Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051060	A. BUILDING: _____ B. WING _____	R 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 a follow-up survey on February, 6, 7, and 8, 2024.	D 000	Response to the citied deficiencies do not consitite an admission agreement by the facility of the truth of rthe facts alleged or conclusion set forth in the Settlement of Deficiencies or Corrective Actions Reports. The Plan of Corrections is prepared soley as a matter of compliance with State Law.	
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: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation is abated. Non-compliance continues. Based on observations, record reviews, and interviews, the facility failed to ensure healthcare referral and follow-up related to failure to implement physician's orders for 1 of 5 sampled residents (#2) for an electrocardiogram (EKG) (an EKG is a recording of the heart's electrical activity). The findings are: Review of Resident #2's current FL-2 dated 03/10/23 revealed diagnoses included diabetes mellitus type 2, dementia, and schizoaffective disorder. Review of Resident #2's Resident Register revealed he was admitted to the facility on 04/14/21. Review of Resident #2 primary care provider's (PCP) visit note dated 01/16/24 revealed: -Resident #2 was seen for an acute visit for abnormal weight loss, hip pain, and muscle	D 273	Four Oaks shall ensure referral and follow-up to meet the routine and acute health care needs of the residnets.	3/25/24

Reviewed and Acknowledged MW 03/18/24

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D 273	Continued From page 1 weakness. -Under the "Orders" section of the 01/16/24 PCP's visit note was an order for an EKG to rule out new ST evaluation. (An elevated ST segment could be indicative of an occlusion or blockage of one or more coronary arteries that supply the heart with blood). Resident #2's EKG ordered on 01/16/24 was requested for review on 02/07/24 and there was no EKG provided for review. Interview with Resident #2 on 02/08/24 at 8:47am revealed: -He denied current or previous chest pain. -He denied a history of heart problems. -He was not aware of an order for an EKG. Interview with Resident Care Coordinator (RCC) on 02/07/24 at 12:28pm revealed: -Resident #2 did not have an EKG result in his record. -There was not an EKG scheduled for Resident #2. -She was not aware of an order dated 01/16/24 for Resident #2 to have an EKG. Second interview with the RCC on 02/07/24 at 12:56pm revealed: -After a resident was seen by the in-house PCP, the PCP e-mailed the visit note and orders to the facility within a day or two of the visit. -It was the Care Managers', (herself, and/or the Memory Care Coordinator's (MCC)) responsibility to review the emails for all PCP visit notes and orders. -When an EKG was ordered by the PCP, she sent the order, electronically, to their contracted mobile EKG provider and they performed the EKG onsite at the facility usually within 24 hours.	D 273	EKG was completed on 2/7/2024. Provider was notified by the Care manager when EKG was completed. Provider signed off on 2/13/2024 once provider was in the commuinity. No issues or concern identified. Resident #2 Executive Director and Care Managers will ensure that all referrals are scheduled and implemented per the PCP orders. Care manager will document in the EMAR system the attempts made at the time the referral was sent for scheduling. Care Managers will continue to document until appointment is scheduled. Care Managers will review daily Activity report at stand up with Exective Director to ensure all referrals has been addressed and implemented. Care Managers was inserviced by Executive Director on the imprtance of using the Order Processing System Four Oaks Executive will also implemeent stand down to meet with all departments at the end of the day to ensure all healthcare referral and follow up has been implemented.	2/13/24 3/25/24 3/13/24 3/25/24

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D 273	Continued From page 2 -She did not review Resident #2's 01/16/24 PCP visit note. -She was not sure why she did not review Resident #2's 01/16/24 visit note. -There was not a system in place to ensure all residents' PCP visit notes were reviewed. -She should have reviewed Resident #2's 01/16/24 PCP visit note. Interview with the Administrator on 02/08/24 at 2:00pm revealed: -The PCP usually notified the Care Managers (the RCC and/or the MCC) of new orders after a resident's visit. -The PCP sent the residents' orders and visit notes via e-mail to the facility usually within 24 hours. -These e-mails came to a group that included himself and the Care Managers. -The Care Managers were responsible for reviewing all the residents' PCP orders and PCP visit notes. -Resident #2's 01/16/24 PCP visit note should have been reviewed by the RCC or MCC on 01/16/24 or within 24 hours. -He expected all residents' PCP visit notes and orders to be reviewed by the RCC or the MCC. -He expected all PCP orders to be processed within 24 hours. -He was not aware that the EKG ordered by Resident #2's PCP on 01/16/24 had not been performed until it was brought to his attention on 02/07/24 by the RCC. -The EKG that was ordered by Resident #2's PCP should have been completed within 24 hours. -There was not a system in place to ensure all residents' PCP visit notes were reviewed by the Care Managers.	D 273		

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D 273	Continued From page 3 Interview with Resident #2's PCP on 02/08/24 at 12:55pm revealed: -Resident #2 did not have a history of heart problems. -Resident #2 had some abnormal heart rhythms on an EKG during a hospitalization for pneumonia earlier in January 2024. -She ordered a routine follow-up EKG for Resident #2 at the 01/16/24 visit. -She was contacted by the facility on 02/07/24 and notified that Resident #2 had not had the EKG ordered on 01/16/24. -She gave a new EKG order for Resident #2 and the EKG was completed on 02/07/24 and sent for her review. -It was reported as unchanged and will continue to follow the resident. -She had no concerns that Resident #2's EKG had not been performed because it was ordered as a routine follow-up. -She expected the facility to review all visit notes and orders and to implement all orders for the residents after she emailed the orders and visit notes.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 276	Four Oaks shall assure healthcare implentation to meet the rountine and acute health care needs of the residents.	3/25/24

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D 276	Continued From page 4 review the facility failed to ensure physician orders were implemented for 1 of 1 sampled resident who had an order to monitor blood pressure (BP) and adjust medication as needed for (Resident #4). The findings are: Review of Resident #4's current FL-2 dated 10/10/23 revealed diagnoses of vascular dementia, failure to thrive, and depression. Review of Resident #4's Progress notes dated 01/16/24 revealed an assessment plan for hypertension to monitor the resident's BP for 1 week and adjust medication as needed. Record review revealed that Resident #1 did not have any documented BP checks from 01/16/24 through 01/23/24. Interview with Resident #4's on 02/07/24 at 9:20am revealed: -The resident was sitting on a sofa in the day room looking around. -He was doing alright; "alive and good." -He did not have any concerns about his care. -He knew he got his BP checked but could not say how often. Interview with the Memory Care Coordinator (MCC) on 02/07/24 at 4:10pm revealed: -She was unaware that Resident #4 had an order to have his BP checked for 7 days on 01/16/24. -The order was in her email, but she missed it and did not review it until 02/07/24. -She checked her emails daily for orders and then translated the orders to the medication administration records (MAR). -She checked Resident #4's BP on 02/07/24 at	D 276	Care Manager will use the Order Processing System daily and will ensure all orders are implemented. Care Manger has been inserviced on the importance of using the Order Processing Systems. Executive Director and Care Managers will review and discuss at stand up the Facility Activity all referrals and healthcare needs of the residents that has been communicated by the Provider. Care Manager wil review vitial signs report to ensure all orders are within parameters. Any order out of parameters the provider will be notified.	2/12/24 ongoing 2/12/24 ongoing 3/25/24 3/25/24

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D 276	Continued From page 5 approximately 4:20pm at the surveyor's request and reported it was 150/83. Interview with Resident's #4 Primary Care Provider (PCP) on 02/08/24 at 1:00pm revealed: -The order for Resident #4's BP check for 7 days was due to the resident's elevated BP, and she wanted to see if there was a trend in his BP levels and if his BP medication adjustment was warranted. -The order was for the BP to be checked for 7 days to see a trend if BP was high or low. -She was unaware the facility missed the order and did not monitor the BP. -Her concern about not monitoring the BP was there could be a delay in the resident's care in case the BP medications needed to be adjusted. -She did not want Resident #4's BP to be out of control and not managing it appropriately. Interview with the Administrator on 02/08/24 at 2:00pm revealed: -He was unaware there was an order on 01/16/24 to monitor the resident's BP for 7 days. -He was unaware that an order to monitor Resident #4's BP was not implemented. -His concern was not knowing the resident's BP levels during that time to see if medication adjustment was needed, and the facility did not monitor the BP as ordered. -The MCC was responsible for reviewing the progress notes in her email for PCP orders. -The MCC should have called the PCP for clarification.	D 276	Executive Director and Care Manager will review daily times 30 days and then weekly.	3/25/24