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D 000	Initial Comments The Adult Care Licensure Section and the Beaufort County Department of Social Services conducted an annual and follow-up survey on 01/31/24 and 02/01/24.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 2 of 3 sampled residents (#1,#2) related to failing to follow-up for a resident that had a fall with complaint of pain (#2) and failing to ensure a resident attended scheduled wound care appointments (#1). The findings are: 1. Review of Resident #2's current FL-2 dated 09/13/23 revealed: -Diagnoses included major neurocognitive disorder, non-epileptic seizures and semi-ambulatory with a walker. -She was incontinent of bowel and bladder. -She required assistance with bathing and toileting. Review of Resident #2's current care plan dated 10/23/23 revealed: -She was incontinent of bowel and bladder. -She required assistance from staff for toileting,	D 273		

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ambulation, bathing, dressing and grooming.

Review of an Accident and Incident report for Resident #2 dated 01/07/24 revealed:
-She was walking to the dining room and reported her leg gave out and she went to the floor.
-She reported pain in her left ankle.

Review of Resident #2's primary care provider (PCP) triage note dated 01/07/24 revealed:
-Resident #2 complained of foot/ankle pain.
-Staff stated it was her left ankle and she was unable to bear weight on it.
-An xray was ordered to be completed.

Review of Accident and Incident report for Resident #2 dated 01/15/24 revealed:
- Resident #2 had been unable to walk since her fall on 01/07/24.
-She complained of ankle pain and her ankle was swollen.
-Emergency Medical Services (EMS) was called to transport her to the local emergency department (ED) for evaluation.

Review of Resident #2's discharge summary from the local hospital (ED) revealed:
-An xray was completed on her right ankle.
-She was diagnosed with a possible fracture to her right foot/ankle.
-There were instructions for Resident #2 to follow up with an orthopedist.

Review of Resident #2's PCP triage note dated 01/16/24 revealed:
-The PCP was notified of Resident #2's ankle injury.
-An orthopedic consultation was scheduled for the Resident.

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Review of the after visit summary with Resident #2's orthopedic physician dated 01/25/24 revealed:
-Resident #2's x-ray revealed a fracture of the right ankle.
-An ultrasound revealed a blood clot her in right leg.
-The physician ordered a wheelchair and boot for Resident #2 to utilize to aid with mobility.

Interview with Resident #2 on 02/01/24 at 9:42am revealed:
-She had fallen 3 weeks ago and hurt her ankle.
-She did not want to go to the hospital the day the incident happened.
-She complained to staff that she was in pain and wanted to go to the hospital after a couple of days after the incident.
-She was unable to walk or get out of bed and had to have her meals brought to her.
-Staff called emergency medical services (EMS) when she was crying in pain.

Interview with a medication aide (MA) on 02/01/24 at 2:43pm revealed:
-She contacted Resident #2's PCP to notify her of the fall and injury on 01/07/24.
-The x-ray was completed the next day.
-Resident #2 had stated she had pain in her left ankle, and that was what was x-rayed.
-Resident #2 had required 2-person assistance after the injury.
-Resident #2 had received several of her meals in bed after the injury because she could not get out of bed.

Telephone interview with Resident #2's PCP on 02/01/24 at 4:17pm revealed:
-Staff notified that Resident #2 fell on 01/07/24 and an x-ray was ordered.

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D 273	Continued From page 3 -Staff told her on 01/08/24 that Resident #2 had fallen and was complaining of pain when she saw her on 01/08/24 but she did not have the results of the x-ray. -Resident #2 was in the common area of the facility when she saw her on 01/08/24 and she did not notice swelling or bruising to her leg and ankle. -She did not see her ambulate. -There was no communication from the facility again until 01/15/24 when Resident #2 was sent out to the ED. -She was not aware of the fracture until she saw Resident #2 wearing a boot on 01/22/24 on the next visit to the facility. -The facility should have notified her of the fracture. -She would have requested Resident #2 to be sent to the hospital for evaluation and xray completed because it was more reliable that a mobile xray. Interview with the Facility Manager on 02/01/24 at 4:03pm revealed: -It was not reported to her that Resident #2 fell on 01/07/24. -Resident #2 stated she was in pain but did not want to be sent to the hospital. -She stayed in bed and she thought Resident #2 just wanted to sleep. -She remembered a man coming into the facility to complete an xray on 01/08/24 but she was not sure who that xray was for and she did not ask about it. -Resident #2 required 2 staff members to assist her going to the bathroom after the injury. -Resident #2 received her meals in bed after the injury. -Resident #2 only asked for pain medication twice during the week following her injury.	D 273		

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-On 01/15/24 Resident #2 was unable to get out of bed and complained of pain and so she was sent to the local hospital ED via EMS.

Interview with the Administrator on 02/01/24 at 5:15pm revealed:
-She expected staff to get vital signs and call EMS when a patient fell.
-Staff should send any resident out for medical evaluation for any change in resident status, even if they "just have a feeling that something is not right".
-Staff should have called EMS and had Resident #2 evaluated on 01/07/24 because she complained of ankle pain, had a history of seizures and was unable to bear weight
-She did not know why staff did not send Resident #2 out for evaluation on 01/07/24.
-The Facility Manager should have followed up on the xray that was ordered on 01/07/24.
-Staff were expected to notify the resident's PCP of all incidents and continued changes in a resident following an incident.

2. Review of Resident #1's current FL2 dated 07/11/23 revealed:
-Diagnoses included uncontrolled diabetes and psychotic disorder.
-The resident was intermittently confused.

Review of Resident #1's current care plan dated 06/06/23 revealed that the resident required supervision with bathing and limited assistance with personal hygiene.

Review of an after visit summary dated 12/15/23 revealed:
-Resident #1 was seen at a wound healing center for a skin ulcer of the abdomen with the fat layer exposed.

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-Resident #1 was scheduled for a follow-up appointment on 12/29/23, at 9:30am.

-Review of a progress note dated 12/29/23 revealed:
-Staff documented Resident #1 refused to go to the appointment at the wound clinic and staff was going to reschedule.
-There was no name or signature that indicated who wrote the progress note.

Review of Resident #1's facility records revealed there was no additional documentation related to follow-up appointments at the wound healing center.

Telephone interview with a Patient Access Representative at Resident #1's wound healing center on 01/31/24 at 12:42pm revealed that Resident #1 was documented as a "no show" for his appointment on 12/29/23.

A second telephone interview with a Patient Access Representative at Resident #1's wound healing center on 02/01/24 at 8:26am revealed:
-Resident #1 had appointments scheduled for 01/05/24, 01/19/24, and 02/02/24.
-There was documentation in Resident #1's records showing the appointments were canceled on 01/05/24 and 01/19/24.
-There was documentation in Resident #1's records showing the facility canceled the appointment on 02/02/24 and re-scheduled for 02/09/24 but the name of the caller was not documented.

Interview with Resident #1 on 02/01/24 at 9:28am revealed:
-He had a wound on his stomach.
-The facility took him to see a doctor for the

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wound.
-He could not recall when the doctor appointment was.
-Facility staff had been changing the bandage since his appointment.
-He could not recall the name of doctor he saw but was able to recall the name of the city where the doctor was located.
-He did not know how to contact the doctor.
-He may have refused to go to an appointment because he did not think he needed anymore appointments because the wound was much better.
-He did not have pain or concerns about the wound.

Telephone interview with Resident #1's guardian on 02/01/24 at 8:04am revealed:
-She met Resident #1 at the wound healing center for appointments on 12/08/23 and 12/15/23.
-She was aware Resident #1 had an appointment on 12/29/23 but she had not planned to meet him at the appointment and the facility was going to take him.
-She was not aware Resident #1 missed his appointment at the wound healing center on 12/29/23.
-She was not aware Resident #1 had appointments on 01/05/24, 01/19/24 and 02/02/24 and she was not aware he missed those appointments.
-She thought that maybe the wound healing center decided to end treatment after the appointment on 12/29/23 because she was not aware of any follow-up appointments needed at the wound healing center.
-She was not aware that Resident #1 had refused to go to any of his appointments.
-She would want the facility to notify her of

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D 273	Continued From page 7 refusals and missed appointments so that she could see if there was anything she could do to help Resident #1 get to his appointments. Telephone interview with a registered nurse (RN) at Resident #1's wound healing center on 01/31/24 at 12:37pm revealed: -Resident #1 was seen at the wound healing center for an abdominal wound on 12/08/23 and 12/15/23. -On 12/08/23, the physician's treatment plan included follow-up visits at the wound healing center every two weeks and a follow-up appointment was scheduled for 12/29/23. -Resident #1 did not come to his appointment that was scheduled for 12/29/23. A second telephone interview with the RN at #1's wound healing center on 02/01/24 at 8:26am revealed: -Resident #1 missed follow-up appointments on 12/29/23, 01/05/24 and 01/19/24. -It was important for Resident #1 to come to all scheduled appointments so that his wound could be assessed and monitored to ensure the treatments were working. -Not following the treatment plan including follow-up appointments increased Resident #1's risk of infection, slow wound healing or worsening of the wound. Interview with a medication aide (MA) on 02/01/24 at 2:37pm revealed: -The Facility Manager scheduled and rescheduled all appointments. -If an MA was notified of an appointment, they wrote it down on the appointment list and told the Facility Manager, the Facility Manager then arranged the transportation. -If a resident refused to go to an appointment,	D 273		

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she would notify the Facility Manager.
-She did not recall Resident #1 refusing to go to any appointments.

Telephone interview with Resident #1's primary care provider (PCP) on 02/01/24 at 4:45pm revealed:
-She referred Resident #1 to the wound healing center on 12/17/23, related to a wound on his abdomen that staff reported was open and bleeding.
-Her most recent visit with Resident #1 was 01/22/24 and he was seen for management of chronic conditions including diabetes.
-Her visit on 01/22/24 did not include review of Resident #1's wound as the wound treatment was provided by the physician at the wound healing clinic.
-She was not aware Resident #1 missed his appointments at the wound healing center on 12/29/23, 01/05/24 and 01/19/24.
-She was not aware Resident #1's appointment that was scheduled for 02/02/24 had been rescheduled.
-The facility should have notified her of the missed and rescheduled appointments so that she could have considered other treatment options such as referring Resident #1 to a home health provider.
-She was concerned that Resident #1 had missed the follow-up appointments because Resident #1 was at increased risk for complications related to a diagnosis of diabetes which could contribute to slow wound healing.
-Additional complications included an increased risk of worsening of the wound, infection of the wound, systemic infection, hospitalization, and death.

Interview with the Facility Manager and the

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D 273	Continued From page 9 Administrator on 02/01/24 at 11:32am revealed: -They were not aware Resident #1 missed the appointments on 01/05/24 and 01/19/24. -They were not aware the appointment that was scheduled for 02/02/24 had been rescheduled. -They did not know who rescheduled the appointments. Interview with the Facility Manager on 02/01/24 at 5:06pm revealed: -She was responsible for scheduling and rescheduling appointments and transportation. -She was aware Resident #1 had refused to go to the appointment on 12/29/23. -When Resident #1 refused to go to the appointment on 12/29/23 she called the wound healing center and rescheduled the appointment. -She did not contact Resident #1's PCP or guardian when Resident #1 refused to go to the appointment on 12/29/23. -She should have contacted Resident #1's PCP and guardian when she rescheduled the appointment on 12/29/23. -She was not aware Resident #1 did not go to the appointments on 01/05/24 and 01/19/24. -She was not aware the appointment scheduled for 02/02/24 had been rescheduled for 02/09/24. -She did not know who canceled the appointments on 01/05/24, 01/09/24 and 02/02/24. -She did not think Resident #1 would know how to call and cancel appointments and she had never seen Resident #1 use the facility's telephone. -If the facility's transportation staff canceled or rescheduled any appointments, they should have notified her so she could notify the PCP and guardian. -She should have followed up to ensure Resident #1 went to his rescheduled appointment on 01/05/24 after he refused to go on 12/29/23.	D 273		

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Interview with the Administrator on 02/01/24 at 5:28pm:
-The Facility Manager was responsible for scheduling and rescheduling appointments and transportation.
-The Facility Manager was responsible for notifying the residents' PCP and guardian or family members of appointments and appointment changes.
-She was not aware Resident #1's PCP and guardian had not been notified of missed and rescheduled appointments for Resident #1.
-The Facility Manager should have contacted Resident #1's PCP and guardian when the resident refused to go to an appointment and when Resident #1's appointments were canceled and rescheduled.

____

The facility failed to notify the primary care provider (PCP) that a resident (#2) was complaining of worsening pain, unable to bear weight to ambulate, required 2 staff to assist her to transfer and could not get out of bed for meals and did not send her to the local emergency department for evaluation for 8 days following a fall which resulted in an ankle fracture and blood clot. The failure of the facility resulted in serious physical harm and neglect and constitutes a Type A1 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/31/24 for this violation.

THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED March 02, 2024.

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D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure physician treatment orders were implemented for 1 of 3 sampled residents (#1) including physician orders for the treatment of a wound. The findings are: Review of Resident #1's current FL2 dated 07/11/23 revealed: -Diagnoses included uncontrolled diabetes and psychotic disorder. -The resident was intermittently confused. Review of Resident #1's current care plan dated 06/06/23 revealed that the resident required supervision with bathing and limited assistance with personal hygiene. Interview with Resident #1 on 02/01/24 at 9:28am revealed: -He had a wound on his stomach. -The facility took him to see a doctor for the wound and staff had been changing the bandage. -He did not currently have any pain.	D 276		

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D 276	Continued From page 12 Review of an after visit summary note dated 12/08/23 revealed: -Resident #1 was seen at a wound healing center for an initial evaluation of an open wound. -After visit instruction orders were to clean the wound by placing a gauze soaked in Vashe (cleansing treatment used to clean the wound and aide in wound healing) on the wound for 5 minutes, apply polymem (a protective foam wound dressing) to the wound facing out, cover with tape, and change daily to every other day. -Review of a signed physician visit note dated 12/08/23 revealed the treatment orders for Resident #1's wound were to wet gauze with Vashe, put on the wound for 5 minutes, cover the wound with polymem dressing and secure with tape. Review of an after visit summary note dated 12/15/23 revealed: -Resident #1 was seen at the wound healing center for a skin ulcer of the abdomen with the fat layer exposed. -After visit instruction orders were to apply Vashe 5 minute soak and polymen every other day, more often if needed. Review of a signed physician visit note dated 12/15/23 revealed: -Treatment orders for Resident #1's wound were to continue with Vashe 5 minute soak and polymem dressing every other day, or more often due to drainage. -The documented contact person was the [Facility Manager]. Review of Resident #1's electronic treatment administration records (eTAR) dated 12/01/23	D 276		

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through 01/31/24 revealed:
-There was an entry to "Wet gauze with Vaseline and put on the wound on stomach for 5 minutes. Cut a piece of polymin to cover the wound and cover with tape. Change every other day."
-Staff documented the treatment was administered every other day 12/10/23 through 01/31/24.

Observations of Resident #1's medications/treatments on hand on 01/31/24 at 2:23 revealed:
-There was a 4-ounce bottle of Vashe wound solution, the bottle was approximately 3/4 full and did not have a pharmacy label on it.
-There was a 13-ounce jar of petroleum jelly.
-The petroleum jelly had a pharmacy label with a label dated 12/08/23, that read "use for treatment of wound on stomach".

Interview with a medication aide (MA) on 01/31/24 at 2:37pm revealed:
-She provided dressing changes for Resident #1's wound on his stomach every other day.
-When she provided the dressing changes she cleansed wound by applying Vashe wound cleanser with gauze, applied petroleum jelly (generic for Vaseline) with gauze and then covered the wound with a foam dressing and secured it with tape.
-The wound clinic sent the Vashe wound cleanser, foam dressing and tape back with Resident #1 after his first appointment on 12/08/23.
-She applied the Vashe because she saw the order in Resident #1's chart.
-She applied the petroleum jelly because the pharmacy sent a jar of petroleum jelly and that was the what eTAR order instructions were.
-She changed Resident #1's dressing on

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01/31/24 and the wound looked much better and it had pretty much healed over.

Interview with a second MA on 02/01/24 at 9:17am revealed:
-She provided dressing changes for Resident #1's wound on his stomach every other day.
-When she provided the dressing changes, she cleansed wound by applying Vashe wound cleanser with gauze, applied Vaseline with gauze and then covered the wound with a foam dressing and secured it with tape.
-The wound clinic sent the Vashe wound cleanser, foam dressing and tape back with Resident #1 after his first appointment.
-She thought Resident #1 returned to the facility after his appointment on 12/08/23 with the after visit summary and written physician visit note but she could not recall if she faxed them to the pharmacy.
-A registered nurse (RN) at Resident #1's wound clinic called the facility after he returned from his appointment on 12/08/23 and gave verbal instruction to clean his wound by placing a gauze soaked in Vashe wound solution on the wound for 5 minutes, then apply the foam dressing to the wound and secure with tape.
-The RN from the wound clinic did not give verbal instructions for Vaseline to be applied.
-She applied the Vashe because those were the instructions stated by the wound clinic RN and she saw the order in Resident #1's chart.
-She applied the petroleum jelly because the pharmacy sent a jar of petroleum jelly and that was what the eTAR order instructions were.
-Resident #1's wound looked better last time she changed the dressing about a week ago.

Telephone interview with a pharmacy technician at Resident #1's pharmacy on 02/01/24 at

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D 276	Continued From page 15 9:06am revealed: -The pharmacy entered orders into the facility's eTAR. -The pharmacy received Resident #1's wound treatment order on 12/08/23. -The order the pharmacy received was to wet gauze with Vashe and apply to the wound for 5 minutes and cover with polymem dressing and secure with tape. -The treatment orders entered on Resident #1's eTAR on 12/08/23, were to wet gauze with Vaseline and put on the wound on stomach for 5 minutes, cut a piece of polymen to cover the wound, cover with tape and change every other day. -The eTAR entry was mistakenly entered incorrectly by the pharmacy. Telephone interview with an RN at Resident #1's wound healing center on 01/31/24 at 12:37pm revealed: -Resident #1 was seen at the wound healing center for an open wound on his abdomen on 12/08/23 and 12/15/23. -On 12/08/23, the physician wrote orders for Resident #1's wound to be cleaned with Vashe wound cleanser by placing a gauze soaked in Vashe on the wound for 5 minutes then apply polymem-max to the wound facing out, secure with tape and change every other day. -On 12/15/23, the physician wrote instructions to continue the treatment that was ordered on 12/08/23. -Vashe wound wash was a cleansing treatment used to clean the wound and aide in wound healing. -Polymen max was a foam wound dressing used to help protect the wound from external contaminants.	D 276		

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A second telephone interview with the RN at Resident #1's wound healing center on 02/01/24 at 8:32am revealed:
-Vaseline was never ordered by the physician at the wound healing center.
-Not following the treatments according to the physician's orders increased Resident #1's risk of infection, slow wound healing or worsening of the wound.

Telephone interview with Resident #1's primary care provider (PCP) on 02/01/24 at 4:45pm revealed:
-She referred Resident #1 to the wound healing center on 12/17/23, related to a wound on his abdomen that staff reported was open and bleeding.
-Her most recent visit with Resident #1 was 01/22/24 and he was seen for management of chronic conditions including diabetes
-Her visit on 01/22/24 did not include review of Resident #1's wound as the wound treatment was provided by the physician at the wound healing center.
-The facility should have implemented Resident #1's wound treatments as directed by the physician at the wound healing center.
-She was not aware the facility had not implemented the correct orders written by the physician at the wound healing center.
-Resident #1 was at increased risk for complications related to his diagnosis of diabetes which could contribute to slow wound healing.
-Additional complications included an increased risk of worsening of the wound, infection of the wound, systemic infection, hospitalization and death.

Interview with the Facility Manager and the Administrator on 02/01/24 at 11:32am revealed:

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D 276	Continued From page 17 -The Facility Manager and Administrator were not aware of the transcription error on Resident #1's eTAR. -The Facility Manager and Administrator were not aware staff had not implemented Resident #1's wound treatment according to the physician's orders. Interview with the Administrator on 02/01/24 at 2:54 revealed: -She contacted the RN at Resident #1's wound healing center on 02/01/24. -The RN requested the facility send pictures of the resident's abdominal wound to the wound healing center for further evaluation. Review of the images of Resident #1's abdominal wound provided by the facility on 02/01/24 at 2:54pm revealed: -The wound did not have any open areas. -There was no apparent redness, swelling or drainage. Interview with the Administrator on 02/01/24 at 5:28pm revealed: -The MAs were responsible for comparing the order to the eTAR to ensure they matched so that the order would be implemented as directed in the physician's orders. -The facility did not currently have an audit system in place to follow behind the MAs to ensure their responsibility had been completed correctly. -The MAs should have reviewed the order in Resident #1's chart and compared it to the eTAR entry before they provided the wound care treatments to the resident's wound. ______________________________ The facility failed to ensure physician treatment orders, for Resident #1's abdominal wound, were	D 276		

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D 276	Continued From page 18 implemented according to the physician's order which put the resident at risk for infection of the wound, slow wound healing, worsening of the wound, systemic infection, hospitalization or death. This failure was detrimental to the health, safety and welfare of Resident #1 and constitutes a Type B Violation. ______________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/01/24. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 17, 2024.	D 276		
D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage;	D 278		

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D 278	Continued From page 19 (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule); (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic	D 278		

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devices except as used in early post-operative treatment for shaping of the extremity;
(24) ambulation using assistive devices that requires physical assistance;
(25) range of motion exercises;
(26) any other prescribed physical or occupational therapy;
(27) transferring semi-ambulatory or non-ambulatory residents; or
(28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure a licensed health professional participated in the on-site review and evaluation of residents' health status, care plan and care provided for 1 of 3 sampled residents (#1) related to medications administered through injection and clean wound dressing changes.

The findings are:

Review of Resident #1's current FL2 dated 07/11/23 revealed:
-Diagnoses included uncontrolled diabetes.
-The resident displayed interment confusion.

Review of Resident #1's current care plan dated 06/06/23 revealed:
-The resident required supervision and limited assistance with his activities of daily living.
-There was no documentation that indicated Resident #1 required subcutaneously injectable

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D 278	Continued From page 21 medications, finger stick blood sugar checks (FSBS) and dressing changes for wound care. Review of Resident #1's medication orders dated 08/28/23 revealed: -There was an order for insulin lispro 100 unit/ML pen inject sub-q (subcutaneously) using a sliding scale four times a day with meals and at bed time for diabetes that was electronically signed by Resident #1's primary care provider (PCP). Review of a triage note from Resident #1's primary care provider (PCP) dated 08/31/23 revealed: -FSBS checks should be four times a day with sliding scale insulin orders. -Review of a physician visit note dated 12/08/23 revealed: -Treatment orders for Resident #1's wound were to wet gauze with Vashe (wound cleansing treatment)and put on wound for 5 minutes then cover the wound with polymem dressing and secure with tape. -The visit note was signed by the physician. Review of a physician visit note dated 12/15/23 revealed: -Treatment orders for Resident #1's wound were to continue with Vashe 5 minute soak and polymem max dressing every other day, or more often due to drainage. -The visit note was signed by the physician. Review of Resident #1's Licensed Health Professional Support (LHPS) Review and Evaluation dated 08/18/23 revealed the facility's LHPS registered nurse (RN) evaluated Resident #1 related to FSBS.	D 278		

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Review of Resident #1's LHPS Review and Evaluation dated 11/04/23 revealed the facility's LHPS RN evaluated Resident #1 related to FSBS.

Telephone interview with the facility's LHPS RN on 02/01/24 at 2:57pm revealed:
-She came to the facility every other month to complete LHPS evaluations and reviews.
-She reviewed residents for LHPS tasks that the facility requested.
-Prior to her visits to the facility, she contacted the Administrator to obtain a verbal list of residents to review.
-The facility provided her with a verbal list of newly admitted residents and any other resident changes that required a LHPS task evaluation.
-She completed LHPS reviews for Resident #1 on 08/18/23 and 11/04/23 related to his order for FSBS
-The facility had not notified her that Resident #1 had orders for subcutaneously injectable medications.
-The facility had not notified her that Resident #1 had orders for dressing changes for wound care treatment.

Interview with the Facility Manager on 02/01/24 at 5:06pm revealed::
-She started the Facility Manager position in August, 2023.
-She had not been trained on the LHPS process yet.

Interview with Administrator on 02/01/24 at 5:14pm revealed:
-The LHPS RN completed the evaluations for newly admitted residents and every three months for current residents with LHPS task needs.
-The LHPS RN called the Administrator before

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D 278	Continued From page 23 she completed the visits to the facility to get a list of newly admitted residents and changes for existing residents who required new LHPS tasks. -The facility did not currently have a system for tracking resident changes that needed to be communicated to the LHPS RN. -She thought the LHPS reviewed the residents' full chart when she completed the LHPS evaluation. -The facility did not currently have a process for reviewing the LHPS evaluations for accuracy. -She was not aware Resident #1 had not been evaluated for his subcutaneous medication injections or his dressing changes for his wound care.	D 278		
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 and procedures. This Rule is not met as evidenced by: Based on observations, records reviews, and interviews, the facility failed to ensure the administration of medications as ordered for 2 of 3 residents (#4, #5) observed during the medication pass on 01/31/24 including errors with medications used to treat indigestion (#4) and a medication used to prevent gum disease (#5). The findings are:	D 358		

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The medication error rate was 6% as evidenced by 2 errors out of 32 opportunities during the 8:00am/9:00am medication pass on 01/31/24.

1.Review of Resident #4 current FL-2 dated 10/13/23 revealed:
-Diagnoses included schizophrenia and glaucoma.
- He was ambulatory.
- There was an order for antacid double strength, 20 ml to be administered twice daily after meals.

Observation of the 8:00am/9:00am medication pass on 01/31/23 revealed:
-Resident #4 was administered 2 pills at 8:13am.
-There was no liquid medication administered to Resident #4.

Review of Resident #4's electronic medication administration record (eMAR) for January 2023 revealed:
-There was a computerized entry for antacid double strength liquid, 20 ml to be administered twice daily with breakfast and dinner for gas and bloating.
-The medication was scheduled to be administered at 9:00am and 6:00pm each day.
-There was documentation antacid double strength liquid, 20 ml was not administered at 9:00am because Resident #4 refused.

Interview with Resident #4 on 01/31/24 at 4:50pm revealed:
-He was typically administered a liquid antacid twice daily.
-He did not experience any gastrointestinal discomfort from missing the dose that morning.

Interview with the medication aide (MA) on

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01/31/24 at 2:55pm revealed the antacid liquid was available for administration that morning but she forgot to administer it because she was nervous being observed administering medications.

Observation of medications on hand for Resident #4 on 01/31/24 at 2:55pm revealed there was a bottle of antacid liquid labeled to adminster 20ml twice daily with a dispense date of 01/08/24 and the bottle was approximately on third full.

Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 02/01/24 at 9:06am revealed:
- 1 bottle of antacid double strength liquid was last dispensed on 01/08/24 for Resident #4.
-The 355 ml bottle should last 8 days if it was administered twice daily as ordered.

Telephone interview with the pharmacist for the facility's contracted pharmacy on 02/01/24 at 9:24am revealed Resident #4 could have increased gas and experience pain and discomfort if the medication is not administered as ordered.

Telephone interview with Resident #4's primary care provider (PCP) on 02/01/24 at 4:17pm revealed Resident #4 could have symptoms of heartburn or indigestion if he is not administered his antacid as prescribed.

Refer to the telephone interview with the pharmacy technician for the facility's contracted pharmacy on 02/01/24 at 9:06am

Refer to the interview with the Administrator on 02/01/24 at 5:15pm.

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D 358	Continued From page 26 2. Review of Resident #5's current FL-2 dated 10/13/23 revealed: -Diagnoses included congestive heart failure and diabetes. -There was an order for Peridex 0.12%, 15 ml was to be administered to swish for 30 seconds and spit twice daily. (Peridex is the brand name for chlorhexidine mouth rinse which is an anitsepic mouth rinse used to treat or prevent gum disease.) Review of Resident #5's physician's orders dated 11/07/23 revealed chlorhexidine 0.12% rinse, 15 ml was to be administered to swish for 30 seconds and spit twice daily for mouth care. Observation of the 8:00am/9:00am medication pass on 01/31/23 revealed there was no chlorhexidine 0.12% rinse administered. Review of Resident #5's electronic medication administration record (eMAR) for January 2023 revealed: -There was a computerized entry for chlorhexidine 0.12% rinse, 15 ml was to be administered to swish for 30 seconds and spit twice daily for mouth care. -The medication was scheduled to be administered at 8:00am and 8:00pm each day. -There was documentation chlorhexidine 0.12% rinse was not administered on 01/31/24 at 8:00am because it was not received from pharmacy. Telephone interview with the pharmacist for the facility's contracted pharmacy on 02/01/24 at 9:24am revealed -1 bottle of chlorhexidine 0.12% rinse was last requested on 01/30/24 for Resident #5 but may not have made it to the facility for the am dose on	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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01/31/24.
-The previous dispense date was 12/11/23.
-Each bottle contained 473 mLs which should last 14-15 days.

Interview with the medication aide (MA) on 01/31/24 at 8:38am revealed:
-Resident #5's chlorhexidine 0.12% rinse was not available for administration.
-A refill was requested on 01/30/24 but had not been received.

Telephone interview with Resident #5's primary care provider (PCP) on 02/01/24 at 4:17pm revealed Resident #5 was prescribed the chlorhexidine mouth rinse as part of her mouth care routine to prevent gum disease.

Refer to the telephone interview with the pharmacy technician for the facility's contracted pharmacy on 02/01/24 at 9:06am

Refer to the interview with the Administrator on 02/01/24 at 5:15pm.

____

Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 02/01/24 at 9:06am revealed liquid medications were a bulk item and had to be requested by the facility for each refill.

Interview with the Administrator on 02/01/24 at 5:15pm revealed:
-Medications should always be available for administration.
-Medications should be requested when there was approximately 1 week of medication available.

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D 367	Continued From page 28	D 367		
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 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 and for 2 of 3 residents (#4, #5) observed during the medication pass on 01/31/24 including errors with medications used to treat indigestion (#4) and a medication used to prevent gum disease (#5) and for 1 of 3 sampled residents including a medication used in wound care (#1). The findings are: 1. Review of Resident #1's current FL2 dated	D 367		

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D 367	Continued From page 29 07/11/23 revealed: -Diagnoses included uncontrolled diabetes and psychotic disorder. -The resident was intermittently confused. Review of Resident #1's current care plan dated 06/06/23 revealed that the resident required supervision with bathing and limited assistance with personal hygiene. Review of an after visit summary note dated 12/08/23 revealed: -Resident #1 was seen at a wound healing center for an initial evaluation of an open wound. -After visit instruction orders were to clean the wound by placing a gauze soaked in Vash (wound cleansing treatment) on the wound for 5 minutes, apply polymem to the wound facing out, cover with tape and change daily to every other day. -Review of a physician visit note dated 12/08/23 revealed: -Treatment orders for Resident #1's wound were to wet gauze with Vashe and put on wound for 5 minutes, cover the wound with polymem dressing and secure with tape. -The visit note was signed by the physician. Review of an after visit summary dated 12/15/23 revealed: -Resident #1 was seen at the wound healing center for a skin ulcer of the abdomen with the fat layer exposed. -After visit instruction orders were to apply Vashe 5 minute soak and polymen-max every other day, more often if needed. Review of a physician visit note dated 12/15/23 revealed: -Written treatment orders for Resident #1's	D 367		

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D 367	Continued From page 30 wound were to continue with Vashe 5 minute soak and polymem max dressing every other day, or more often due to drainage. -The visit note was signed by the physician. Review of Resident #1's electronic treatment administration records (eTAR) dated 12/01/23 through 01/31/24 revealed: -There was an entry to "Wet gauze with Vaseline and put on the wound on stomach for 5 minutes. Cut a piece of polymin to cover the wound and cover with tape. Change every other day." -Staff documented the treatment was administered every other day 12/10/23 through 01/31/24. -There was not an entry for Vashe wound cleanser. Observations of Resident #1's medications/treatments on hand on 01/31/24 at 2:23 revealed: -There was a 4-ounce bottle of Vashe wound solution, the bottle was approximately 3/4 full and did not have a pharmacy label on it. -There was a 13-ounce jar of petroleum jelly. -The petroleum jelly had a pharmacy label with a label dated 12/08/23, that read "use for treatment of wound on stomach". Interview with a medication Aide (MA) on 01/31/24 at 2:37pm revealed: -She completed dressing changes for Resident #1's wound on his stomach every other day. -When she provided the dressing changes, she cleansed wound by applying Vashe wound cleanser with gauze, applied Vaseline with gauze and then covered the wound with a foam dressing and secured it with tape and then documented it as completed in eTAR. -The wound clinic sent the Vashe wound	D 367		

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cleanser, foam dressing and tape back with Resident #1 after his first appointment on 12/08/23.
-She applied the Vashe because she saw the order in Resident #1's chart and she applied the Vaseline because that was what the eTAR instructions were.

Interview with a MA on 02/01/24 at 9:17am revealed:
-She completed dressing changes for Resident #1's wound on his stomach every other day.
-When she provided the dressing changes, she cleansed the wound by applying Vashe wound cleanser with gauze, applied Vaseline with gauze and then covered the wound with a foam dressing and secured it with tape and documented it as completed on eTAR.
-The wound clinic sent the Vashe wound cleanser, foam dressing and tape back with Resident #1 after his first appointment.
-A Registered Nurse (RN) at Resident #1' wound clinic called the facility after he returned from his appointment on 12/08/23 and gave verbal instruction to clean his wound by placing a gauze soaked in Vashe wound solution on the wound for 5 minutes, then apply the foam dressing to the wound and secure with tape.
-The wound nurse did not give verbal instructions for Vaseline to be applied.
-She applied the Vashe because those were the instructions stated by the wound clinic RN and she saw the order in Resident #1's chart.
-She applied the Vaseline because that was what the eTAR order instructions were.
-She documented the dressing changes in the eTAR but there was not a separate entry for the Vashe wound cleanser.

Telephone interview with a pharmacy technician

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D 367	Continued From page 32 at Resident #1's pharmacy on 02/01/24 at 9:06am revealed: -The pharmacy entered orders into the facility's eTAR. -The pharmacy received Resident #1's wound treatment order on 12/08/23. -The order the pharmacy received gave instructions to wet gauze with Vashe and apply to the wound for 5 minutes and cover with polymen dressing and secure with tape. - The orders entered on Resident #1's eTAR on 12/08/23, were to wet gauze with Vaseline and put on the wound on stomach for 5 minutes, cut a piece of polymem to cover the wound, cover with tape and change every other day. -The eTAR entry was mistakenly entered incorrectly by the pharmacy and there was not an order for petroleum jelly (generic Vaseline) to be applied. Telephone Interview with an RN at Resident #1's wound healing center on 01/31/24 at 12:37pm revealed: -Resident #1 was seen at the wound healing center for an abdominal wound on 12/08/23 and 12/15/23. -On 12/08/23, the physician wrote orders for Resident #1's wound to be cleaned with Vashe wound cleanser by placing a gauze soaked in Vashe on the wound for 5 minutes then apply polymem max to wound facing out, secure with tape and change every other day. -On 12/15/23, the physician wrote instructions to continue the treatment that was ordered on 12/08/23. -Vashe wound wash was a cleansing treatment used to clean the wound and aide in wound healing. -Polymen Max was a foam wound dressing used to help protect the wound from external	D 367		

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D 367	Continued From page 33 contaminants. A second telephone interview with an RN #1's wound healing center on 02/01/24 at 8:32am revealed Vaseline was never ordered by the physician at the wound healing center. Interview with the Facility Manager and the Administrator on 02/01/24 at 11:32am revealed: -The MAs or transportation staff were supposed to bring any new orders to the Facility Manager for review. -The Facility Manager reviewed the orders and sent them to the pharmacy and then gave the orders to the MA. -The Facility Manager and Administrator were not aware Resident #1's wound care orders were inaccurately transcribed on the eTAR. -The Facility Manager and Administrator were not aware staff had been administering the Vashe wound cleanser without documenting it on eTAR. Interview with the Administrator on 02/01/24 at 5:28pm revealed: -The MAs were responsible for comparing the order to the eTAR to ensure they matched. -Once the MAs compared the orders to the eTAR they approved the eTAR in the system and began to administer the medication or treatment as ordered and then documented the administration in the eTAR. -The facility did not currently have an audit system in place to follow behind the MAs to ensure their responsibility had been completed correctly. -The MAs should have reviewed the order in Resident #1's chart and compared it to the eTAR entry before they provided the wound care treatments to Resident #1's wound and the MAs should have notified of the pharmacy of any	D 367		

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transcription discrepancies.

Refer to the telephone interview with the pharmacy technician for the facility's contracted pharmacy on 02/01/24 at 9:06am.

Refer to interview with the primary care provider (PCP) on 02/01/24 at 4:17pm.

2.Review of Resident #4 current FL-2 dated 10/13/23 revealed:
-Diagnoses included schizophrenia and glaucoma.
- He was ambulatory.
- There was an order for antacid double strength, 20 ml to be administered twice daily after meals.

Observation of the 8:00am/9:00am medication pass on 01/31/23 revealed:
-Resident #4 was administered 2 pills at 8:13am.
-There was no liquid medication administered to Resident #4.

Review of Resident #4's electronic medication administration record (eMAR) for January 2023 revealed:
-There was a computerized entry for antacid double strength liquid, 20 ml to be administered twice daily with breakfast and dinner for gas and bloating.
-The medication was scheduled to be administered at 9:00am and 6:00pm each day.
-There was documentation the antacid double strength liquid, 20 ml was administered twice daily on 01/01/24 through 01/30/24.
-There was documentation antacid double strength liquid, 20 ml was not administered on 01/31/24 at 9:00am because Resident #4 refused.

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D 367	Continued From page 35 Interview with Resident #4 on 01/31/24 at 4:50pm revealed: -He was typically administered a liquid antacid twice daily. -He did not experience any gastrointestinal discomfort from missing the dose that morning. Interview with the medication aide (MA) on 01/31/24 at 2:55pm revealed the antacid liquid was available for administration that morning but she forgot to administer it because she was nervous being observed administering medications. Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 02/01/24 at 9:06am revealed: - 1 bottle of antacid double strength liquid was last dispensed on 01/08/24 for Resident #5. -The 355 ml bottle should last 8 days if it was administered twice daily as ordered and he should have been out around 01/16/24. Telephone interview with the pharmacist for the facility's contracted pharmacy on 02/01/24 at 9:24am revealed Resident #4 could have increased gas and experience pain and discomfort if the medication is not administered as ordered. Telephone interview with Resident #4's primary care provider (PCP) on 02/01/24 at 4:17pm revealed Resident #4 could have symptoms of heartburn or indigestion if he is not administered his antacid as prescribed. ________________________________ Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 02/01/24 at 9:06am revealed liquid medications were a bulk item and had to be requested by the facility	D 367		

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D 367	Continued From page 36 for each refill. Telephone interview with the primary care provider (PCP) 02/01/24 at 4:17pm revealed: -She relied on the eMAR to be accurate so that she could evaluate effectiveness and guide her treatment. -If a resident was not receiving a medication that was ordered and it was documented the medication was administered, it was difficult for her to know when and how to adjust medications for a resident.	D 367		