.
-There was an evaluation note for a seatbelt check (unspecified).

Review of Resident #4's Increased Supervision & Accountability Checklist sheet dated 10/28/23 revealed:
-Staff documented Resident #4 was in the living room from 10:15am until 12:00pm.
-Staff documented Resident#1 was in the dining room from 12:15pm until 12:45pm.
-Staff documented Resident #4 was in the living room from 1:00pm until 3:00pm.
-There was no documentation Resident #4 was in the hallway from 10:15am to 3:00pm.

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Based on review of Resident #4's 10/28/23 accident/incident report and 15 minute check sheet, there was a discrepancy in the resident's documented location (hallway verses living room) at 11:50am.

Review of Resident #4's accident/incident report dated 11/05/23 revealed:
-Resident #4 had an unwitnessed fall in her bedroom.
-Resident #4 was laying on her right side on her bathroom floor at 3:50am on 11/03/23.
-Resident #4 had no injury.
-Monitoring every shift from 11/05/23 through 11/08/23 was implemented.
-There was an evaluation note to reassure call bell pendant was attached to resident at all times.

Review of Resident #4's Increased Supervision & Accountability Checklist sheet dated 11/02/23-11/03/23 revealed:
-Staff documented Resident #4 was in her bedroom from 11:00pm on 11/02/23 until 2:15am on 11/03/23.
-Staff documented Resident #4 was on the bathroom floor at 2:30am.
-Staff documented Resident #4 was in her wheelchair from 2:45am until 6:45am on 11/03/23.

Review of Resident #4's Increased Supervision & Accountability Checklist sheet dated 11/03/23 revealed there was no documentation from 3:00pm to 3:30pm.

Based on review of Resident #4's 11/02/23 - 11/05/23 accident/incident report and 15 minute check sheets, there was a discrepancy in the resident's documented location (wheelchair

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verses bedroom) at 3:50am and no documentation of 15 minute checks for 0.5 hours on 11/03/23.

Review of Resident #4's accident/incident report dated 11/25/23 revealed:
-Resident #4 had an unwitnessed fall in hallway.
-Resident #4 was laying on the floor on her right side at 6:30pm on 11/25/23.
-Resident #4 had a skin tear on her left leg.
-Monitoring every shift from 11/25/23 through 11/28/23 was implemented.
-There was an evaluation note for wheelchair maintenance.

Review of Resident #4's Increased Supervision & Accountability Checklist sheet dated 11/25/23 revealed:
-Staff documented Resident #4 was in the dining room from 5:30pm until 6:00pm.
-Staff documented Resident #4 was in the living room from 6:15pm until 7:15pm.
-Staff documented Resident #4 was in her bedroom after 7:30pm.

Based on review of Resident #4's 11/25/23 accident/incident report and 15 minute check sheet, there was a discrepancy in the resident's documented location (hallway verses living room) at 6:30pm.

Review of Resident #4's accident/incident report dated 11/27/23 revealed:
-Resident #4 had an unwitnessed fall in hallway at 4:00pm on 11/27/23.
-The report was incomplete and did not include a description of the fall and presence of any injury.
-There was a note to implement proper footwear checks.

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Interview with a PCA on 11/30/23 at 11:30am revealed:
-She had never seen Resident #4 remove her seatbelt and she did not think the resident was able to.
-Resident #4 could get up and stand if the seatbelt were not in place.

Second interview with a MA/PCA on 12/01/23 at 2:55pm revealed:
-Resident #4 wore her seatbelt all the time when she was out of bed.
-She did not think the resident could unbuckle the seatbelt.
-She was able to propel her wheelchair in halls using her feet.
-When a resident fell, MAs were responsible for implementing fall monitoring and 15-minute checks.
-MAs communicated the 15 minute checks to staff on duty.
-Outgoing staff verbally told the oncoming shift when every 15 minute checks were implemented.
-The Special Care Coordinator (SCC) or the Administrator implemented any other fall prevention interventions.

Interview with a MA on 12/01/23 at 2:55pm revealed:
-She had seen Resident #4 unbuckle the seatbelt on her wheelchair in the past.
-She did not remember how long ago.

Telephone interview with Resident #4's primary care provider (PCP) on 11/30/23 at 4:21pm revealed he did not understand how a resident with a seatbelt in use continued to fall out of her chair.

Interview with the SCC on 12/01/23 at 3:00pm

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revealed:
-Resident #4's last 2 falls (11/25/23 and 11/27/23) involved her flipping her wheelchair over while she was down the hall.
-Staff reported to her that the seatbelt on Resident #4's wheelchair was not buckled.
-She thought a staff might have taken Resident #4 to the bathroom and forgotten to buckle the seatbelt.
-Resident #4 had daily documentation of 15 minute checks from 05/01/23 through 11/28/23 because staff did not pay attention to when 72 hour documentation was complete.
-Resident #4's restraint monitoring was documented every 30 minutes by the MA in the electronic charting system.

Interview with the Administrator on 12/01/23 at 4:15pm revealed:
-Staff were responsible for checking residents as assigned and when needed for safety and location.
-All residents on the Special Care Unit (SCU) were checked every 30 minutes.
-Residents were placed on increased supervision after a fall and were checked every 15 minutes.
-Staff were responsible for documenting accurately on monitoring sheets.
-Increased supervision was implemented after each fall Resident #4 which was the facility's policy for fall prevention.
-She did not know there were discrepancies in documented the location of falls between accident/incident reports and every 15 minute check sheets.
-Sometimes Resident #4 was able to unlock the seatbelt on her wheelchair if she was in the hallway.
-Staff were expected to ensure bed alarms were on and working properly.

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Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.

____

The facility failed to provide supervision for 2 of 5 sampled residents (#1, and #4) who required increased supervision for repeated falls with injuries. Resident #1 sustained two spinal fractures and traumatic head injury. This failure resulted in risk for serious physical harm which constitutes a Type A2 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/01/23 for this violation.

THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 31, 2023.

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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 B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure health care follow up with the provider for 4 of 5 sampled residents (#1, #2, #3, #4) who required monthly blood levels for monitoring and dosage adjustment of an anticoagulant (blood thinning) medication (#3), contacting the home health agency for acute wound care, reporting of low

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blood pressures to the provider and scheduling an orthopedic referral appointment following a lumbar fracture (#1), reporting of high blood pressure results outside the ordered parameter (#4) and coordinating nail care for a diabetic resident whose fingernails were long, jagged, and needed trimming (#2).

The findings are:

1. Review of Resident #3's current FL-2 dated 03/10/23 revealed:
-Diagnoses included history of placement of prosthetic heart valve, anticoagulation and history of CVA (cerebral vascular accident).
-There was an order for Warfarin 10mg, 1 tablet by mouth every evening. (Warfarin is a medication used to treat or prevent blood clots.)

Review of Resident #3's physician's order dated 08/28/23 revealed an order for Warfarin 10mg, 1 tablet by mouth once daily except Sunday and ½ tablet (5mg) by mouth once a week on Sunday.

Review of a physician's orders dated 12/23/22 revealed there was an order to ensure the lab draws monthly for prothrombin time/international normalized ratio (PT/INR) levels. (Measures clotting time of a person's blood who is being treated with blood thinner medications.)

Review of the physician's order dated 04/25/23 revealed the target INR level was 2.5 to 3.5.

Review of Resident #3's labs dated 08/15/23 revealed the INR level dated 08/15/23 was 4.35.

Review of a physician's order sheet dated 08/17/23 revealed a telephone order to skip Resident #3's 5:00pm Warfarin dose on 08/17/23

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that was signed by the primary care provider (PCP) on 08/22/23.

Review of a physician's order dated 09/12/23 revealed:
- There was an order for INR levels to be drawn for Resident #3. (Date of the lab to be completed was not specified.)
-There was no documentation of a September 2023 INR lab in the resident's records.

Review of a fax transmission coversheet revealed the request for a lab draw to the laboratory from the facility was sent on 09/13/23.

-Review of Resident #3's labs for her INR level dated 10/10/23 revealed an INR of 3.71 (the target INR level was 2.5 to 3.5).

Review of electronic correspondence between the previous Resident Care Coordinator (RCC) and the PCP on 10/11/23 revealed the PCP was notified of the high PT/INR from 10/10/23 on 10/11/23 and advised to "skip today or tomorrow dose and then resume regular schedule."

Interview with the previous RCC on 11/30/23 at 10:55am revealed:
-She was the RCC in September 2023.
-She was responsible for sending the order for labs to the facility's contracted laboratory company.
-When the PCP sent the order for labs, she faxed the order to the facility's contracted laboratory company.
-She logged lab results in the computer once received.
-She reported abnormal labs to the PCP and normal lab results were placed in a folder for the PCP to sign off on when she visited Resident #3.

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-She was not aware the September 2023 labs were not drawn.
-No one checked behind her to ensure the labs were drawn.
-There was no process in place to alert her to follow up with the lab if labs were not drawn.

Interview with the Administrator on 11/30/23 at 11:10am revealed:
-The PCP was responsible for sending the order for INR labs to the facility.
-The RCM was responsible for sending the INR lab order to the contracted laboratory company.
-The lab staff was responsible for coming to the facility to draw blood samples for labs.
-She was not aware that the September 2023 lab was not drawn.
-There was no system in place to alert the RCM when a lab was not drawn.

Telephone interview with the PCP on 11/30/23 at 4:40pm revealed:
-She was aware of the order written for monthly INR labs and the September 2023 order for INR labs.
-She was not aware the September 2023 labs were not drawn.
-If labs were not done to get the latest INR results, the resident's level could have been out of range and the blood could have been too thin or not thin enough.
-The resident could have thrown a clot or bled out.

Attempted telephone interview with the facility's contracted laboratory company on 12/01/23 at 2:40pm was unsuccessful.

2. Review of Resident #1's current FL-2 dated 08/30/23 revealed diagnoses included

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neurocognitive disorder, atrial fibrillation, and hypertension.

a. Review of Resident #1's primary care provider (PCP) order dated 11/07/23 revealed an order for a wound care nurse for multiple wounds to Resident #1's buttocks.

Review of Resident #1's home health nurse (HHN) visit note dated 11/27/23 revealed:
-Resident #1 was seen twice weekly for wound care starting on 11/07/23.
-Resident #1 had 3 wounds on his right buttock with 25-50% granulation tissue (healthy tissue) and minimal (less than 25%) drainage.
-The date of onset for the 3 wounds on the right buttock was 11/07/23.
-Staff verbalized where to find the HHN's contact number.
-Resident #1's wounds were improving.

Review of Resident #1's home HHN visit note dated 11/29/23 revealed:
-There were two new wounds and existing wounds showed more slough (dead cells and debris) than granulation.
-The HHN contacted Resident #1's PCP and received new wound care orders.
-Staff were educated to call the HHN of the dressing came off.
-There was a new stage II pressure ulcer on Resident #1's left lower buttock with date of onset on 11/29/23.
-The three existing right buttock wounds had 10% granulation tissue and moderate (wet 25-75%) drainage.
-There were no documented details of the second new wound.

Telephone interview with the HHN on 12/01/23 at

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10:51am revealed:
-She had educated staff several times to call the home health agency and "several many" times she has found that there was no dressing in place when she came to do scheduled wound care.
-She saw Resident #1 regularly for scheduled wound care visits.
-The wounds on Resident #1's buttocks started as boils that were hard and angry looking with a significant amount of hot redness.
-The wounds opened, and the redness decreased.
-There was some improvement of Resident #1's buttocks wounds when she saw him on Monday (11/27/23), but the wounds had worsened when she saw him on Wednesday (11/29/23).
-She found two new open wounds on Wednesday (11/29/23).
-The new wounds were located on the lower buttocks bilaterally near the thigh.
-The existing wounds had pink granulation tissue on Monday (11/27/23) and on Wednesday (11/29/23) the existing wounds had yellow slough.
-Staff were instructed to call when the dressing came off, was loose or soiled.
-A HHN would come out to the facility and replace the dressing.
-She did not know of any occasion of staff calling to report a loose, soiled, or missing dressing.

Observation of Resident #1 on 11/29/23 at 10:09am revealed:
-There was a cushioned dressing on Resident #1's left buttock.
-There was generalized deep redness to both buttocks and a foul odor.
-There were 3 open wounds on the right buttock that were not covered with a dressing.
-All 3 wounds had smooth, macerated (softening due to extended exposure to moisture) edges

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and moist yellow tissue inside the wounds.
-The wound at the top of the buttock was approximately the size of a quarter.
-The wound at the middle of the buttock was approximately the size of a nickel.
-The wound at the bottom of the buttock near the thigh was approximately the size of a dime (new according to HHN visit note).

Observation of Resident #1 on 11/30/23 at 11:46am revealed:
-There was a cushioned dressing on Resident #2's right buttock.
-There was a large purple and yellow bruise on the resident's left buttock (covered by cushioned dressing on 11/29/23).
-There was an open wound approximately the size of a dime at the bottom of Resident #1's left buttock near the thigh (new according to interview on 12/01/23 with the HHN and not seen on 11/29/23).
-There was yellow tissue inside the wound, no odor and less general redness than on the right buttock seen 11/29/23.

Interview with a personal care aide (PCA) on 11/30/23 at 11:43am revealed she did not know if staff were supposed to put a dressing on the resident if the one placed by the HHN had come off.

Interview with a medication aide (MA)/PCA on 11/30/23 at 11:35am revealed:
-Resident #1's wounds on his buttocks were managed by the HHN.
-There were no specific orders or instructions for wound care if the dressing placed by the HHN was loose, soiled or off.
-She kept the wound clean.
-There were dressing supplies to put on the

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wound if needed but she had never had to put a clean dressing on Resident #1.
-She had not seen his wounds since the HHN started managing them.

Interview with the Special Care Coordinator (SCC) on 11/30/23 at 11:43am revealed:
-Staff were responsible for calling the HHN if the dressing on Resident #1's buttocks was off, lose or soiled.
-There were supplies to clean the wound and cover it while awaiting the HHNs arrival.
-The HHN changed the dressing to Resident #1's buttocks on 11/29/23.

Telephone interview with Resident #1's PCP on 11/30/23 at 4:21pm revealed:
-She saw Resident #1's wounds on 11/07/23.
-There was an infection and she treated Resident #1 with oral and topical antibiotics and had home health see him for wound care.
-The wounds had improved since 11/07/23, with decreased redness and the infection was cleared when she saw the wounds on 11/28/23.

Interview with the Administrator on 12/01/23 at 4:15pm revealed:
-If a resident was kept sitting for safety reasons, she expected staff to offer a pillow to sit on, check the resident buttocks with incontinence care, and report any redness or changes immediately to the SCC.
-MAs were responsible for contacting the HHN with any concerns related to the dressing.
-The PCP should be contacted for wound care orders in the absence of the HHN.

b. Review of Resident #1's primary care provider (PCP) order dated 10/19/23 revealed:
-An order to check the resident's blood pressure

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daily for 10 days.
-An order to notify the provider for systolic blood pressure less than 90 or greater than 180 and a diastolic blood pressure less than 50 or greater than 100.

Review of Resident #1's PCP triage visit note dated 10/25/23 revealed:
-There was an order to check vital signs every shift.
-There was an order to monitor for acute changes and follow up with the PCP.

Review of Resident #1's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for blood pressure checks daily for 10 days from 10/20/23 through 10/29/23.
-The entry included an order to notify the PCP if the systolic blood pressure was less than 50 or greater than 180, or the diastolic blood pressure was less than 50 or greater than 100.
-On 10/27/23, the blood was documented as 80/58.
-There was no documentation the PCP was notified.

Review of Resident #1's November 2023 eMAR revealed:
-There was an entry for vital signs every shift.
-Vital signs were scheduled for 7:00am-3:00pm, 3:00pm-11:00pm, and 11:00pm-7:00am.
-Staff documented vital signs results from 11/01/23 through 11/28/23 except second shift on 11/24/23 due to the resident being at the hospital.
-On 11/24/23, the blood pressure was documented as 81/66.
On 11/27/23, the blood pressure was documented as 89/66.
-There were no reporting parameters included in

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the entry to check vital signs every shift.
-There was no documentation the PCP was notified.

Review of Resident #1's electronic progress notes dated 10/26/23 through 11/28/23 revealed there was no documentation the PCP was notified of Resident #1's blood pressure results on 10/27/23, 11/24/23 and 11/27/23.

Interview with a medication aide (MA)/personal care aide (PCA) on 11/29/23 at 2:31pm revealed:
-She did not notify the PCP of Resident #1's blood pressure results on 10/27/23, 11/24/23, and 11/27/23 because there was no order to notify the PCP.
-She did not see the parameters to notify the PCP on the October 2023 eMAR.

Review of Resident #1's accident/incident report dated 11/24/23 revealed:
-Resident #1 was unresponsive while sitting at a table in the dining room at 1:00pm on 11/24/23.
-Resident #1 was sent to the emergency room (ER) at 1:03pm on 11/24/23 via Emergency Medical System (EMS).
-Resident #1's blood pressure was documented as 151/63.
-Monitoring every shift from 11/24/23 through 11/27/23 was implemented.

Review of Resident #1's ER discharge instructions dated 11/24/23 revealed the resident was seen for altered mental status, his blood pressure was 119/76 and diagnosis included unresponsiveness.

Telephone interview with a PCA on 12/01/23 at 5:49pm revealed:
-Resident #1 was sitting at the table in the dining

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room.
-His eyes were open, but he did not respond to staff.
-The MA called EMS.
-She did not know anything else about what happened to Resident #1 on 11/24/23.

Telephone interview with a MA/PCA on 12/01/23 at 5:18pm revealed:
-She was at the medication cart when a PCA told her Resident #1 was unresponsive on 11/24/23 after breakfast.
-Resident #1 did not respond when she called his name.
-She checked Resident #1's vital signs but could not remember if there were abnormal results.
-She reported Resident #1 being unresponsive to the Special Care Coordinator (SCC) and she told her to send him to the emergency room (ER).

Telephone interview with Resident #1's PCP on 11/30/23 at 4:21pm revealed:
-She did not know if she had been notified of low blood pressure results for Resident #1 on 10/27/23, 11/24/23 and 11/27/23 because she did not have access to the resident's electronic office record.
-On 11/24/23 her triage office was only notified Resident #1 was unresponsive and sent to the emergency room.
-She often did not receive an accurate accounting of what was going on with a resident including the details of what happened.

Interview with the SCC on 12/01/23 at 3:00pm revealed:
-On 11/24/23, lunch was starting and Resident #1 was awake but did not make eye contact or respond to verbal prompts.
-She did not know Resident #1's blood pressure

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on first shift that day was 81/66.
-A normal systolic blood pressure was 120-130.
-Low systolic blood pressures could make the resident weak and the blood pressure could drop lower when the resident stood up causing a fall.

Interview with the Regional Nurse on 12/01/23 at 5:05pm revealed:
-She completed clinical skills validation for staff.
-She reviewed normal blood pressures of 120-130/80-90.
-She instructed staff to report anything greater than 140/90.
-A systolic blood pressure less than 90 was low.
-PCAs were taught to report systolic blood pressures lass than 90 to the MA or SCC.
-MAs were responsible for reporting to the SCC or the PCP.
-The SCC should catch when no parameter was written when the order was entered in the electronic charting system.

Interview with the Administrator on 12/01/23 at 4:15pm revealed:
-MAs were responsible for checking ordered parameters.
-The SCC was responsible for follow up with the PCP if there were no written parameters with orders to check vital signs.
-The facility did not have a policy on reporting higher or lower than normal blood pressure results.
-MAs and the SCC were responsible for printing vital sign reports and placing it in the PCP's visit folder for review.
-The PCP signed the report, and it was scanned into the resident's electronic record.
-Resident #1 was sent to the ER on 11/24/23 because his blood pressure was low.
-EMS no longer left a copy of their reports with

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facility staff.

Upon request on 12/01/23, PCP signed vital signs reports for Resident #1's were not provided for review.

c. Review of Resident #1's ER visit notes dated 10/19/23 revealed:
-Resident #1 presented after being found sitting on the floor, slipping out of his wheelchair.
-Resident #1 complained of mild dizziness and low back pain.
-Computed topography (CT) scan of Resident #1's spine showed two fractures to his lower spine.
-Resident #1 was to follow up as an outpatient with orthopedics for a lumbar brace as needed for comfort.

Review of Resident #1's primary care provider (PCP) order dated 10/24/23 revealed an order for referral to an orthopedic service provider due to lower spine fractures due to a fall.

Telephone interview with Resident #1's Guardian on 11/29/23 at 12:58pm and 2:51pm revealed she did not know anything about a referral to an orthopedic provider on 10/24/23.

Interview with a medication aide (MA)/personal care aide (PCA) on 11/29/23 at 2:31pm revealed:
-The PCP usually had referrals sent from her office.
-She could not remember if Resident #1 was seen by an orthopedic provider.

Interview with the Special Care Coordinator (SCC) on 11/30/23 at 12:34pm revealed:
-She sent the referral to the orthopedic office on 10/27/23.

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-She had not heard back from them.
-She did not call and follow up on the appointment.
-She did not notify the PCP of the delay on getting the orthopedic appointment scheduled for Resident #1.

Telephone interview with Resident #1's PCP on 11/30/23 at 4:21pm revealed:
-She did not know Resident #1 was not seen by an orthopedic provider for the lumbar fracture ordered on 10/24/23.
-Staff were responsible for scheduling referral appointments based on the facility wide schedule.
-Based on Resident #1's age and physical condition, the orthopedic provider would likely have evaluated him for a brace for comfort if needed.

Interview with the Administrator on 12/01/23 at 4:15pm revealed:
-The SCC was responsible to follow up within 48 hours if there was no response to forwarded referral information.
-She did not know the SCC did not follow up on the orthopedic referral for Resident #1.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

3. Review of Resident #4's current FL-2 dated 09/19/23 revealed:
-Diagnoses included dementia, hypertension, and chronic kidney disease.
-There was an order for carvedilol 6.25mg twice daily, call for heart rate greater than 100/systolic blood pressure greater than 180.

Review of Resident #4's September 2023

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electronic medication administration record (eMAR) revealed:
-There was an entry for carvedilol 6.25mg twice daily - call for heart rate greater than 100, systolic blood pressure greater than 180 scheduled at 8:00am and 8:00pm.
-The heart rate was documented greater than 100 on 09/04/23 at 8:00am (112), 8:00pm (110), 09/07/23 at 8:00am (102), and 09/09/23 at 8:00am (110).
-The systolic blood pressure was documented greater than 180 on 09/10/23 at 8:00am (184/78), 09/14/23 at 8:00am (184/74), 09/24/23 at 8:00pm (185/69), 09/25/23 at 8:00pm (185/83), and 09/29/23 at 8:00pm (186/91).
-There was no documentation the primary care provider (PCP) was called.

Review of Resident #4's October 2023 eMAR revealed:
-There was an entry for carvedilol 6.25mg twice daily - call for heart rate greater than 100, systolic blood pressure greater than 180 scheduled at 8:00am and 8:00pm.
-The systolic blood pressure was documented greater than 180 on 10/04/23 at 8:00am (186/72) and 10/28/23 at 8:00pm (184/86).
-There was no documentation the PCP was called.

Review of Resident #4's November 2023 eMAR revealed:
-There was an entry for carvedilol 6.25mg twice daily - call for heart rate greater than 100, systolic blood pressure greater than 180 scheduled at 8:00am and 8:00pm.
-There was no documented heart rate greater than 100 or systolic blood pressure greater than 180.

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Review of Resident #4's electronic progress notes dated 08/16/23 through 10/31/23 revealed there was no documentation Resident #4's PCP was notified of heart rate and blood pressure results outside the ordered parameters on 09/04/23, 09/07/23, 09/09/23, 09/10/23, 09/14/23, 09/24/23, 09/25/23, 09/29/23, 10/04/23, and 10/28/23.

Interview with the Special Care Coordinator (SCC) on 12/01/23 at 4:05pm revealed:
-She had documented Resident #4's blood pressure on 10/04/23.
-She should have notified the PCP.
-Normally she documented notifying the PCP in telemed electronic communication app.
-She could not find documentation that she notified the PCP.
-She did not realize there was an entry on the eMAR to document a parameter note.

Telephone interview with Resident #4's PCP on 11/30/23 at 4:21pm revealed:
-She did not have access to the office notes for Resident #4 and could not say if she was notified of Resident #4's systolic blood pressures greater than 180.
-She expected staff to notify her when there were written parameters to notify her.
-If she was not notified, then there was no recheck and follow up with medication changes.
-Systolic blood pressures greater than 180 could lead to an aneurysm or stroke.

Interview with the Administrator on 12/01/23 at 4:15pm revealed:
-MAs were responsible for checking ordered parameters and following written orders to report blood pressure results.
-She did not know systolic blood pressures

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D 273	Continued From page 83 greater than the written parameter of 180 for Resident #4 were not reported to the PCP. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. 4. Review of Resident #2's current FL-2 dated 08/15/23 revealed: -Diagnoses included vascular dementia without disturbance, type 2 diabetes mellitus with specified complications, chronic diastolic congestive heart failure, chronic anemia without bleeding, hypoxia, aspiration pneumonia of right lower lobe, bacteremia, and history of gout. -The resident was constantly disoriented. -The resident was semi-ambulatory. -The resident was incontinent of bowel and bladder. -The resident required assistance with bathing, dressing, and feeding. -The resident was documented as having wandering behavior. Review of Resident #2's Special Care Unit (SCU) resident profile and care plan dated 10/04/23 revealed: -The resident was incontinent and required staff assistance for toileting needs and hygiene. -Staff would provide hands-on assistance to perform hygiene and cleaning up after incontinent episodes. -The resident required limited assistance with bathing. -Staff would provide showers and sponge baths to ensure the resident was clean and report any skin changes. -The resident required limited assistance with grooming and hygiene. -Staff would provide grooming including nail and	D 273		

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hair care every shift.

Observation of Resident #2 during tour of the facility on 11/28/23 at 2:20pm revealed:
-Resident #2 was sitting in a chair.
-The resident's fingernails on both hands were ¼ - ½ inches long, jagged with sharp edges, and yellow.
-There was a substance with some brown debris underneath all the resident's fingernails.

A second observation of Resident #2 on 11/30/23 at 12:36pm revealed:
-Resident #2 was lying in bed on his back.
-The resident's fingernails on both hands were still ¼ - ½ inches long, jagged with sharp edges, and yellow.
-There was still a substance with some brown debris underneath all the resident's fingernails.

Interview with a personal care aide (PCA) on 11/30/23 at 12:38pm revealed:
-She came to assist Resident #2 to the dining room for lunch.
-She was not sure when the resident last had a shower because he was usually bathed by second shift.
-The resident's fingernails should be cleaned when he was bathed.
-She was not sure who was responsible for trimming the resident's fingernails.

Review of Resident #2's shower skin assessments for September 2023 - November 2023 revealed:
-There was a shower skin assessment dated 09/04/23 at 2:16pm and for the question of did the resident's fingernails need to be cut, staff checked the boxes for yes and no.
-There was a shower skin assessment dated

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11/28/23 at 10:06pm noted "shower day".
-Staff documented the resident's fingernails did not need to be cut.
-There were no other shower skin assessment sheets for Resident #2 from 09/01/23 - 11/30/23.

Interview with a medication aide (MA) on 11/30/23 at 1:15pm revealed:
-The PCAs on second shift were assigned to bathe the resident.
-The PCAs were responsible for cleaning Resident #2's fingernails and filing them.
-The PCAs could not clip the resident's fingernails because he was diabetic.
-She did not know who could cut or trim the resident's fingernails.
-Resident #2's fingernails needed to be cleaned and filed.

Interview on 11/30/23 at 5:37pm with the PCA who documented the shower assessment for Resident #2 on 11/28/23 revealed:
-She was still learning how to fill out the shower assessment form.
-She had noticed Resident #2's fingernails were long and dirty but the resident would not let her clean or trim them.
-She did not document the resident refused to let her trim his fingernails because she did not know she had to document it.
-She had not notified anyone about the resident's long, dirty fingernails.
-She did not know why she did not report the resident's long fingernails to anyone.

Interview with the Special Care Coordinator (SCC) on 11/30/23 at 3:30pm revealed:
-The PCAs were responsible for doing shower assessments with each shower.
-The PCAs should be trimming and cleaning the

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resident's fingernails when the resident was bathed and anytime the fingernails were visibly long or soiled.

A second interview with the SCC on 11/30/23 at 5:18pm revealed:
-On 09/04/23, she clicked both the yes and no boxes for the resident's fingernails needed trimming.
-She trimmed the resident's fingernails on 09/04/23.
-She thought they could clip diabetic residents' fingernails but not their toenails.
-A podiatry provider usually trimmed diabetic residents' toenails.
-She checked the shower skin assessments, "less than I should".

A third observation of Resident #2 on 11/30/23 at 5:27pm revealed:
-The resident was lying in bed.
-The resident's fingernails on both hands were shorter than observed today, 11/30/23, at 12:36pm.
-The resident's fingernails were trimmed unevenly with sharp points at the center of the end of the nails.
-There was still some debris underneath the resident's fingernails.
-The middle finger of the resident's right hand had blood smeared from the right side of the fingernail halfway up the finger.

A third interview with the SCC on 11/30/23 at 5:30pm revealed:
-She had a PCA trim Resident #2's fingernails today, 11/30/23.
-It looked like the PCA cut the fingernails too close.
-She would get a band aid for the resident's

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finger.

Interview on 11/30/23 at 5:31pm with the PCA who trimmed Resident #2's fingernails on 11/30/23 revealed:
-She trimmed Resident #2's fingernails with clippers today, 11/30/23.
-She did not notice Resident #2's finger was bleeding when she trimmed his fingernails.

Interview with the Administrator on 11/30/23 at 5:50pm revealed:
-For diabetic residents, the PCAs and MAs could file their fingernails but not trim or cut them.
-The PCA should not have trimmed Resident #2's fingernails with clippers today, 11/30/23, because she was concerned about the fingernails being cut too close and causing an open wound.
-The PCAs or MAs should notify the SCC or Resident Care Coordinator (RCC) when a diabetic resident's fingernails were long and needed cutting.

Telephone interview with Resident #2's primary care provider (PCP) on 11/30/23 at 4:34pm revealed:
-The facility's PCAs and MAs should not be trimming or filing diabetic residents' fingernails because they could cut or file them too close and cause an open wound that could lead to an infection.
-The facility could get a nurse or maybe a podiatry provider to trim the resident's fingernails.

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

____

The facility failed to ensure health care referral an follow-up for 4 sampled residents. Resident #3

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did not have labwork drawn as ordered in September 2023 to ensure the resident's blood thinning medication was in therapeutic range putting the resident at risk of blood clots or bleeding. The facility failed to coordinate nail care for Resident #2 who was diabetic and had long, jagged fingernails resulting in unlicensed staff cutting the resident's fingernails with clippers causing the resident's finger to bleed putting him at risk of infection. The facility failed to notify the home health nurse for loose, soiled or missing dressings covering buttocks wounds, notify the primary care provider (PCP) of low blood pressure results and follow up on an ordered orthopedic referral for Resident #1 resulting in reversed improvement of the wounds and delayed coordination of medication management and potential treatment of spinal fractures. The facility failed to notify the PCP of heart rate and blood pressure results outside the ordered parameter for Resident #4 resulting in delayed medication management. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/22/23 for this violation.

THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 15, 2024.

D 315 — 10A NCAC 13F .0905 (a & b) Activities Program — D 315

10A NCAC 13F .0905 Activities Program
(a) Each adult care home shall develop a program of activities designed to promote the

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residents' active involvement with each other, their families, and the community.
(b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure residents were provided an activities program.

The findings are:

Review of the facility's November 2023 activity calendar on 11/28/23 revealed:
-There were at least 14 hours of scheduled activities weekly.
-There were 4 activities listed for 11/28/23 which included ball toss scheduled at 9:00am, a puzzling puzzle scheduled at 10:00am, share and compare trivia scheduled at 2:00pm and movie of choice scheduled at 3:00pm.

Observations of activities throughout the day on 11/28/23 revealed:
-There was no ball toss, puzzling puzzle or share and compare trivia observed at scheduled times.
-Residents were either sitting in the common area, in the hallway or in their rooms.
-The television was on in the common area throughout the day.

Review of the facility's November 2023 activity calendar on 11/29/23 revealed:
-There were 4 activities listed for 11/29/23 which included chair stretches at 9:00am, November

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dawn scheduled at 10:00am, Bible study at 2:00pm and arts & crafts scheduled at 3:00pm.

Observations of activities throughout the day on 11/29/23 revealed:
-There was no chair stretching, November dawn, Bible study or arts & crafts observed at scheduled times.
-Residents were either sitting in the common area, in the hallway or in their rooms.
-Music was observed to be playing in the common area throughout the day.

Observation on the Special Care Unit (SCU) on 11/29/23 from 7:40am until 10:29am revealed there was no activity event on the SCU.

Review the facility's November 2023 activity calendar on 11/30/23 revealed there were 4 activities listed for 11/30/23 which included exercise at 9:00am, pretty nails at 10:00am, dream list at 2:00pm and coloring at 3:00pm.

Observations of activities throughout the day on 11/30/23 revealed:
-There was no exercise, pretty nails, dream list or coloring observed at scheduled times.
-Residents were either sitting in the common area, in the hallway or in their rooms.
-Music was observed to be playing in the common area throughout the day.
-One resident was observed to be coloring in her room.

Observation of the activity room in the assisted living unit on 11/30/23 at 11:40am revealed:
-The door was locked and the Resident Care Coordinator (RCC) had to get maintenance to open the door.
-The room was stocked with games, puzzles,

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crafting supplies and crossword books.
-The artwork on the wall was from fall and read "Happy Fall".

Observation of the SCU on 11/30/23 at 11:55am revealed:
-There were puzzles, bingo, board games, balls, maracas, a radio and VHS tapes in the activity room.
-There was no one in the room and no resident activities were being conducted.
-Residents were observed sitting in a common area or in the hallway.

Observations of the activity room in the Assisted Living unit on 12/01/23 at 2:50pm revealed:
-The door was open and the light was on.
-There was no one in the activity room and no activities were being conducted.

Observation of the letter received by the previous Activity Director (AD) on 12/01/23 revealed:
-The letter was dated 11/08/23 and signed by the Vice President (VP) of Human Resources.
-The temporary reduction in force (RIF) went into effect 11/09/23.
-The position of Life Enrichment Coordinator was temporarily suspended.
-The AD was instructed to work with the Administrator to transfer into an open care or dietary position.
-The duration was subject to change based on evolving circumstances.

Interview with a resident on 11/28/23 at 9:20am revealed:
-They did activities every once in a while.
-A lot of staff members were laid off recently.
-The staff members that were not laid off were trying to do everything.

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-The staff member in charge of activities was cleaning on yesterday, 11/27/23.

Interview with a second resident on 11/28/23 at 9:31am revealed:
-The facility used to offer bingo.
-The facility had not been providing activities (no time frame given).

Interview with a resident on the special care unit (SCU) on 11/28/23 at 9:12am revealed:
-There were no activities on the SCU.
-He did not do anything except lay around all day.
-Residents were able to go outside in the enclosed area to smoke and that was it.

Interview with a second resident on the SCU on 11/28/23 at 10:00am revealed there was nothing to do except sit around all day.

Interview with a personal care aide (PCA) on 11/28/23 at 10:57am revealed:
-The facility did not have a person responsible for conducting activities on the SCU.
-No one did activities on the SCU.
-The activities listed on the monthly activity calendar were not done.

Interview with the RCC on 11/30/23 at 11:25am revealed:
-The facility had an AD up until the end of October 2023.
-Corporate eliminated the AD position at the end of October 2023.
-The previous AD now worked in another position but tried to play music for the residents.
-Previous activities included going to see Christmas lights, going to the fair, dog therapy, bingo, nail polishing and hair styling but no longer occurred due to the elimination of the AD position.

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-There had been no activities since the elimination of the AD position.
-There had been no outings since the elimination of the AD position.
-There was no one responsible for activities or the activities calendar.
-There was no process in place to continue activities in the absence of an AD.
-She was unaware of who created the November 2023 activities calendar.

Interview with the Special Care Coordinator (SCC) on 11/30/23 at 11:50am revealed:
-The facility had an AD up until mid November 2023.
-Corporate took the AD position away mid November 2023.
-The was no process in place to continue activities in the absence of an AD.
-Staff colored and danced with residents on no set schedule since the elimination of the AD position.
-The previous AD created the activities schedule that was posted for November 2023.
-There were no outings for the memory care unit prior to the elimination of the AD position.

Interview with the Administrator on 11/30/23 at 12:04pm revealed:
-The AD position was "reallocated" due to the holiday season (no explanation/definition given for "reallocated").
-The previous AD was still with the facility working as a personal care aide (PCA) and assisted with activities.
-The previous AD created the November 2023 activities calendar.
-The responsibility of activities was spread throughout staff to include her and staff on the floor after the elimination of the AD position.

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D 315	Continued From page 94 -There have been no activities the past couple of days. -Outings mostly included a shopping trip to the local dollar store that they tried to schedule once per month. -She ensured activities occurred by observing and participating. Telephone interview of the previous AD on 11/30/23 at 1:34pm revealed: -She was the AD for 3 years. -She received a letter from Corporate at the beginning of November 2023 saying her position was being cut. -She was already filling in as a PCA when needed so she chose to take a PCA position. -Not many activities occurred since the elimination of the AD position because the PCA position required most of her time. -Activities prior to the elimination of the AD position included Bingo, crafts, games, spa days, hair styling, non-baking activities, reading, exercise and an outing to the local dollar store once per month. -Since the elimination of the AD position, she printed crossword puzzles when residents got bored.	D 315		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies	D 358		

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and procedures.

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

Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 residents (#1, #2, #4) sampled for review including errors with a topical cream for inflammatory skin conditions (#2), a laxative for constipation (#4), and a diuretic for excess fluid and swelling (#1); and for 3 of 5 residents (#6, #7, #8) observed during the medication pass including errors with a long-acting insulin (#6), a heart / blood pressure medication (#7), an inhaler for lung disease (#8), and a vitamin supplement for eye health (#8).

The findings are:

1. The medication error rate was 12% as evidenced by 4 errors out of 32 opportunities during the 8:00am and 9:00am medication passes on 11/29/23.

a. Review of Resident #6's current FL-2 dated 09/12/23 revealed:
-Diagnoses included vascular dementia with behavioral disturbance and diabetes mellitus type II.
-There was an order for Levemir FlexPen inject 13 units twice daily, hold if blood sugar was less than (<) 80 and notify primary care provider (PCP) if blood sugar was greater than (>) 450.
(Levemir is long-acting insulin used to control blood sugar in diabetics. According to the manufacturer, Levemir Flexpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles. Once the needle is

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inserted into the skin, the dose knob should be pushed all the way in and held for at least 6 seconds to ensure the full amount is injected.)

Review of Resident #6's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Levemir FlexPen inject 13 units twice daily, hold if blood sugar was <80 and notify PCP if blood sugar was >450.
-Levemir FlexPen was scheduled for 8:00am and 8:00pm.
-Levemir FlexPen was documented as administered from 11/01/23 - 11/29/23.
-The resident's blood sugar ranged from 107 - 526 from 11/01/23 -11/29/23.

Observation of the 8:00am medication pass on 11/29/23 revealed:
-Resident #6's blood sugar was 170 at 8:15am.
-The medication aide (MA) administered 13 units of Levemir FlexPen into Resident #6's right abdomen at 8:16am.
-The MA did not perform a 2-unit air shot prior to dialing the insulin pen to 13 units to ensure no air bubbles were present and to ensure insulin was flowing from the pen.
-The MA immediately removed the insulin pen from the skin as soon as the last click was heard when pressing the button.
-The MA did not hold the insulin pen in the skin after injecting the needle and pressing the button to allow time for the full amount of insulin to be injected.

Interview with the MA on 11/29/23 at 1:50pm revealed:
-She had training on the use of insulin pens and she thought it was done in 2021.
-She remembered the word "prime" from the

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training but she could not recall how to prime an insulin pen.
-She did not hold in the insulin pen after injecting because she was not aware she needed to hold it in.

Interview with the Special Care Coordinator (SCC) on 11/29/23 at 2:24pm revealed:
-She was not sure if the MAs had been trained on the use of insulin pens.
-The MAs were supposed to dial 2 units and do an air shot prior to dialing the dose to be administered with the insulin pens.
-She thought the insulin pen injections should be held in for 10 seconds.

Telephone interview with Resident #6's PCP on 11/30/23 at 4:16pm revealed:
-The MAs should use proper technique with administering insulin pens to make sure the correct amount of insulin was administered.
-If the insulin pen was not primed to get the air bubbles out and not held in to make sure all of the insulin was released, the resident would not receive the full amount of insulin.
-Not receiving the full amount of insulin could cause the resident's blood sugar to be more elevated than usual which could cause the resident's diabetes to be less controlled.

Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable.

b. Review of Resident #7's current FL-2 dated 01/06/23 revealed:
-Diagnoses included essential hypertension, hemiplegia and hemiparesis affecting the left side, hyperlipidemia, asthma, chronic obstructive pulmonary disease, and depression.

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-There was an order for Metoprolol Tartrate 25mg ½ tablet (12.5mg) twice a day. (Metoprolol Tartrate is an immediate-released medication for heart and blood pressure.)

Review of Resident #7's physician's order dated 02/10/23 revealed:
-There was an order to stop taking Metoprolol Tartrate.
-There was an order to start Metoprolol Succinate ER 25mg take 1 tablet once daily. (Metoprolol Succinate ER is an extended-released medication for heart and blood pressure.)

Review of Resident #7's physician's order dated 09/05/23 revealed an order to crush the resident's medications and put in applesauce.

Review of the facility's standing house orders dated 10/10/23 revealed an order for all medication may be given by mouth and/or crushed (check do not crush list) and placed in applesauce or pudding unless otherwise noted.

Review of Resident #7's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Metoprolol Succinate ER 25mg take 1 tablet once daily scheduled at 8:00am.
-Metoprolol Succinate ER 25mg was documented as administered from 11/01/23 - 11/29/23.

Observation of the 8:00am medication pass on 11/29/23 revealed:
-The medication aide (MA) crushed Resident #7's oral tablets, including the Metoprolol Succinate ER 25mg tablet, and administered the crushed medications to the resident at 8:40am.
-The Metoprolol Succinate ER was

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extended-released and should not be crushed.

Observation of Resident #7's medications on hand on 11/29/23 at 2:04pm revealed:
-There was a supply of Metoprolol Succinate ER 25mg tablets packaged in the weekly multi-dose pack dated 11/22/23.
-The instructions were to take 1 tablet once daily.
-There were no instructions to indicate the Metoprolol Succinate ER should not be crushed.

Interview with the MA on 11/29/23 at 2:22pm revealed:
-She had been crushing Resident #7's oral tablets, including the Metoprolol Succinate ER tablet for about 2 months.
-They had an order to crush the resident's medications because the resident was observed holding medication in his mouth to save the pills for another resident about 2 months ago.
-The facility had a Do Not Crush (DNC) medication list and the MAs were supposed to reference the DNC list to make sure medications could be crushed.
-She had not noticed Resident #7's Metoprolol Succinate ER was listed on the DNC list as a medication that should not be crushed.
-Sometimes the medication label or the eMARs were marked with DNC when a medication should not be crushed.
-The resident had not complained to her of any symptoms of low blood pressure such as dizziness or lightheadedness.

Review of the facility's DNC medication list dated November 2019 revealed Metoprolol Succinate ER was included on the list as medication that should not be crushed because it was an extended-release formulation.

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Interview with the Resident Care Manager (RCM) on 11/29/23 at 2:30pm revealed:
-There was a DNC list in a notebook in the medication carts.
-Most of the time, the pharmacy would put instructions on the eMAR when a medication should not be crushed and sometimes on the medication label.
-The MAs should check the DNC list prior to crushing medications
-Resident #7's Metoprolol Succinate ER should not be crushed.

Telephone interview with Resident #7's primary care provider (PCP) on 11/30/23 at 4:16pm revealed:
-Metoprolol Succinate ER should not be crushed.
-The resident could get too much Metoprolol Succinate ER all at once if the medication was crushed.
-The resident could have low blood pressure when the Metoprolol Succinate ER was crushed.
-The resident had not had any critically low blood pressures to her knowledge.

Interview with Resident #7 on 11/19/23 at 1:16pm revealed:
-The MAs always crushed all his medications.
-He had high blood pressure before he came to the facility.
-His blood pressure was low about once a week in the afternoons.
-He felt dizzy or lightheaded when his blood pressure was low.

Review of Resident #7's vital signs report from 10/01/23 - 11/30/23 revealed the resident's blood pressure was 112/75 on 10/02/23; 118/79 on 11/02/23; and 120/80 on 11/06/23.

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c. Review of Resident #8's current FL-2 dated 04/14/23 revealed:
-Diagnoses included dementia, diabetes mellitus type 2, hypertension, hyperlipidemia, hypothyroidism, and major depressive disorder.
-There was an order for Symbicort 160-4.5mcg inhale 2 puffs into the lungs twice a day; use Aerochamber Plus with Symbicort inhaler. (Symbicort is used to treat asthma and chronic obstructive pulmonary disease. Aerochamber is an inhalational spacing device used to help with the administration of inhalers.)

Review of Resident #8's physician's order dated 10/03/23 revealed an order for Symbicort 160-4.5mcg inhale 2 puffs into the lungs twice a day; use with Aerochamber device; staff may hand to resident to administer 2 puffs, then clean and store on medication cart.

Observation of the 8:00am medication pass on 11/29/23 revealed:
-Resident #8 was in her room.
-The medication aide (MA) shook the Symbicort 160-4.5mcg inhaler and connected the mouthpiece to the Aerochamber device.
-The MA handed the Symbicort inhaler with Aerochamber to Resident #8 and offered no instructions to the resident on how to use the inhaler or how many puffs to take.
-The resident put the Aerochamber mouthpiece in her mouth and pressed the inhaler 2 quick times in a row.
-The MA did not instruct the resident to inhale or wait between puffs (According to Guidelines for the Medication Administration Clinical Skills Checklist, waiting at least 1 minute between puffs may permit additional puffs to penetrate the lungs better.)
-The resident did not inhale so the medication

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vapors remained in the Aerochamber device and did not go into the resident's lungs.

Review of Resident #8's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Symbicort 160-4.5mcg inhale 2 puffs by mouth twice a daily; use with Aerochamber device; staff may hand to resident to administer.
-Symbicort inhaler was scheduled at 8:00am and 8:00pm.
-Symbicort inhaler with Aerochamber device was documented as administered from 11/01/23 - 11/29/23.

Interview with the MA on 11/29/23 at 2:13pm revealed:
-She always handed the Symbicort inhaler with the Aerochamber device to Resident #8.
-She forgot to instruct the resident on how to use the inhaler that morning, 11/29/23.
-She should have instructed the resident to use deep breaths and wait between puffs.
-The resident had not complained of shortness of breath to her.

Interview with Resident #8 on 11/29/23 at 1:23pm revealed:
-She received the Symbicort inhaler with the Aerochamber device twice a day, morning and night.
-A former staff member had shown her how to use the inhaler a long time ago.
-That staff member told her to hold her breath and let go but she did not tell her a specific time frame.
-The inhaler helped with her breathing "a little bit".
-She had shortness of breath when she walked.

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D 358	Continued From page 103 Interview with the Resident Care Manager (RCM) on 11/29/23 at 2:30pm revealed: -The MAs had been trained on how to properly administer inhalers. -The MAs should hold the inhaler during administration of the inhaler and instruct the resident on how to inhale and wait between puffs. Telephone interview with Resident #8's primary care provider (PCP) on 11/30/23 at 4:16pm revealed: -The MAs should use proper technique and instruct the resident on how to use the Symbicort inhaler with the Aerochamber device. -Without using proper technique, the resident was not getting the full dose of medication and therefore not getting the full effectiveness of the medication. -Without the proper dosage, the resident would not get adequate treatment of her lung disease and over time could lead to shortness of breath. d. Review of Resident #8's current FL-2 dated 04/14/23 revealed an order for Preservision AREDS-2 vitamin take 1 capsule twice a day with meals. (Preservision is a vitamin and mineral supplement used for eye health. According to the manufacturer, Preservision AREDS-2 should be taken with meals to ensure that the body absorbs the vitamins and nutrients more effectively.) Review of Resident #8's November 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Preservision AREDS-2 take 1 capsule twice daily with meals scheduled at 8:00am and 5:00pm. -Preservision AREDS-2 was documented as administered from 11/01/23 - 11/29/23.	D 358		

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Observation of the 8:00am medication pass on 11/29/23 revealed:
-Resident #8 told the medication aide (MA) that she was not going to eat breakfast because she was not hungry, and she did not want anything to eat.
-The MA did not offer or encourage Resident #8 to eat a snack.
-The MA administered Preservision AREDS-2 tablet to Resident #8 at 8:52am.
-Preservision AREDS-2 was not administered with a meal as ordered.

Interview with the MA on 11/29/23 at 2:13pm revealed:
-If medications were ordered to be administered with meals, she usually waited until the resident was finished eating to administer the medication.
-If a resident was not eating, the resident may have their own snacks and would eat a snack such as a crackers.
-Sometimes Resident #8 would not eat breakfast but she thought the resident would eat a snack in her room sometimes.

Interview with Resident #8 on 11/29/23 at 1:23pm revealed:
-She usually ate breakfast most of the time.
-She did not eat breakfast or a snack this morning, 11/29/23, because she was not hungry.
-She denied any side effects from taking her medication on an empty stomach that morning, 11/29/23.

Interview with the Resident Care Manager (RCM) on 11/29/23 at 2:30pm revealed:
-If a medication was ordered with meals, it should be administered within 15 minutes after taking the first bite of food.
-If a resident was not eating a meal, it should be

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administered with crackers or applesauce.

Telephone interview with Resident #8's primary care provider (PCP) on 11/30/23 at 4:16pm revealed:
-Resident #8's Preservision AREDS-2 should be administered with meals as ordered.
-If administered on an empty stomach, the resident might experience nausea or an upset stomach.
-If the resident was not going to eat breakfast, the MA should at least give the resident a cracker or other snack with the medication.

2. Review of Resident #2's current FL-2 dated 08/15/23 revealed:
-Diagnoses included vascular dementia without disturbance, type 2 diabetes mellitus with specified complications, chronic diastolic congestive heart failure, chronic anemia without bleeding, hypoxia, aspiration pneumonia of right lower lobe, bacteremia, and history of gout.
-There was an order for Hydrocortisone Cream 1% apply topically to affected area(s) of face once daily for redness and flakiness.
(Hydrocortisone Cream is used to treat inflammatory skin conditions.)

Review of Resident #2's September 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Hydrocortisone Cream 1% apply topically to affected area(s) of face once daily for redness and flakiness scheduled at 7:00am - 3:00pm.
-Hydrocortisone Cream 1% was documented as administered from 09/01/23 - 09/30/23.

Review of Resident #2's October 2023 eMAR revealed:

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D 358	Continued From page 106 -There was an entry for Hydrocortisone Cream 1% apply topically to affected area(s) of face once daily for redness and flakiness scheduled at 7:00am - 3:00pm. -Hydrocortisone Cream 1% was documented as administered from 10/01/23 - 10/31/23. Review of Resident #2's November 2023 eMAR revealed: -There was an entry for Hydrocortisone Cream 1% apply topically to affected area(s) of face once daily for redness and flakiness scheduled at 7:00am - 3:00pm. -Hydrocortisone Cream 1% was documented as administered from 11/01/23 - 11/30/23. Observation of Resident #2's medications on hand on 11/30/23 at 12:59pm revealed there was no Hydrocortisone Cream 1% available for administration. Interview with a medication aide (MA) on 11/30/23 at 12:59pm revealed: -There was no Hydrocortisone Cream 1% available to administer to Resident #2. -She applied the last of the Hydrocortisone Cream 1% to the resident on Monday, 11/27/23. -The resident had not been administered Hydrocortisone Cream 1% since Monday, 11/27/23. -Resident #2's Hydrocortisone Cream 1% was ordered today, 11/30/23, and would be delivered to the facility tomorrow, 12/01/23. -The MAs were responsible for ordering medications about 1 week before the medications ran out. -She could not explain why the Hydrocortisone Cream 1% was not ordered until 11/30/23, 3 days after they ran out of the cream. -Resident #2's facial skin was red and flaky today,	D 358		

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11/30/23.
-The resident's face was usually not as red and his facial skin was not flaky at all when the Hydrocortisone Cream 1% was applied every day.

Telephone interview with an order entry technician at the facility's contracted pharmacy on 11/30/23 at 5:03pm revealed:
-The pharmacy dispensed a 15-gram tube of Hydrocortisone Cream 1% for Resident #2 on 08/26/23.
-There had been no refill requests for the Hydrocortisone Cream 1% since 08/26/23 until today, 11/30/23.

Observation of Resident #2 on 11/30/23 at 12:36pm revealed:
-Resident #2 was lying in bed on his back.
-The resident's face was red and the skin on his face, especially on the forehead, was flaking with pieces of skin hanging down.

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

Interview with the Special Care Coordinator (SCC) on 11/30/23 at 3:30pm revealed:
-The MAs were responsible for ordering topical medications when there was about a one-week supply remaining.
-The MAs did medication cart audits daily on Monday - Friday each shift.
-The MAs should have identified Resident #2's Hydrocortisone Cream 1% needed ordering during the medication cart audits.
-Resident #2's Hydrocortisone Cream 1% should have been ordered before it ran out.

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Telephone interview with Resident #2's primary care provider (PCP) on 11/30/23 at 4:34pm revealed:
-If Resident #2's Hydrocortisone Cream 1% was unavailable, the MAs needed to order it.
-If a new prescription was needed, they could reach out to her.
-Without the Hydrocortisone Cream 1%, the resident's face was going to be inflamed with redness and his skin would be flaking off.

3. Review of Resident #4's current FL-2 dated 09/19/23 revealed:
-Diagnoses included dementia, hypertension, and chronic kidney disease.
-There was an order for senna 8.6mg 2 tablets daily at bedtime, hold for diarrhea.

Observation of Resident #4 on 11/29/23 at 10:23am revealed the resident had an episode of diarrhea when assisted with toileting.

Interview with the personal care aide (PCA) on 11/29/23 at 10:23am revealed:
-The resident usually had diarrhea when she drank milk and ate eggs for breakfast.
-Resident #4 had diarrhea, but most of it went into the toilet.

Review of Resident #4's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for senna 8.6mg daily at bedtime scheduled for 8:00pm.
-There was documentation senna was administered to Resident #4 on 11/28/23 and 11/29/23.

Observation of Resident #4's medications on hand on 12/01/23 at 3:59pm revealed:

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-There was a multidose pack (MDP) with the resident's name and a list of medications and instructions for each contained in morning, midday, and bedtime MDPs.
-Instructions included senna 8.6mg 2 tablets at bedtime, hold for diarrhea.
-The list of medications contained in bedtime MDPs included senna 2 tablets.
-There were 4 remaining bedtime MDPs dated 12/01/23, 12/02/23, 12/03/23, and 12/04/23.

Interview with a second shift PCA on 12/01/23 at 3:55pm revealed she did not know of Resident #4 having diarrhea within the last 3 days.

Interview with a second shift medication aide (MA) on 12/01/23 at 4:00pm revealed no one had reported Resident #4 having diarrhea in the last 3 days to her.

Telephone interview with Resident #4's primary care provider (PCP) on 11/30/23 at 4:21pm revealed:
-Staff were expected to adhere to written parameters for administering medications.
-Administering senna with active diarrhea could cause electrolyte imbalances and increase the risk of falls and skin breakdown.

Interview with the Special Care Coordinator (SCC) on 12/01/23 at 3:00pm revealed:
-If the PCA (first shift) did not communicate to the MA (second shift) that the resident had diarrhea, then the MA would not know to hold the senna.
-She was not aware of Resident #4 having issues with diarrhea in relation to eggs and milk.
-If she had known she would have made sure the senna was held and that the PCP was notified.

Interview with the Administrator on 12/01/23 at

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4:15pm revealed:
-PCAs were responsible for reporting diarrhea to the MA and the MA was responsible for holding Resident #4's senna according the PCP's order.
-MAs were responsible for checking ordered parameters and following written orders.

Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.

4. Review of Resident #1's current FL-2 dated 08/30/23 revealed diagnoses included neurocognitive disorder, atrial fibrillation, and hypertension.

Review of Resident #1's primary care provider (PCP) order dated 10/31/23 revealed an order for Lasix 20mg daily for edema; hold for systolic blood pressure 110 and below.

Review of Resident #1's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Lasix 20mg daily at 8:00am; hold for systolic blood pressure 110 and below.
-On 11/06/23, the blood pressure result documented was 106/60 and there was documentation Lasix 20mg was administered.
-On 11/07/23, the blood pressure result documented was 94/55 and there was documentation Lasix 20mg was administered.
-On 11/13/23, the blood pressure result documented was 107/56 and there was documentation Lasix 20mg was administered.
-There was no documentation Lasix was administered on 11/09/23 and 11/10/23.

Interview with a medication aide (MA)/personal

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care aide (PCA) on 11/29/23 at 2:31pm revealed:
-If Resident #1's blood pressure was low, low was 94/55, then she did not administer the Lasix.
-She might have documented it was administered but she did not give the Lasix to Resident #1 on 11/07/23.

Interview with a second MA/PCA on 11/29/23 at 2:57pm revealed:
-She could not remember if she gave Resident #1 Lasix on 11/06/23 when his blood pressure was 106/60 and on 11/13/23 when his blood pressure was 107/56.

Interview with Resident #1 on 11/30/23 at 1:20pm revealed:
-He sometimes felt dizzy.
-He was very tired.

Interview with the Special Care Coordinator (SCC) on 11/30/23 at 12:34pm revealed:
-She was told today (11/30/23) that Lasix was given to Resident #1 on 11/06/23, 11/07/23 and 11/13/23 when his systolic blood pressure was less than 110.
-Normally the electronic medication administration system alerted staff when a result was outside an ordered parameter.
-The Lasix should not have been given to Resident #1 on 11/06/23, 11/07/23 and 11/13/23.

Telephone interview with Resident #1's PCP on 11/30/23 at 4:21pm revealed:
-If there were written orders to hold a medication due to written blood pressure parameters, if the blood pressure was outside the parameter, then the medication should have been held.
-Administering Lasix when the blood pressure was low could cause an even lower blood pressure, unresponsiveness, and falls.

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-The point of checking blood pressure prior to administering Lasix was safe administration and avoiding adverse outcomes.
-Not following written orders could lead to serious harm.

Interview with the Administrator on 12/01/23 at 4:15pm revealed:
-She did not know Lasix was administered to Resident #1 when his systolic blood pressure was less than written parameter of 110 on 3 occasions in November 2023.
-MAs were responsible for checking ordered parameters and following written orders.
-MAs were responsible for notifying the PCP and completing a medication error report if the MA was aware of the error.
-The PCP was not notified, and a medication error report was not completed for Resident #1 and Lasix.

____

The facility failed to administer medications as ordered to 3 of 5 residents observed during the medication pass on 11/29/23, which included 4 errors out of 32 opportunities. The medication aide did not use proper technique when administering insulin via an insulin pen to Resident #6, putting the resident at risk of not receiving the full dosage of insulin. Resident #7's extended-released blood pressure medication was crushed putting the resident at risk of low blood pressure. Resident #8's inhaler for lung disease was not administered properly and the resident experience shortness of breath. There were errors with 3 residents sampled for record review, including Resident #2 who did not receive a topical cream due to the medication being unavailable resulting in red, flaky skin on the resident's face. Resident #4's laxative was not held as ordered for diarrhea resulting in the

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D 358	Continued From page 113 resident continuing to have diarrhea. Resident #1's diuretic was not held based on ordered parameters putting the resident at risk of low blood pressures and resulting in Resident #1 being dizzy. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. ____________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/01/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 14, 2024.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a	D 367		

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signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 5 sampled residents (#2, #4) including inaccurate documentation for a medication for heart and blood pressure (#2), a topical cream for inflammatory skin conditions (#2), bed alarm checks (#2), and activity checks (#4).

The findings are:

1. Review of Resident #2's current FL-2 dated 08/15/23 revealed diagnoses included vascular dementia without disturbance, type 2 diabetes mellitus with specified complications, chronic diastolic congestive heart failure, chronic anemia without bleeding, hypoxia, aspiration pneumonia of right lower lobe, bacteremia, and history of gout.

a. Review of Resident #2's current FL-2 dated 08/15/23 revealed an order for Carvedilol 6.25mg 1 tablet twice daily. (Carvedilol is used for heart and blood pressure.)

Review of Resident #2's physician's order dated 09/12/23 revealed:
-There was an order to stop Carvedilol 6.25mg 1 tablet twice a day.
-There was an order to start Carvedilol 3.125mg 1 tablet twice a day.

Review of Resident #2's physician's order dated 11/07/23 revealed:
-There was an order to stop Carvedilol 3.125mg 1

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tablet twice a day.
-There was an order to start Carvedilol 3.125mg 1 tablet once a day.

Review of Resident #2's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Carvedilol 3.125mg take 1 tablet twice daily scheduled at 9:00am and 9:00pm.
-Carvedilol 3.125mg was documented as administered twice daily from 11/01/23 - 11/30/23 at 8:00am.
-There was a second entry for Carvedilol 3.125mg take 1 tablet once daily scheduled at 8:00am.
-Carvedilol 3.125mg was documented as administered once daily at 8:00am from 11/09/23 - 11/30/23.
-Staff had documented Carvedilol 3.125mg as being administered 3 times a day at 8:00am, 9:00am, and 9:00pm from 11/09/23 - 11/30/23.

Interview with a medication aide (MA) on 11/30/23 at 12:59pm revealed:
-Resident #2 was only receiving Carvedilol 3.125mg once day because that was how it was dispensed in the multi-dose packs.
-She had not noticed Carvedilol was coming up twice on the eMAR and that she was documenting the administration of Carvedilol twice.

Interview with the Special Care Coordinator (SCC) on 11/30/23 at 3:30pm revealed:
-The pharmacy usually entered orders into the eMAR system.
-She was responsible for checking to make sure the eMARs were accurate and then approving the orders in the eMAR system.

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D 367	Continued From page 116 -She must have overlooked the duplicate orders for Carvedilol on the eMAR. -The MAs should have let her know that the Carvedilol order was on the eMAR twice. Interview with the Administrator on 11/30/23 at 5:50pm revealed: -If there was a discrepancy with the eMARs, the MAs should notify the SCC or the Resident Care Coordinator (RCC). -The MAs should not have documented the administration of Resident #2's Carvedilol 3 times a day. -The MAs should have stopped to see why it did not match and get the eMAR corrected. b. Review of Resident #2's current FL-2 dated 08/15/23 revealed an order for Hydrocortisone Cream 1% apply topically to affected area(s) of face once daily for redness and flakiness. (Hydrocortisone Cream is used to treat inflammatory skin conditions.) Review of Resident #2's November 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Hydrocortisone Cream 1% apply topically to affected area(s) of face once daily for redness and flakiness scheduled at 7:00am - 3:00pm. -Hydrocortisone Cream 1% was documented as administered from 11/01/23 - 11/30/23. Interview with a medication aide (MA) on 11/30/23 at 12:59pm revealed: -There was no Hydrocortisone Cream 1% available to administer to Resident #2. -She applied the last of the Hydrocortisone Cream 1% to the resident on Monday, 11/27/23. -The resident had not been administered	D 367		

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Hydrocortisone Cream 1% since Monday, 11/27/23.
-She documented the Hydrocortisone as administered when it was not available because she had been trained at the facility not to put a medication was unavailable on the eMAR.
-She could not recall who trained her on how to document on the eMARs.

Interview with the Special Care Coordinator (SCC) on 11/30/23 at 3:30pm revealed:
-If a medication was unavailable, the MAs should not document the medication was administered on the eMAR.
-The MAs should not document a medication was unavailable on the eMAR.
-The MAs should document they called the pharmacy in the action section of the eMAR.
-That was how she was trained but she could not recall who trained her.

Interview with the Administrator on 11/30/23 at 5:50pm revealed:
-The MAs should not have documented Resident #2's Hydrocortisone Cream 1% was administered on the eMAR when none was available to administer.
-That was false documentation.
-The MAs should have documented the medication was not administered due to being on order.
-The SCC and the Resident Care Coordinator (RCC) were responsible for reviewing the medications on hand each week.
-She was not aware of a system for the SCC or RCC to check the eMARs for accuracy.

c. Review of Resident #2's electronic hospice visit note report dated 09/05/23 revealed:
-The resident had an unsteady gait.

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-The resident had bruising on his arms and left eyelid.
-The resident had a fall since the last routine hospice skilled nursing visit.
-The resident had a purplish bruise on his left eyelid.
-Staff requested a bed alarm and falls mat, which would be ordered as well as a hospital bed and a scoop mattress.

Review of Resident #2's Fall Risk Intervention Care Plan dated 09/05/23 revealed:
-The resident had a fall on 09/03/23.
-The intervention documented was to obtain bed alarm/fall mat from hospice.

Review of a hospice equipment invoice for Resident #2 revealed:
-A bed alarm, high/low electric hospital bed, a scoop mattress, and a fall pad/mat were delivered to the facility on 09/06/23.
-The bed alarm, hospital bed, scoop mattress, and fall mat were picked up from the facility by the hospice provider on 10/04/23.

Observation of Resident #2's room on 11/30/23 at 12:38pm revealed:
-There was a note on the wall near the bed with instructions to make sure the bed alarm was on and functioning while the resident was in bed for his safety.
-There was no bed alarm in the resident's room.

Review of Resident #2's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for bed alarm: ensure that bed was on and working and sign was posted every shift at 7:00am - 3:00pm, 3:00pm - 11:00pm, and 11:00pm - 7:00pm.

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-Staff documented the bed alarm was on and working each shift from 10/01/23 - 10/31/23.
-There was an entry for assistive device reminders ever shift: remind resident to use assistive device and reminder sign was posted for the resident.

Review of Resident #2's November 2023 eMAR revealed:
-There was an entry for bed alarm: ensure that bed was on and working and sign was posted every shift at 7:00am - 3:00pm, 3:00pm - 11:00pm, and 11:00pm - 7:00pm.
-Staff documented the bed alarm was on and working each shift from 11/01/23 through first shift on 11/30/23.

Interview with a medication aide (MA) on 11/30/23 at 12:59pm revealed:
-Resident #2 did not currently have a bed alarm, hospital bed, scoop mattress, or fall mat.
-The resident had not had those items since he was receiving hospice services about a month or two ago.
-She had not noticed she had documented the resident's bed alarm was in place and working on the eMAR when there was no bed alarm.
-She documented it in error.

Interview with the Special Care Coordinator (SCC) on 11/30/23 at 3:30pm revealed:
-Resident #2 no longer had a bed alarm after he was discharged from hospice (could not recall date).
-She could not explain why she or the MAs continued to document bed alarm checks on the eMAR after the bed alarm was picked up by hospice on 10/04/23.
-She had been the SCC for about a month and to her knowledge, there was no system to check the

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D 367	Continued From page 120 eMARs for accuracy. Interview with the Administrator on 11/30/23 at 5:50pm revealed: -The MAs should not have documented Resident #2's bed alarm was checked and working each shift when the resident did not have a bed alarm. -That was false documentation. -The resident was discharge from hospice and the bed alarm was picked up by hospice about 2 months ago. -The MAs should have notified the SCC so the bed alarm entry could have been removed form the eMAR system. -She was not aware of a system for the SCC or RCC to check the eMARs for accuracy. 2. Review of Resident #4's current FL-2 dated 09/19/23 revealed diagnoses included dementia, hypertension, and chronic kidney disease. Review of Resident #4's September, October, and November 2023 electronic medication administration records (eMARs) revealed: -There was an entry to encourage and assist resident to activities as part of fall prevention every shift initiated on 04/24/23. -Staff initialed first and second shift daily from 09/01/23 until 11/29/23. Second interview with a medication aide (MA)/ personal care aide (PCA) on 12/01/23 at 2:55pm revealed: -The Special Care Coordinator (SCC) or the Administrator chose fall prevention interventions. -Resident #4 did not do any activities. -She was active when rolled around in her wheelchair and that was what MAs documented as an activity.	D 367		

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D 367	Continued From page 121 Interview with the SCC on 12/01/23 at 3:00pm revealed: -Activities as a fall intervention meant staff did an activity with Resident #4. -Activities as a fall intervention was implemented by the previous SCC and she (current SCC) had not had the time to review and update interventions. Interview with the Administrator on 12/01/23 at 4:15pm revealed: -Fall interventions for Resident #4 had not yet been reviewed and updated. -Staff were expected to do activities with Resident #4 as documented on the eMAR. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.	D 367		
D 461	10A NCAC 13F .1304 Special Care Unit Building Requirements 10A NCAC 13F .1304 Special Care Unit Building Requirements In addition to meeting all applicable building codes and licensure regulations for adult care homes, the special care unit shall meet the following building requirements: (1) Plans for new or renovated construction or conversion of existing building areas shall be submitted to the Construction Section of the Division of Facility Services for review and approval. (2) If the special care unit is a portion of a facility, it shall be separated from the rest of the building by closed doors. (3) Unit exit doors may be locked only if the	D 461		

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locking devices meet the requirements outlined in the N.C. State Building Code for special locking devices.
(4) Where exit doors are not locked, a system of security monitoring shall be provided.
(5) The unit shall be located so that other residents, staff and visitors do not have to routinely pass through the unit to reach other areas of the building.
(6) At a minimum the following service and storage areas shall be provided within the special care unit: staff work area, nourishment station for the preparation and provision of snacks, lockable space for medication storage, and storage area for the residents' records.
(7) Living and dining space shall be provided within the unit at a total rate of 30 square feet per resident and may be used as an activity area.
(8) Direct access from the facility to a secured outside area shall be provided.
(9) A toilet and hand lavatory shall be provided within the unit for every five residents.
(10) A tub and shower for bathing of residents shall be provided within the unit.
(11) Use of potentially distracting mechanical noises such as loud ice machines, window air conditioners, intercoms and alarm systems shall be minimized or avoided.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure there was a system of monitoring exit doors on the Special Care Unit (SCU) when the magnetic locking system failed.

The findings are:

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Review of an electronic email (email) dated 11/29/23 revealed:
-The email was sent from the Director of Maintenance on 11/29/23.
-There was a copy of a work order dated 11/17/29 included in the email.
-The work order indicated a generator malfunction with the transfer switch.
-The generator had been running on and off continuously.
-A technician identified that a new board in the transfer switch was needed.
-A approval to complete the work was needed.
-The generator would have to be manually turned on in the event of a power outage.
-On 11/29/23, the Director of Maintenance notified the fire safety company of issues with the facility's maglocks (magnetic door locks).
-There were blown fuses that had been replaced but the maglock malfunction continued on the Assisted Living (AL) side.

Review of the Special Care Unit (SCU) Medication Aide 2-HR Resident Check sheet dated 11/28/23 revealed:
-There were 35 residents' names listed with boxes for staff to mark every 2 hours from 7:00am to 5:00am.
-One resident's name was hand written at the bottom of the page and did not have check marks for 1:00am, 3:00am and 5:00am.
-One resident had an "H" documented in each check off box.

Observation upon entrance to the facility and SCU on 11/29/23 from 7:35am until 8:00am revealed:
-The Administrator was in her office at 7:35am.
-There were 2 residents at tables in the SCU

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dining room at 7:40am.
-There were 2 personal care aides (PCAs) distributing plates and beverages in the SCU dining room.
-There were 2 other PCAs assisting residents from the living room and resident rooms to the dining room.
-The medication aide (MA) was at the medication cart on the short hall near the living room administering morning medications.
-No staff was observed monitoring SCU exit doors or halls.

Observation of exit doors on the SCU from 8:02am until 8:38am revealed:
-There were 6 exits leading out of the SCU.
-At 8:02am, the lights on the 600 hall and the SCU dining room went out accompanied by a beeping sound.
-At 8:05am, the light on the 600 hall and the SCU dining room came on, but the beeping sound continued.
-The entrance to the SCU from the AL side was observed unlocked and the keypad next to the door was not illuminated at 8:29am.
-There was a wheeled laundry cart and dining room chair in front of the exit door to the courtyard on the 600 hall.
-There was a dresser in front of the outside of the exit door at the end of the 600 hall.

Interview with a medication aide (MA)/PCA on 11/29/23 at 8:30am revealed:
-She was working as a PCA that day (11/29/23).
-All the exit doors on the SCU unlocked when the power went out (10:45pm 11/28/23).
-Staff kept the residents in the living room area for monitoring.

Interview with a PCA on 11/29/23 at 8:35am

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D 461	Continued From page 125 revealed: -PCAs were on the halls to monitor exit doors. -PCAs walking up and down the halls were responsible for checking that residents were in their rooms. -She was not documenting each resident she saw. Interview with a second PCA on 11/29/23 at 9:59am revealed: -She found out the doors to the SCU were unlocked on arrival at work that morning (11/29/23). -The keypad on the door was not lit. -She was told by other staff that she needed to watch the doors. -She was not told specifically how to watch the door and care for residents, just to keep an eye on the doors. -She did not know of any previous issues with the facility's power or the maglocks. -The generator had been running 24/7 for approximately the last 2 weeks (11/15/23 - 11/29/23). -She knew the generator was on because it was located near the SCU outside enclosure and she could hear it. Interview with a second MA/PCA on 11/29/23 at 8:36am revealed: -She was working as a MA that day (11/29/23). -Staff kept an eye on all the residents. -Staff made sure all residents were on the SCU by keeping an eye on the residents in the living room and having staff on the hall to watch the exit doors. -There was no check off sheet for residents. -Staff were documenting checks that doors were locked.	D 461		

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Interview with the maintenance person on 11/29/23 at 8:39am revealed:
-He was sent a message on his phone at 11:02pm on 11/28/23 that the generator went out and the doors on the SCU were unlocked.
-He did not see the message until that morning (11/29/23).

Interview with the Special Care Coordinator (SCC) on 11/29/23 at 8:40am and 8:47am revealed:
-The maglocks on the SCU were not locked.
-Staff called her at 10:45pm on 11/28/23 and told her that the power went out and all the exit doors were unlocked.
-The maintenance person was working on fixing the locks.
-There were 3 residents on the SCU with exit seeking behaviors.
-One resident was out of the facility with a family member, a second was in the living room and the third was in his room at 8:47am on 11/29/23.
-A MA/PCA was monitoring all exit doors from the center area of the hall because the third resident was in his room.
-She instructed staff to monitor the exit doors on the SCU every hour.
-Staff were responsible for documenting a head count of residents on the SCU every 2 hours.
-Staff normally documented a head count of all residents every 2 hours every day.
-Staff were responsible for staying on the hall while the exit doors were unlocked to ensure all residents were there and that no one had left the building.
-Staff were instructed to keep residents with exit seeking behaviors in the living room area.
-The MA on duty was responsible for completing the MA 2 Hour Resident Check sheet every shift.
-The MA checked each resident off by seeing the

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resident or asking PCAs.

Interview with the Administrator on 11/29/23 at 8:40am revealed:
-She arrived to the facility early that day (11/29/23) to assist SCU staff with monitoring.
-There was no documentation of monitoring.
-She did not have a response to the monitoring process of the unlocked SCU exit doors during increased levels of care assistance such as meals, toileting rounds, morning bathing and dressing for the breakfast meal.

Interview with the Regional Maintenance Person on 11/29/23 at 10:30am revealed:
-There was a power surge that caused a fuse to blow.
-He and the facility maintenance person were currently replacing the fuse.
-Problems with the generator started a couple of weeks ago (11/15/23).
-He had the generator service company come out and evaluate the generator.
-The technician found that the computer board was sending message errors resulting in false signals for the generator to turn on.
-The generator needed a new piece for the board that was on back order.
-The piece for the computer board made it so the generator would turn on automatically.
-They were having to manually switch the generator on and off.
-He came out and resolved the problem when it started.
-He was called on 11/28/23 and told the generator was on again.
-He switched the generator to manual start and stop today (11/29/23).

Second interview with the maintenance person on

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11/30/23 at 11:56am revealed:
-About a month ago, the generator just kicked on; he did not know how it happened.
-He used the key to turn the generator off and the facility lights went off.
-The Director of Maintenance came out and called the generator service company the first time the generator turned on about a month ago.
-The generator service company technician said a part was needed for the computer board.
-They had to shut the power off in the facility, turn the generator off and then turn the power back on to the facility.
-The power in the facility stayed on and the generator stayed off.
-Two weeks later or two weeks ago (11/16/23), the generator turned on again for 2 days and cut off on its own.
-The generator came on once again 2-3 days ago (11/27/23 -11/28/23).
-The Regional Maintenance person told him to manually turn the generator off; he did, and the facility lights went out.
-The generator had been on continuously for 2-3 days until 11/29/23.
-Then the maglocks failed.
-First thought to be related to the generator issues, but the fire safety company said the relay inside the box was bad.
-He did not know of any problems with the maglocks prior to 11/29/23.

Interview with the Administrator on 12/01/23 at 4:15pm revealed:
-She did not remember when, but the generator came on by itself one day.
-The facility maintenance person and the Regional Maintenance person handled repairing the generator.
-There was no power loss to the facility during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051060	A. BUILDING: ______ B. WING ______	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	**565 BOYETTE ROAD FOUR OAKS, NC 27524**

(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 461	Continued From page 129 generator troubles. -There were no issues with the maglocks prior to 11/29/23. -When a power outage occurred and the maglocks stopped working, staff were responsible for notifying her. -She was responsible for contacting the maintenance person and Regional Maintenance person. -The MA on the SCU was responsible for completing an immediate head count. -Staff on the SCU were responsible to be stationed to ensure exit doors were visible at all times. -Secured doors on the SCU were the primary source of security and staff monitoring the doors was the secondary source of security.	D 461		