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D 000	Initial Comments The Adult Care Licensure Section and the Martin County Department of Social Services conducted a follow-up survey and complaint investigation on 04/09/24 through 04/11/24 with an exit conference via telephone on 04/12/24. The complaint investigation was reopened and an onsite visit was conducted from 05/07/24 through 05/08/24 with an exit date of 05/08/24. The complaint investigation was initiated by the Martin County Department of Social Services on 02/29/24.	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: 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 provide a safe and clean environment free of hazards related to bed bugs and mice in the facility. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed with a	D 079		

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capacity of 122 beds including 72 beds for the assisted living (AL) unit and 50 beds for the special care unit (SCU).

Review of the facility's census reports provided on 04/09/24 revealed:
-The facility's in-house census was 47 residents.
-There were 27 residents residing in the AL unit of the facility.
-There were 20 residents residing in the SCU.

1. Review of the facility's undated Bed Bug Policy for residents revealed:
-If you find bed bugs in a resident's room, Do Not Move Them to another room in the facility.
-This will cause the bed bugs to spread as they are hitchhikers.
-Purchase a vacuum cleaner with a bag to use specifically for bed bugs (do not use this vacuum cleaner for anything else than bed bug clean up).
-Please label the vacuum for bed bug use only.
-Do not purchase chemicals to use to treat your community for bed bugs, this could counteract the effectiveness of the treatment that the pest control company uses, this is also a safety issue for the residents and staff.
-If your community has hard flooring (ex: vinyl, tile, laminate), after pest control comes and sprays allow the chemical to dry completely (2 hours) before cleaning.
-Spot mop as needed for spills and messes.
-The chemical used by pest control is residual and will continue to work up to 30 days after it has been sprayed and dried.
-The chemical is also registered by the Environmental Protection Agency (EPA) and is regulated to only being sprayed every 30 days.
-This is why the pest control company does not come back for "repeat" sprays.
-It is up to us to follow our own policies and

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D 079	Continued From page 2 procedures during those times in between treatments to ensure it does not get out of hand. -Inspection: Inspect all rooms/common areas of the community to identify where there is live activity. -Inspect mattress (top and bottom), box spring, bed frame, behind bed, dressers, closets, chairs/recliners (look under), linens, and clothing, -This needs to be completed on a monthly basis and the rooms/areas that have live activity in them need to be reported to the director which will be passed along to our pest control company. -Rooms/Areas with bed bug activity, room/area needs to be vacuumed daily with a vacuum specifically and only for bed bugs, the vacuum cleaner must have a bag. -Areas to be vacuumed (after vacuuming all bed bug rooms, immediately take bag from the vacuum to the dumpster and dispose) mattresses (all sides and in cracks), box springs (all sides), bed frame, corners and edges of the room/area, inside dresser (if activity found inside dresser), closets (if activity found), chair/recliner, behind furniture. -If bed bugs are found in clothing, bag up and take to the laundry room to dry on high heat for 40 minutes, if the clothing is dirty, wash and dry after treating. -If bed bugs are found on linens, bag up and take to the laundry room to dry on high heat for 40 minutes, if linens are dirty, wash and dry after treating, return the same linens back to the resident's room. -Clutter/cleanliness, bed bugs along with other pests like to hide, assure rooms are cleared of clutter and trash. -There does not need to be a lot of items stacked up in the corners of rooms, along walls and in dressers and closets. -Ensure that rooms are cleaned daily, trash is	D 079		

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taken out daily and more if needed.

Review of the facility's undated bed bug room cleaning check sheet on 04/11/24 revealed:
-Instructions: staff need to initial daily that the resident's room has been vacuumed (dresser, closet, and room in its entirety). It needs to be vacuumed with a vacuum that has a bag, after vacuuming the bag needs to be immediately taken out to the dumpster and thrown away.
-All clothing and linens need to be inspected daily, if bed bug activity is found on linen or clothing, then they need to be dried for 40 minutes on high heat and then washed and dried before being returned to the resident's room.
-There were 3 columns, one for the date, one for the shift and one for staff initials
-All three columns were completed and initialed from 03/01/24 through 04/11/24.

Interview with the facility's contracted pest control provider on 04/11/24 at 8:12am revealed:
-He treated the facility monthly for general pests that included roaches, bed bugs and rodent control.
-He was last at the facility on 04/09/24 and treated several resident rooms for bed bug activity.
-He used a residual type of chemical that killed the bedbugs immediately and would continue to kill them for up to 30 days.
-Bed linens and clothing in the active rooms should be dried, washed and dried at least every 2 days if not daily until the room was removed from the active list.
-He communicated this information to either the Business Office Manager (BOM) or the Executive Director (ED) to make sure everyone was on the same page as far follow-up from treatment.
-Sanitation and daily cleaning of the residents'

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rooms were important to control the bed bugs in the facility.
-He came to the facility on a monthly basis, he was last in the facility on 04/09/24, 03/09/24 and 02/05/24.
-The facility provided him with a list of resident rooms to treat bed bugs.

Interview with the resident in resident room #1 on the AL unit on 04/09/24 at 9:30am revealed:
-The facility had on-going issues with mice and bed bugs.
-He had bed bugs in his room about 3 or so months ago, but not recently.
-Resident room #3 had bed bugs.

Interview with resident in resident room #3 on the AL unit on 04/09/24 at 9:41am revealed:
-He was lying in bed.
-He saw a bed bug last night but could not remember where he saw it.
-He did not remember being bitten by bed bugs.
-He thought his room had been treated for bed bugs.
-Staff changed his bed linens about every 2 weeks.

Interview with the resident in resident room #30 on the AL unit on 04/10/24 at 10:28am revealed:
-She saw bed bugs in her room last week and reported it to one of the personal care aides (PCAs) but was unsure of which PCA.
-Her room was treated for bed bugs yesterday by the facility's pest control service.

Interview with the Maintenance Director on 04/11/24 at 11:43am revealed he was not aware of complaints of bed bugs and said he was not involved in the bed bug treatment process.

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Observation of resident room# 3 on the AL unit on 04/11/24 at 10:56am revealed:
-The room was occupied by one resident.
-A resident was sitting in a recliner in his room.
-There were blood smears and spots on his pillowcase on his bed.
-There was a bed bug observed on the resident's pillow.
-There were black specks on his bedside table.

Interview with the resident in resident room #3 on the AL unit (room 3 was on the facility provided list of residents on bed bug procedure) on 04/11/24 at 10:56am revealed:
-He saw bed bugs in his room but could not remember where in his room.
-He had not been bitten by bed bugs that he knew of.
-His room had been recently treated for bed bugs by the facility's pest control company.
-Housekeeping mopped and swept his room daily but did not vacuum.
-He was not sure his room had ever been vacuumed.
-He denied itching or rash.
-His bed linens were changed about every 2 weeks and were last changed 2 to 3 days ago.

Observation of resident room #51 on the SCU on 04/11/24 at 1:28pm revealed:
-The room was occupied by one resident.
-The resident was not present in the room.
-The bed was stripped of sheets.
-There were no bed bugs observed.
-One pillow in a pillowcase remained on the bed.
-There were black spots and blood smears on the pillowcase.

Interview with a resident in resident room #34 on the AL unit (room 34 was on the facility provided

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list of residents on bed bug procedure) on 04/11/24 at 8:49am revealed:
-His room had been treated for bed bugs late last year and this improved after he received a new mattress before Christmas 2023.
-His room was treated for bed bugs this month and last month, but he had not seen any bed bugs.
-Housekeeping usually swept and mopped his room daily but his room and mattress were not vacuumed daily.
-His room had not been vacuumed since last year.
-His bed linens were changed weekly.

Interview with a resident in resident room #36 on the AL unit (room 36 was on the facility provided list of residents on bed bug procedure) on 04/11/24 at 9:34am revealed:
-She had not seen bed bugs in her room.
-She did her own laundry including clothing and bed linens.
-Housekeeping mopped and swept her room and emptied her trash daily but had never vacuumed her room or mattress.

Interview with a resident in resident room #14 on the AL unit (room#14 was on the facility provided list of residents on bed bug procedure) on 04/11/24 at 11:03am revealed:
-He had not seen bed bugs in his room.
-His room had never been vacuumed.

Interview with a resident in resident room #12 on the AL unit (room #12 was on the facility provided list of residents on bed bug procedure) on 04/11/24 at 2:17pm revealed:
-He saw a bed bug in his room last week and reported it to the BOM.
-He thought his room was treated when the

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facility's pest control provider came in this week.
-Housekeeping swept and mopped his room daily but had not vacuumed.
-His bed linens were changed weekly.

Interview with the resident in resident room #25 on the AL unit (room #25 was on the facility provided list of residents on bed bug procedure) on 04/11/24 at 2:17pm revealed:
-She had not noticed bed bugs in her room but knew they were in the facility.
-Housekeeping mopped and swept her room daily but did not vacuum.
-Her bed linens were changed and washed weekly.

Review of the facility's Residents on bed bug procedure list revealed:
-The list was not dated.
-Linens and clothes need to be put in a bag and sealed up, taken to the dryer, let dry for 45 minutes, then wash and dry again, while linens are being treated, housekeepers will go in and follow protocol of vacuuming the bed, floors, and window seals.
-There were 17 residents names and room numbers (rooms 36,25,28,8,3,18,33,10,14,30,16, 12,31,35,29,27, and 17) listed and noted continuous cleaning beside each name.
-Rooms were to be cleaned every day until they were taken off of the list.

Observation of the facility during the survey 04/09/24 through 04/11/24 revealed vacuum cleaning was not observed or heard during the 3 days in the facility.

Observation of a housekeeping closet on the AL unit on 04/11/24 at 3:45pm revealed:
-There was a black and yellow upright vacuum

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cleaner behind a push broom in the back of corner of the housekeeping closet.
-There was no vacuum bag or canister attached to the vacuum.
-Staff were not sure where the vacuum bags were located.

Review of the facility's contracted pest control service log dated 03/09/24 revealed:
-Rooms 1,14,18,22,26,30,34 and 56 were treated for bedbugs.
-Activity was reported in rooms 22 and 34.

Review of the facility's contracted pest control service log dated 04/09/24 revealed:
-Rooms 2,3,10,14,16,18,24,25,27,33,36,48,50,51, and 55 were treated for bed bugs.
-Activity was reported in rooms 3, 27,48,50, and 51.

Interview with a PCA on 04/11/24 at 9:50am revealed:
-If she found bed bugs in a resident's room, she reported this to the medication aide (MA).
-If bed bugs were identified, the PCAs inspected the room, stripped the resident's bed and took the linens to the laundry room and dried them first then washed and dried them and returned the linens to the residents' room, after this treatment, the resident 's bed linens were washed and dried weekly.
-She thought the residents were re-located to another room if bed bugs were found.
-It had been about a month since bed bug activity was reported that she knew of.

Interview with a second PCA on 04/11/24 at 1:25pm revealed:
-If she saw bed bugs in a resident's room, she

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D 079	Continued From page 9 reported it to the Executive Director (ED). -If bed bugs were identified, the PCAs immediately took the bed linens and residents' clothes to the laundry room and dried the linens and clothes first then wash and dried them and returned them to the same resident's room. -This was done initially and after this initial treatment, bed linens were washed weekly, and the residents' clothes were washed twice per week. -She thought there may be only 2 resident rooms currently in the facility that were being treated for bed bug activity. Interview with a housekeeper working on the AL unit on 04/11/24 at 9:25am: -She worked in the AL unit and the SCU. -She cleaned the residents' rooms daily, which included sweeping, mopping, and emptying the trash. -The facility had a bed bug procedure for cleaning if bed bugs were identified in a resident's room. -The bed bug procedure consisted of vacuuming the resident's room, windowsills, and mattress daily for 14 days. -It had been a long time since the facility had bed bugs and she could not remember exactly how long it had been since she had to perform the bed bug cleaning procedure for a resident. -She was not aware of a list of resident rooms that required the bed bug cleaning procedure. Interview with a housekeeper working in the SCU on 04/11/24 at 11:16am revealed: -She had been employed at the facility as a housekeeper for about one year. -She worked as a housekeeper in the SCU and the AL unit. -She had never seen bed bugs in the facility in the SCU or the AL unit.	D 079		

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-No one had ever reported bed bug activity to her.
-If she saw bed bugs, she reported them to her supervisor.
-She was not sure who her supervisor was.
-She cleaned the resident's rooms daily which consisted of sweeping, mopping, and emptying the resident's waste can.
-She was not aware of any additional cleaning of resident's rooms with bed bug activity.
-She had been trained by a staff member that was no longer employed at the facility.
-She was not aware of a list of resident rooms that required the bed bug cleaning procedure.

Interview with the lead housekeeper on 04/11/24 at 1:35pm revealed:
-If bed bugs were identified in a resident's room, the house keepers were to inspect the room.
-After the bed had been stripped by the PCA and taken to the laundry, the housekeepers vacuumed the resident's room, mattress, and windowsills daily for 14 days.
-She notified either the ED or the BOM if bed bugs were seen or suspected and they would notify the pest control provider when he came monthly.
-She had a list of the residents' rooms that required the bed bug cleaning procedure and shared this with the housekeepers.

Interview with the MA working on the AL unit on 04/11/24 at 10:05am revealed:
-If a resident or staff reported bed bug activity, the PCAs stripped the resident's bed, dried the bed linens first then washed and dried the bed linens.
-She thought this was to be done daily for 10 days.
-She thought housekeeping kept a log of rooms that required the bed bug cleaning protocol.
-Any bed bug activity was to be reported to the

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BOM or the ED.
-She thought it had been about 3 weeks since bed bug activity had been reported and thought it was only in resident room #3.

Interview with ED on 04/11/24 at 1:52pm revealed:
-The facility had a contracted pest control service that came out on a monthly basis and treated for bed bugs.
-The facility had a continuous cleaning bed bug protocol for resident rooms with bed bugs.
-There was a list of resident rooms with suspected or active bed bug activity for the bed bug cleaning protocol.
-This list was provided to the lead housekeeper, who was to share it with the housekeepers for the bed bug cleaning procedure.
-The list was placed in the PCA's activities of daily living (ADLs) binder as well.
-Staff were to notify her or the BOM when there was a suspicion or concern for bed bugs so they could notify the facility's pest control provider and add them to the spray list and the bed bug cleaning protocol list.
-The BOM kept a list of resident rooms that were to be treated for bed bugs by the facilty's pest control provider.
-The bed bug cleaning procedure was to be continued until the contracted pest control provider returned and inspected the room, if the room was cleared by the pest control provider, then the room was removed from the list.
-She was not sure why the current list was not dated.
-Continuous cleaning as part of the bed bug procedure included stripping the bed, drying, washing then drying the bed linens daily and wiping down the mattress daily until the room was inspected and cleared by the pest control

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provider.
-She thought they were told to not to vacuum or mop the resident's room for a certain amount of time after the room was treated but could not remember for certain.
-She was not aware that two of the housekeepers were not aware of the bed bug cleaning procedure list of residents.
-She was not aware that linens were not being cleaned daily for the rooms on the bed bug cleaning procedure list.
-She expected the bed bug continuous cleaning procedure described to be completed for the residents on the list by housekeeping and the PCAs.

2. Interview with the facility's contracted pest control provider on 04/11/24 at 8:12am revealed:
-The best prevention for mice in the facility was to prevent them from getting in.
-Any holes or openings should be repaired and secured so mice could not get in.
-Exterior traps or stations should be placed every 8 to 10 feet surrounding the building.
-Tin traps which can catch up to 12 to 13 mice and glue traps were used inside the facility in the kitchen and pantry areas, common areas and the in the residents' room.
-Sanitation was key as well to preventing mice, such as keeping areas clean and uncluttered and securing food sources.
-He communicated with the Maintenance Director (MD) regarding the rodent situation.

Interview with the resident in resident room #31 on the AL unit on 04/09/24 at 9:22am revealed:
-The facility continued to have mice.
-She saw mice nightly, the last time she saw a mouse was the night before.
-She had a glue trap in her room that was placed

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by the M D.
-The MD checked the glue traps in her room on the days he worked.

Second interview with the resident in resident room #31 on the AL unit on 04/11/24 at 8:07am revealed:
-She saw a mouse again last night.
-The MD removed her mouse trap yesterday.
-She was not sure why the mouse trap was removed, she guessed it was because "the state was here".

Interview with the resident in resident room #32 on the AL unit on 04/09/24 at 9:25am revealed:
-Mice and bed bugs have been an on-going issue at the facility.
-She did not have bed bugs but saw mice daily.
-She last saw a mouse last night.
-A mouse would come out of her closet each evening.
-She heard the mice at night and sometimes this kept her awake.
-She had a glue trap and a tin trap in her room for mice placed by the MD.
-Mice had been caught in the tin trap but not the glue trap.

Second interview with the resident in resident room #32 on the AL unit on 04/10/24 at 10:12am revealed she saw a mouse last night in her room.

Interview with the resident in resident room #1 on the AL unit on 04/09/24 at 9:30am revealed:
-The facility had on-going issues with mice and bed bugs.
-He last saw a mouse about 2 weeks ago after it came out of his closet.

Interview with resident in resident room #3 on the

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AL unit on 04/09/24 at 9:41am revealed he last saw a mouse last week.

Observation of resident room #34 on the AL unit on 04/09/24 at 9:47am revealed the resident was not in the room but there was a glue trap in the room on the floor.

Interview with the resident in resident room #30 on the AL unit on 04/10/24 at 10:28am revealed:
-She saw a mouse 2 nights ago, it ran out of her closest and picked up a piece of popcorn her previous roommate had dropped and ran back to the closet.
-She saw and heard mice at night.
-There was a glue trap in her room a day or two ago, but someone had removed it.
-The glue traps did no good and the mouse just played with it.

Interview with a resident in resident room #12 on the AL unit on 04/11/24 at 2:17pm revealed he had a glue trap in his room earlier this week, but someone had removed it.

Interview with the resident in resident room #25 on the AL unit on 04/11/24 at 2:17pm revealed:
-Mice were all over the facility.
-A mouse ran up her arm about 3 days ago around 2:00am.
-She could hear the mice making noise at night.
-It was sometimes hard for her to sleep at night due to hearing mice and one jumped on her arm while she was in the bed.
-She had a glue trap in her room, but someone removed it a day or two ago, but she was not sure why.

Interview with the MD on 04/11/24 at 11:43am revealed:

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D 079	Continued From page 15 -He had worked with a team in the facility to fill in holes and gaps to prevent mice from entering the building. -Weather stripping had been replaced and steel wool was placed in holes and gaps. -He thought all the holes and gaps had been filled in or repaired. -If a resident saw a mouse, he placed either a tin trap or glue trap in their room. -He checked the traps daily when he was at the facility. -The traps caught quite a few mice about 3 months ago but now there was one in the traps every now and then. Interview with ED on 04/11/24 at 1:52pm revealed: -The facility had a contracted pest control service that came out on a monthly basis. -The facility had a team come in recently and fill in holes and gaps where mice could get in and they also used tin traps and glue traps.	D 079		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the window alarms on the special care unit (SCU) were functioning.	D 105		

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The findings are:

Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of 122 beds including 72 beds for Assisted Living (AL) and 50 beds for the Special Care Unit (SCU).

Review of the facility's resident census list provided on 04/09/24 revealed there were 20 residents who resided on the SCU.

Review of the facility's Identification and Supervision of Wandering Residence Policy (not dated) revealed environment safeguards: check door alarms regularly to assure they are working properly; notify staff when alarms fail and request staff to ensure extra precautions for residents at risk of wandering; and repair alarm system as soon as practicable.

Observation of a window in the TV room on 05/07/24 at 3:57pm revealed:
-The window had a double lock with a magnetic alarm.
-The maintenance staff used a flat head screwdriver to turn a button lock, then used his fingers to push the levers to release the second lock.
-He lifted the window up and an alarm sounded.
-The alarm stopped while the window was still up.
-No additional staff entered the TV room.

Observation of all windows on the SCU on 05/08/24 at 3:00pm - 3:30pm revealed:
-All windows had magnetic sensors except resident room #45.
-There was only one side of the magnetic sensor on each window in resident room #45.

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-The window was double locked, without a functional alarm.

Interview with a resident on 04/09/24 at 9:37am revealed:
-He climbed out of the window in the TV room.
-He left the facility because he was looking for heat and trying to find the woman who had his house which wanted back.

Interview with the lead MA on 05/07/24 at 11:27am revealed she was not aware of the window alarms but was aware that the doors alarmed.

Interview with a PCA on 04/11/24 at 1:30pm revealed:
-When the door or window alarm beeped, the alarm panel on the SCU hall would sound and show which area was triggered.
-The door must be closed for the alarm to stop sounding.
-When a door or window alarmed, staff were to check the windows/doors to make sure they were closed and then ensure all residents were present and accounted for.
-She was never told to check for a magnetic sensor on the SCU windows when the alarm sounded to make sure it was secured.

Interview with a second PCA on 05/07/24 at 9:57am revealed:
-She was aware that the doors alarmed but not the windows.
-She was not aware that there were magnet sensors on the windows.

Interview with a second lead MA on 05/07/24 at 11:23am revealed:
-When a door/window alarm was triggered, staff

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looked at the alarm panel to see which area was triggered then went to that area to see if a resident went out.
-The window alarm would not stop until the window was shut.
-She was unsure if the alarm panel showed which window was triggered, but the panel showed the resident's room number.
-She was not aware who was responsible for monitoring the door and window alarms to makes sure they were functioning properly.

Interview with a maintenance staff on 04/11/24 at 11:20am revealed:
-When the alarm on the panel went off, staff could reset the panel and may not notice that the window's magnetic sensor was gone.
-The staff did not know to look for magnetic sensors and if the blinds were down, they would not notice that they were gone.
-He did not know the magnetic sensor in the TV room only had one side of the magnetic sensor until he was fixing the window after an elopement.
-He reported this immediately to the Executive Director and to the Business Office Manager.

Second interview with a maintenance staff on 05/07/24 at 3:41pm revealed:
-He received a call around 7:53am on 03/31/24 that he needed to fix a window on the SCU.
-He saw a window on the floor and a screen ripped in a T shape in the TV room.
-There was no system in place to ensure the door and window alarms were working properly and this had not been part of his responsibilities.
-He was never told to check doors or windows and did not know who was responsible for doing so.

Interview with the Executive Director (ED) on

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05/08/24 at 11:07am revealed:
-During orientation staff were trained on the different sounds of doors, windows, and call bells on the SCU and the Assisted Living side.
-The door must be closed to reset the alarm panel.
-The window must be closed to reset the alarm panel.
-She was unaware that some staff did not know that the window alarmed if triggered.
-When the door or window alarmed, the staff would go to where the alarm was triggered and be sure all residents had been accounted for and safe.
-If there was an issue with the alarm, the staff would let the maintenance staff know immediately.
-Any staff could go directly to the maintenance staff with this issue.
-She was unaware if there was a maintenance checklist/task for him to check the alarms on a regular basis.
-The maintenance staff was responsible for checking the doors and window's alarm then the she was responsible for checking the alarms.
-Checking the doors and window alarms was to be done once a week unless identifiable concerns or issues were noted.

Second interview with the ED on 05/08/24 at 2:43pm revealed:
-The purpose of the door and window alarms was to alert staff what window or door had been opened so they could check the area triggered and account for the residents.
-This was the facility's method to keep all residents safe.

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The facility failed to ensure window alarms were operational on the special care unit and a system

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D 105	Continued From page 20 was in place to ensure they were maintained in a safe, operating condition. This failure was detrimental to the health, safety, and welfare of the residents and constituted a Type B Violation. ____________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/08/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 22, 2024.	D 105		
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;	D 255		

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(G) threat to life such as stroke, heart condition, or metastatic cancer;
(H) emergence of a pressure ulcer at Stage II, 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 interviews, and record reviews, the facility failed to update the care plan for 1 of 1 sampled resident (#2) who had a significant change in functional health status who on admission on 05/18/23 was assessed as needing extensive care regarding bathing, dressing, and grooming/personal hygiene, but was currently assessed and observed by the staff as being independent with bathing, dressing and grooming/personal hygiene.

The findings are:

Review of Resident #2's current FL-2 dated 03/05/23 revealed:
-Diagnoses included a stroke, diabetes, hypertension, and expressive aphasia related to a

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stroke. (Expressive aphasia is a condition where a person may understand speech, but may have difficulty speaking).
-The resident was ambulatory,
-The resident required assistance with bathing and dressing.
-The resident resided on the assisted living (AL) unit.

Review of Resident #2's Resident Register revealed an admission date of 04/27/23 and a discharged date of 03/14/24 to a skilled nursing facility (SNF).

Review of the Resident #2's signed Care Plan dated 05/18/23 revealed the resident required extensive assistance with bathing, dressing, and grooming/personal hygiene.

Interview with Resident #2's Power of Attorney (POA) on 04/12/24 at 9:10am revealed:
-When the resident was admitted to the facility about a year ago, he had just had a stroke and needed a lot of assistance.
-He assumed the resident took his own showers and dressed himself, but was not sure.
-When he took the resident on outings, the resident would bring a sweater or jacket and he observed him putting on the jacket if he got cold without needing assistance.
-He assumed the resident also trimmed his fingernails and toenails.

Review of Resident #2's February 2024 personal care record revealed:
-There was a code C that denoted activities of daily living (ADL) tasks completed, R for refused, H for hospital, and TL for therapeutic leave.
-There was an entry for personal hygiene which included shower, bath, shampoo, nail care,

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grooming, and shave.
-The resident had code C documented on first shift 02/01/24 through 02/28/24 except 02/02/24, 02/15/24, 02/16/24 and 02/21/24 which were blank and 02/27/24 and 02/28/24 which had the code H for hospital.
-The resident had code C documented on second shift 02/01/24 through 02/28/14 except 02/01/24, 02/11/24, and 02/28/24 which were blank.
-The resident had code C documented on third shift on 02/02/24, 02/05/24, 02/09/24, 02/13/24, and 02/20/24, the other dates were blank.
-There was an entry for dressing/undressing.
-The resident had code C documented on first shift from 02/01/24 through 02/28/24 except 02/02/24, 02/15/24, 02/16/24, and 02/21/24, which were blank.
-The resident had code C documented on second shift from 02/01/24 through 02/18/24 except 02/01/24, 02/11/24, and 02/28/24 which were blank and 02/27/24 and 02/28/24 which had the H code for hospital.
-The resident had code C documented on third shift on 02/02/24, 02/05/24, 02/09/24, 02/13/24, and 02/20/24, the other dates were blank.

Interview with a personal care aide (PCA) on 04/10/24 at 9:50am revealed:
-Resident #2 liked to be independent but she would check on him.
-He took his own showers.
-She had not seen his feet.
-Staff made sure he had his clothes and toiletry items when he went to the spa for his showers.
-She was not aware the care plan said the resident needed extensive assistance with bathing, dressing, and grooming/personal hygiene.
-Personal hygiene tasks and dressing/undressing were documented on the personal care record

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regardless whether staff or the resident completed the tasks.

Interview with a second PCA on 04/10/24 at 4:35pm revealed:
-Resident #2 was very independent and took his own showers and dressed himself, so she had not seen his feet.
-When PCA's provided showers and if there were any skin issues, they would report it to the medication aide (MA).

Interview with the lead medication aide (MA) on 04/10/24 at 10:10am revealed:
-Resident #2 did not talk much and kept to himself.
-He took his own showers and dressed himself.
-She was not aware the care plan said the resident required extensive assistance with bathing, dressing, and grooming/personal hygiene.

Interview with the Executive Director (ED) on 04/10/24 at 4:47pm revealed:
-The facility did not have an updated care plan for Resident #2.
-The Care Manager, which included the Memory Care Coordinator (MCC) and the Resident Care Coordinator (RCC) who was currently the same person, and who was on leave was responsible for notifying the PCP when a change in a resident's health status warranted an updated care plan.
-In her absence, the ED and the lead MA's were responsible.
-She did not not know why Resident #2's care plan was not updated.
-Resident #2 was very "modest" and wanted to be independent and took his own showers and dressed himself.

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D 255	Continued From page 25 -He ambulated well and would walk a lot in the facility and outside the building. -She did not know the resident's care plan on admission said he required extensive assistance with bathing, dressing, and grooming/personal hygiene. -She expected staff to know when a change in a resident's health status occurred and to contact the primary care provider (PCP) so an updated care plan could be done. Telephone interview with Resident #2's PCP on 04/11/24 at 9:00am revealed: -Resident #2 ambulated well and was independent. -To her knowledge, he took his own showers and dressed himself and was capable of performing these tasks. -Staff reported that he would decline assistance with showers and dressing.	D 255		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 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. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE A1 VIOLATION Based on these findings, the previously Unabated Type A1 Violation has not been abated.	D 270		

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Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#3) as evidenced by a resident who eloped from the facility's special care unit (SCU) by accessing a window in the TV room area and was found 1 mile away from the facility.

The findings are:

Review of the facility's Missing Residents Policy (policy not dated) revealed:
-A resident will be considered missing when he/she is not in the facility and we cannot verify their whereabouts: and in addition, there is reason to be concerned for the resident's safety.
-If the facility discovers a resident is missing, we will notify the supervisor and all other staff immediately.
-Perform a hasty search of the building and the immediate areas outside the building.
-If the resident is not found, we will immediately notify the Local Law enforcement - call 911, the resident's family member/responsible person, and the County Department of Social Services.
-Cooperate fully with law enforcement and or authority in charge of search and rescue.

Review of the facility's Identification and Supervision of Wandering Residence Policy (policy not dated) revealed:
-The facility will not admit residents that are wanderers or at high risk for wandering.
-Should a current resident of the facility begin to exhibit signs of wandering, the resident will be reassessed for appropriate placement and an immediate discharge notice will be issued.
-As long as the resident remains in the facility the remainder of this policy will apply.

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-The facility will identify residents who walk or wheel around unrestricted and are a threat to leave the facility unattended due to their confusion.
-Environment safeguards: check door alarms regularly to assure they are working properly; notify staff when alarms fail and request staff to ensure extra precautions for residents at risk of wandering; and repair alarm system as soon as practicable.

Review of Resident #3's current FL-2 dated 11/07/23 revealed:
-Diagnoses included type II diabetes mellitus with hyperglycemia, dementia without behavioral disturbance, anxiety, hypertension, gout, and hydronephrosis.
-The resident was ambulatory.
-The resident was intermittently disoriented.
-The resident had wandering behaviors.
-The resident's current level of care was Special Care Unit (SCU).

Review of Resident #3's current Resident Register revealed admission date was 11/01/23.

Review of Resident #3's incident and accident (I/A) report dated 03/31/24 revealed:
-The incident was an elopement and occurred on 03/31/24 at 12:07am.
-There were no injuries or vitals for Resident #3 documented.
-The Primary Care Provider (PCP) was contacted.
-Resident #3's legal guardian was contacted.

Review of the Police Department (PD) report dated 03/30/24 at 11:54pm revealed:
-On 03/30/24 at 11:54pm, the PD responded to a call from a local citizen who stated that there was

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an older male at his family member's house.
-The resident told the PD he had been kidnapped and held captive for 2 years and he crawled out of a window to escape and had been walking around all night.
-The PD contacted the Department of Social Services who stated that Resident #3 was a Ward of State and lived at a local facility.
-The PD transported him to the local facility where a staff member stated that he was missing and the last time she saw him was approximately at 10:00pm.
-The PD asked the staff why the facility did not call 911 once they knew that he was missing, and the staff did not have a response.

Review of google maps on 04/09/24 revealed:
-The facility was a 23-minute walk away from where the resident was found by the PD.
-The facility was located 1 mile away from where the resident was found by the PD.
-The resident walked across approximately 7 streets to his destination.

Observation of the location of the facility on 04/09/24 at 11:45am revealed:
-The facility was located on a 4-lane highway with a median with various restaurants and businesses across the highway.
-To the right of the facility there a gas station and a service road.
-To the left of the facility there was a dense, wooded area.
-The street had 2 lanes on each side of the median traveling in opposite directions.
-The parking lot entrance of the facility was connected to the 4-lane highway.
-The were no crosswalks or crossing signals located at the entrance of the facility which led to the highway.

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-On 04/09/24 for 1 minute, there were 8 vehicles observed traveling the four-lane highway.
-There were 2 transfer trucks and 6 automobiles observed during the 1-minute observation.
-The speed limit was 45 miles.

Observation of the outside premises of the facility's SCU on 05/08/24 at 3:30pm revealed:
-There was a door exiting from the SCU TV room to an outside fenced in area.
-The chain linked fence surrounded the outside of the SCU with a gate which could be secured with a keyed padlock.
-The gate was in an open position leading to a side road on the right and a dead end road on the left.

Interview with Resident #3 on 04/09/24 at 9:37am revealed he climbed out of a window to find heat and he was looking for the lady who had his house that he wanted back.

Interview with a lead medication aide (MA) on 04/10/24 at 9:37am revealed:
-Around 10:00pm, Resident #3 said that he was getting ready to go to bed then he walked to his room.
-She made her rounds at 12 midnight and his door was closed which was not unusual and she did not enter.
-She received a phone call at approximately 12:03am from a staff member (who was not working that night) that a resident had eloped from a facility, and he wanted to be sure it was not a resident from the facility.
-She walked towards Resident #3's room and a PCA asked what she knew about the window in the TV room, and the PCA stated that she was trying to find a different resident, she then realized that Resident #3 was missing.

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-She called the Executive Director and while on the phone, the PD pulled up with Resident #3, and she gave the phone to the policeman.
-She completed an I/A report.

Second interview with a lead MA on 05/07/24 at 11:27am revealed:
-At 11:00pm on 03/30/24, the beginning of 3rd shift, she was the supervisor and responsible for the entire building (which included the SCU and Assisted Living Unit), and the PCA's on both units reported to her.
-When she did her rounds at 12 midnight on 03/31/24, she did not physically check on Resident #3, she peeked in the room and saw a body in the bed.
-When she received the call at 12:03am, she went to Resident #3's room and saw a light on, a body was in Resident #3's bed; she pulled back the covers to find a different resident in the bed; she asked the PCA to take this resident back to his room.
-She was very busy the night Resident #3 eloped and had to perform rounds on the AL unit.
-Some residents on the AL unit had to be checked every 30 minutes to an hour because they had been smoking in their rooms at night.
-Resident #3 had anxiety and he would talk about someone trying to take his house.
-She told the Executive Director (ED) about these behaviors during Supervisor meetings but could not recall when she mentioned it.
-Resident rounds were performed every 2 hours and entailed knocking on each resident's door, make sure everything was ok, ensure they were breathing and provide incontinence care, if needed.

Interview with a PCA on 05/07/24 at 9:57am revealed:

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-She worked third shift and was assigned to the women's hall on the SCU on 03/30/24.
-A little after midnight she found out that a resident on the SCU male hall left the building.
-Resident #3 would become angry and talked about wanting to leave the facility and spoke with her about going to the courthouse to see about his house.
-She notified the MA about the resident's behaviors because he was delusional about his house; and the MA would go to speak with him to calm him down.
-She was never given instructions to increase supervision of Resident #3.
-Resident rounds meant to walk in every resident's room on the hall that you were assigned, physically check and make sure they were ok, and provide incontinence care if needed, every 2 hours on third shift.

Second interview with a PCA on 05/07/24 at 4:15pm revealed:
-She was assigned to the male hall and Resident #3 on the SCU on 03/30/24.
-About 11:05pm she "peeked in" on Resident #3; opened the door, saw a body in the bed, and walked away to check on other residents.
-It was not until the MA received a phone call and she went into Resident #3's room that she realized that he was not in there and that it was a different resident in Resident #3's bedroom.
-During her rounds when she "peeked in" on Resident #3, she figured he was asleep and assumed it was him because typically when Resident #3 went to bed he stayed in his room.
-During her rounds at 11:05pm, when she checked on another resident and did not find him in his bedroom, she asked the MA about his whereabouts, and she stated that he was most likely in the spa bathroom.

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-She did not check the resident's bathroom or the spa bathroom to confirm that assumption.

Interview with a second lead MA on 05/07/24 at 4:30pm revealed:
-Resident #3's behaviors had always been consistent; speaking about leaving and being on his own.
-Behaviors were discussed during supervisors' meetings, but she was never told to increase his supervision.
-The Primary Care Provider (PCP) was not contacted about behaviors to her knowledge.
-When there was a concern about behavior issues and the need for increased supervision, the PCAs notified her and she reported to the Resident Care Coordinator (RCC), to the ED, or to the Business Office Manager (BOM) with concerns and the she notified the PCP.
-Once a doctor's order was confirmed regarding a behavior, the facility used a 1-hour safety check or a 30-minutes safety check depending upon the order.

Interview with a personal care aide (PCA) on 04/11/24 at 9:55am revealed:
-Resident #3 was agitated the day he eloped, snappy towards staff and cursing at staff and talked about the need to take care of his house.
-He said that he wanted to go to see the judge about his house.
-She did not mention this to management because the staff working saw and heard what he was saying.

Interview with Resident #3's Primary Care Provider (PCP) on 04/11/24 at 9:10am revealed:
-The facility notified her that Resident #3 eloped, and the police department returned him to the facility.

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-He could become very irritable and negative in demeanor.
-She had observed him wandering in the halls aimlessly and sitting in the day room.
-She changed the dosage to his Lexapro (a medication used to treat anxiety) back to 10mg from 20mg on 03/21/24 but did not notice a difference in changing the dosage.
-Supervision was important due to his dementia and delusions and he was not fully set in reality.
-She expected the facility to keep him safe and secure.

Second interview with Resident #3's PCP on 05/08/24 at 12:05pm revealed:
-She did not recall being contacted about the elopement seeking behaviors.
-Supervision meant to redirect Resident #3, keep him in a common area during the day, and frequent checks.
-The facility should have informed the PCP and contacted psychological services regarding the resident's psychological issues to review current medications due to acute anxiety.

Interview with the Executive Director (ED) on 04/11/24 at 3:00pm revealed:
-Resident #3 had a "fresh mouth" (cussed) and could be mean towards staff.
-He believed someone was trying to take his house.
-Staff did not know that he was out of the facility on or around early morning on 03/31/24.
-The MA was ultimately responsible for supervision of all residents on the Special Care Unit (SCU).
-Third shift staff went back and forth between the SCU and the Assisted Living (AL) units.
-There was an alarm on all the windows on the SCU.

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D 270	Continued From page 34 -The window the resident climbed out of did not alarm and that was the first time it was reported to her that the window did not activate properly. -She and the maintenance staff were responsible for any security issues dealing with windows and doors. -She did not know when or how the magnet came off the window for it not to alarm. -She did not know how or why he climbed out of the window. -When a resident was missing, the staff did a quick sweep of the entire facility and in the immediate areas outside of the building to find the resident. -If unable to locate the resident, the MA would contact the ED, law enforcement, and notify the PCP. Second interview with the ED on 05/08/24 at 11:07am revealed: -She was not told that Resident #3 wanted to go to the courthouse to discuss his house or that he had behavior issues. -She was on leave between 03/28/24 and 03/30/24 and returned to work on 03/31/24; and the BOM was the Administrator in Charge (AIC) during that time. -When there was an increase in behavior, staff must document what was going on with the behavior and contact mental health services. -The lead MA did not call the PCP, mental health services, or guardian regarding behaviors to her knowledge. -The MA was responsible for contacting the PCP and mental health services. -Staff found their own methods of redirecting Resident #3 -There was no documentation of redirecting Resident #3. -The MA would contact the ED through group text	D 270		

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D 270	Continued From page 35 or during a supervisor's monthly meeting that was held on the second Wednesday of every month to discuss behavior issues. -Once an order to increase supervision was given by the PCP the staff implemented a safety check every 15 minutes, 30 minutes, or one hour per order. ______________________ The facility failed to provide supervision for a resident (#3) who was diagnosed with dementia, wandering behaviors, verbalized wanting to leave the facility and eloped from the facility's locked special care unit (SCU) without staff's knowledge. Resident #3 wandered by foot approximately 1 mile away from the facility and was found by the police department who responded to a call that an older male was at their home. This failure resulted in serious neglect and constitutes a Type A1 Violation. ______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/10/24 for this violation.	D 270		
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 interviews and record reviews, the facility failed to ensure the routine and acute health care needs of 1 of 5 sampled residents (#2) diagnosed with diabetes who was sent to the local hospital emergency room for an infection in	D 273		

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his right foot, that was immediately amputated below the ankle and subsequently amputated below the knee.

The findings:

Review of Resident #2's current FL-2 dated 03/05/23 revealed:
-Diagnoses included a stroke, diabetes, hypertension, and expressive aphasia related to a stroke. (Expressive aphasia is a condition where a person may understand speech but have difficulty speaking).
-The resident was ambulatory.
-The resident required assistance with bathing and dressing.
-The resident resided on the assisted living (AL) unit.

Review of Resident #2's Resident Register revealed an admission date of 04/27/23 and a discharge date of 03/14/24 to a skilled nursing facility (SNF).

Review of Resident #2's Care Plan dated 05/18/23 revealed:
-The resident required extensive assistance with bathing.
-The resident required extensive assistance with dressing.

Review of Resident #2's recent diagnostic laboratory report dated 02/06/24 revealed:
-There was a blood sugar level of 123mg/dl which was noted to be high (normal is 66-99mg/dl).
-There was a Hemoglobin (Hgb) A1C value of 7.2% (normal is less than 5.7%). (Hgb AIC is a blood test that measures the average blood sugar levels over a period of 3 months and monitors how well a person's blood sugar is being

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controlled).
-For someone with known diabetes, a Hgb AlC greater than or equal to 7% indicated suboptimal (not at the best possible level) control.

Review of Resident #2's Licensed Health Professional Support (LHPS) review and evaluation report dated 05/11/23 revealed:
-The resident was a recent admission to the facility.
-He was independent in both ambulation and transfers.
-His finger stick blood sugars (FSBS) were monitored twice daily with a recent range of 113-252.
-He was prescribed Metformin 500mg twice daily. (Metformin is a medication used to control high blood sugar).
-There was a recommendation to place the resident on the podiatry list.
-There was documentation the report was reviewed and signed by the Executive Director and completed by the facility's contracted LHPS Registered Nurse (RN).

Review of Resident #2's Incident/Accident (I/A) Report dated 02/21/24 revealed:
-Resident #2 had a fall on 02/21/24 outside of the facility.
-The resident's POA and the Primary Care Provider (PCP) were notified of the fall.
-The POA responded to keep him informed and he would come to the facility tomorrow (02/22/24).
-The resident was not sent to the local hospital emergency room (ER).
-There was no injury observed.
-The resident's blood pressure was 127/74, pulse was 81 beats per minute, respiration was 19 breaths per minute, and temperature was 97.6

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VINTAGE INN RETIREMENT COMMUNITY	**826 EAST BOULEVARD HWY 17 N BYPASS WILLIAMSTON, NC 27892**

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Fahrenheit.

Review of an email correspondence dated 02/22/24 at 9:45am revealed:
-The email was sent from Resident #2's POA to the PCP via her office staff.
-Resident #2 fell yesterday outside the facility.
-The resident stated he fell on his ribs.
-When someone from the facility called yesterday to tell him the resident fell, staff stated he was not cut or bruised and apparently not hurt.
-The resident may not have told them what actually happened, and staff did not press him.
-The resident declined his offer to take him out to lunch today, which was his favorite thing to do, so he must be in bad shape.
-The POA requested the PCP to assess Resident #2 at the next visit to the facility.

Review of an email correspondence dated 02/22/24 at 2:19pm revealed:
-The email was from Resident #2's PCP to the resident's POA via her office staff.
-The PCP was not going to the facility this week, but would be going next week.
-She would be glad to order a mobile x-ray of the ribs, if he felt that was warranted.
-There was a standing order at the facility for Resident #2 for Tylenol if needed.
-The correspondence was signed by the PCP.

Review of an email correspondence dated 02/22/24 at 2:24pm revealed:
-The email was sent from Resident #2's POA to the PCP via her office staff.
-He did not know what was warranted.
-He would check on the resident tomorrow.
-His concern was that staff at the facility did not know how bad it was.
-He would follow up with the PCP.

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Review of an email correspondence dated 02/22/24 at 3:03pm revealed:
-The email was sent from Resident #2's POA to the PCP via her office staff.
-He talked to the MA in charge and she checked him out.
-The MA was going to give the resident Tylenol if he was still having pain and order the x-ray on Monday, 02/26/24, as requested.

Review of Resident #2's progress notes dated 02/22/24, no time documented revealed:
-The lead MA spoke to the resident's POA regarding the resident being in pain and not wanting to eat in the dining room.
-The POA instructed the MA to give the resident some pain medication and then he would make a decision on what to do.
-Pain medication was administered to the resident.

Review of an email correspondence dated 02/23/24 at 3:04pm revealed:
-The email was sent from Resident #2 PCP to the resident's POA via her office staff.
-The facility knew how to reach her if anything changed before then.
-The correspondence was signed by the PCP.

Review of Resident #2's progress note dated 02/23/24, no time documented revealed the resident requested to have lunch brought to his room due to being sore.

Review of Resident #2's progress note dated 02/24/24, no time documented revealed the resident ate breakfast and lunch in his room.

Review of Resident #2's progress note dated

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02/25/24, no time documented revealed:
-The lead MA spoke to the resident's POA to inform him that the resident was still in pain and not eating well and had started to chew his morning medications.
-The POA requested that x-rays be done on 02/26/24.
-The MA would contact the PCP to get a verbal order for mobile x-ray.
-The PCP was made aware of the resident not eating well and chewing his medications.

Review of Resident #2's progress note dated 02/26/24, no time documented revealed:
-The PCP wrote orders for mobile x-ray of the ribs and urine sample to rule out a urinary tract infection (UTI).
-Mobile x-ray was called and the order was placed.
-A lead MA noticed the resident was not acting normal and did not want breakfast.
-She went to check on the resident after the personal care aide (PCA) informed her that she noticed his right foot "did not look right."
-The resident's breathing was abnormal.
-A picture of the swollen foot was sent to the PCP.
-The PCP gave instructions to send Resident #2 to the local hospital ER.
-Resident #2's POA was notified.

Review of Resident #2's I/A Report dated 02/26/24 at 10:30am revealed:
-Resident #2's foot wound was discovered by a medication aide (MA) who observed the resident's right foot was swollen and red.
-Resident #2 was sent to the local hospital emergency room (ER) on 02/26/24 due to a swollen right foot.
-Resident #2's POA was notified.

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-Resident #2's Primary Care Provider (PCP) was notified who instructed the MA to keep her updated.
-The resident's blood pressure was 132/80, pulse was 72 beats per minute, respiration was 18 breaths per minute, and temperature was 97.6 Fahrenheit.

Review of a picture taken on 02/26/24 of Resident #2's right foot on 04/10/24 at 2:19pm revealed:
-The right foot was dark red to purple in color that extended slightly above the ankle.
-Toes two through four were swollen and a lighter pale pink than the rest of the foot.
-The foot was swollen and the skin was taut and shiny.
-The right great toe was yellowish green and gray in color.
-The lateral side of the great toe was dark black and brown.
-The joint at the base of the great toe was gray.
-The toenail extended past the tip of the toe.
-The inner aspect of the right foot, near the ankle had two dark scabbed areas.
-The skin over the inner ankle had a dark, scabbed area.

Review of Resident #2's local hospital ER discharge summary report dated 03/15/24 revealed:
-Resident #2 was admitted to the local hospital ER on 02/26/24 with a complaint of right foot injury and foul smelling drainage, and was discharged on 03/14/24 to a SNF.
-Resident #2 was admitted to the local hospital ER with a diagnosis of gas gangrene (a highly lethal soft tissue infection that produces foul smelling gas) and osteomyelitis (Osteomyelitis is an infection of bone).

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-On physical exam, the right foot showed gangrenous changes, blistering and drainage from the right great toe with cellulitis (serious bacterial skin infection) extending up to the ankle.
-Vitals on admission on 02/26/24 at 11:27am were blood pressure 160/97 (normal 120/80), pulse 110 beats per minutes (normal 60-100), respiration 20 breaths per minute (normal 12-18), and temperature 98.2 Fahrenheit; at 12:15pm pulse was 130 beats per minute; at 2:39pm blood pressure was 145/87, and at 3:17pm blood pressure was 152/75, pulse was 113 beats per minute, and respiration was 20 breaths per minute.
-Resident #2's POA stated the resident was brought to the local hospital ER due to confusion and altered mental status with right foot pain and swelling after a recent fall 5 days ago.
-Skin assessment noted soft tissue swelling and concern for wet gangrene.
-Hospital course of treatment was guillotine amputation on 02/26/24 followed by below right knee amputation (BKA) on 02/29/24. (A guillotine amputation is performed when the presence of severe infection or death of the tissue is present in an effort to eliminate the bacteria and provide a safer wound environment for a definitive amputation at a later date).

Telephone interview with Resident #2's POA on 04/10/24 at 10:30am revealed:
-The facility stated there was no way to know how long Resident #2's right foot had been infected or how long it took to get to the point where he had an infection when he was admitted to the local hospital ER.
-He did not know if the fall on 02/21/24 caused the infection or if the foot was infected prior to the fall and the fall made it worse.
-When he came to the facility on 02/25/24, the

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resident was confused and agitated, which was not normal.
-The resident was in bed so he did not observe his foot.
-He had been in a mental state of confusion and agitation for at least a full day.

Interview with a personal care aide (PCA) on 04/10/24 at 9:50am revealed:
-Resident #2 liked being independent and took his own showers without assistance.
-She did not recall looking at his feet.
-She was not working when he fell, but after the fall she noticed he was different and did not want to come to the dining room to eat meals.
-She notified the MA that he was acting different on 02/26/24.
-The resident had not complained to her about pain in his ribs or foot.
-The MA came to the room and discovered the foot was swollen and red and she contacted the PCP and 911 for the resident to be taken to the local hospital ER.

Interview with a lead medication aide (MA) on 04/09/24 at 3:34pm at revealed:
-She was getting off work when she saw Resident #2 on the ground outside of the facility on 02/21/24.
-She helped staff to get him up off the ground.
-An I/A report would have been completed by the incoming MA and she would have notified the POA and PCP.
-The resident never complained to her about anything hurting.
-A day or two later after the fall he was not acting normal and did not want to come out of his room to go to the dining room for meals.
-The resident's POA was notified and he wanted the PCP to order an x-ray of the resident's ribs.

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-The PCP was due to come to the facility on 02/29/24 because she visited the facility every Thursday.

A second interview with the lead MA on 04/10/24 at 4:00pm revealed:
-She was the MA in charge.
-The resident never complained to her about his foot being in pain.
-If the resident fell, the MA was supposed to complete an I/A report, notify family and the PCP, and do a skin assessment.
-She did not know if his socks and shoes were removed to look at his feet after the fall.
-The resident was not coming to the dining room for meals and requested meals be brought to his room after the fall.
-Because she was the lead MA in charge, she went to the resident's room on 02/26/24 when the MA notified her that something was wrong with the resident's foot.
-When she entered the room, there was an "awful" smell coming from the resident's foot and it was swollen, red in color, discolored and leaking drainage on the floor.
-The resident was sitting on the the edge of the bed with his socks and shoes off and she could see how badly the foot looked.
-She did not notice a smell on 02/25/24 when she came to the room when the resident's POA visited.
-She instructed the MA to call 911 and have the resident transported to the local hospital ER and to notify the PCP and POA.

A third interview with the lead MA on 05/07/24 at 10:40am revealed.
-She wrote the progress notes on 02/22/24, 02/23/24, 02/25/24 and 02/26/24.
-When she asked Resident #2 if he was in pain

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and where, he make a gesture by rubbing his hands up and down over his ribs and chest area.
-She asked the resident are you okay, he said "yes."
-The POA and the PCP were in contact with each other via email regarding the resident's pain so she assumed they were discussing the plan of care.
-She did not know what they discussed.
-She did not communicate with the PCP regarding the resident not going to the dining area for meals and chewing medications from 02/22/24 through 02/24/24.
-She did contact the PCP on that Sunday, 02/25/26 regarding a verbal order for x-ray of the ribs per the request of the resident's POA.
-She should have contacted the PCP on 02/22/24 when the residents first complained about not feeling well, not getting up for meals, which was unusual, and chewing his medications.

Interview with the ED on 04/11/24 at 2:34pm revealed:
-She was not in the facility when Resident #2 fell on 02/21/24.
-The process after a fall was for staff to do a "full body" assessment, take vitals, notify the PCP and the POA, complete the I/A report and review the hospital discharge summary when the resident returned to the facility.
-Staff reported that the resident refused to be assessed, denied hitting his head, did not want to go to the local hospital ER, and stated he was fine and did not complain of any foot pain.
-The resident was capable of voicing concerns.
-She went to the resident's room on 02/26/24 when the MA notified her that something was going on with his right foot.
-She observed the foot to be swollen, red and purple, but no smell and no drainage.

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-The resident was sent to the local hospital ER.
-There was no policy or protocol for routine skin assessments to be conducted for a resident who had diabetes.
-The resident took his own showers and staff would not have known if anything was going on with his foot unless he told them.

Second interview with the ED on 05/08/24 at 10:30am revealed:
-She was not aware Resident #2 was not feeling well and was requesting to eat in his room instead of going to the dining room as usual for meals and chewing his medications between 02/22/24 and 02/25/24.
-She thought the facility was in contact with the PCP.
-She was not sure if or when the PCP was contacted regarding Resident #2's change in behaviors between 02/22/24 an 02/25/24.
-The lead MA should have notified the PCP regarding changes in behaviors of the resident for guidance.
-The PCP was available via email and phone if the facility needed to contact her.

Telephone interview with Resident #2's PCP on 05/08/24 at 11:30 am revealed
-She was aware of Resident #2's fall on 02/21/24 and his rib pain after the fall.
-To her knowledge, the facility had not notified her and she was not aware the resident was not getting up out bed and going to meals and chewing his medications during the 2-3 days leading up to him being sent to the hospital on 02/26/24.
-She had been in contact with the POA during that time via email regarding the fall, the resident experiencing rib pain, pain medication that was available for the resident via a standing order,

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and the request for ordering an x-ray of his ribs.
-She had not heard anything from the facility over the weekend before 02/26/24 and thought the resident was doing fine.
-Had she known the resident had experienced a significant change in behaviors, she would have contacted the POA to discuss plan of care and provided guidance to facility staff on what to do.
-She did not expect staff to do an assessment of the resident because they were unlicensed professionals.
-She expected to be notified by facility staff when there was a significant change in a resident's behaviors.

____

The facility failed to notify the PCP of a resident with diagnosis of diabetes who experienced a change in condition for several days after a fall (#2). The resident complained of being in pain, not getting out of bed, refusing to go to the dining room for meals, and chewing up his medications for 2-3 days leading up to him being sent to the local hospital ER for a swollen, discolored, red and purplish right foot which had foul smelling drainage which was diagnosed as gas gangrene and osteomylitis that resulted in below the knee amputation. This failure resulted in serious physical harm and neglect to the resident and constitutes a Type A1 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/12/24.

THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 06/07/24.

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10A NCAC 13F .0903 Licensed Health Professional Support
(c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:
(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

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

Based on observations, interviews, and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) review and evaluation included a physical assessment for 1 of 5 sampled residents (#2) who was diagnosed with diabetes and was sent to the local hospital emergency room for an infected right foot and subsequently had a below the right knee amputation.

The findings are:

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Review of Resident #2's current FL-2 dated 03/05/23 revealed:
-Diagnoses included a stroke, diabetes, hypertension, and expressive aphasia related to a stroke. (Expressive aphasia is as condition where a person may understand speech but have difficulty speaking).
-The resident was ambulatory, required assistance with bathing and dressing.
-The resident resided on the assisted living (AL) unit.

Review of Resident #2's Resident Register revealed an admission date of 04/27/23 and a discharge date of 03/14/24 to a skilled nursing facility (SNF).

Review of Resident #2's recent diagnostic laboratory report dated 02/06/24 revealed:
-There was a blood sugar level of 123mg/dl which was noted to be high (normal is 66-99mg/dl).
-There was a Hemoglobin (Hgb) A1C value of 7.2% (normal is less than 5.7%). (Hgb AIC is a blood test that measures the average blood sugar levels over a period of 3 months and monitors how well a person's blood sugar is being controlled).
-For someone with known diabetes, a Hgb AIC greater than or equal to 7% indicated suboptimal (not at the best possible level) control.

Review of Resident #2's Licensed Health Professional Support (LHPS) review and evaluation dated 05/11/23 revealed:
-The LHPS care task listed was finger stick blood sugar (FSBS).
-The resident was a recent admission to the facility.
-The resident was independent with both

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ambulation and transfers.
-He took Metformin 500mg two times a day. (Metformin is a medication used to treat high blood sugar).
-The resident was currently on a no concentrated sweets diet (NCS).
-He received speech therapy services with most recent documented visit on 05/08/23.
-On assessment, resident was alert and cooperative but guarded, respirations were even and unlabored.
-There was a recommendation to place resident on podiatry list.
-Vitals per chart were blood pressure 123/78, pulse 80, and weight 238lbs.
-There was documentation the report was reviewed and signed by the Executive Director (ED) and completed by facility's contracted LHPS Registered Nurse.

Review of Resident #2's Licensed Health Professional Support (LHPS) review and evaluation dated 09/01/23 revealed:
-The LHPS care task listed was finger stick blood sugar (FSBS).
-The resident ambulated and transferred independently.
-The finger stick blood sugar (FSBS) was ordered two times a day with a range of 128-337 (normal range for someone with a diagnosis of diabetes is 80-130 prior to meals and a high range of 180 within 1-2 hours of a meal.)
-The resident was on an oral agent and no concentrated sweet for blood sugar control.
-The resident's most recent hemoglobin A1C (HgbA1C) was 7.3% on 05/20/23.
-Resident was discharged from Speech Language Pathologist (SLP) due to being at maximum function.
-The recommendation was to continue current

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plan of care.
-Vitals were per chart and none were listed on report.
-There was documentation the report was reviewed and signed by the ED and completed by the facility's contracted LHPS RN.

Review of the National Institute of Diabetes and Digestive and Kidney Diseases, National Institute of Health website revealed keeping HgbA1C levels below 7% can reduce the risk of diabetes complications to include nerve damage, poor blood flow which can make it hard for a sore or infection to heal which can lead to gangrene (gangrene is the death of body tissue which can lead to amputation).

Review of Resident #2's Licensed Health Professional Support (LHPS) review and evaluation dated 11/20/23 revealed:
-The LHPS care task listed was finger stick blood sugar (FSBS).
-The resident ambulated and transferred independently.
-The fingerstick blood sugar (FSBS) was ordered two times a day with a range of 112-315.
-The resident was on oral agents (Metformin and Farxiga) and no concentrated sweets diet for blood sugar control.
-There was a recommendation to follow protocols and physician orders for diabetic residents.
-Vitals were per chart with blood pressure being 131/71 and no other vitals were listed.
-There was documentation the report was reviewed and signed by the ED and completed by the facility's contracted LHPS RN.

Review of Resident #2's Licensed Health Professional Support (LHPS) review and evaluation dated 02/15/24 revealed:

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-The LHPS care task listed was finger stick blood sugar (FSBS).
-The resident was independent with ambulation and transfers.
-His FSBS was checked two times a day with a range of 102-315.
-He was taking oral agents and was on a no concentrated sweets diet for blood sugar control.
-The resident had no falls noted in chart.
-The recommendation was to continue current plan of care and follow facility diabetes protocol.
-Vital were per chart with blood pressure 127/79, pulse 79 and weight 248lbs.
-There was documentation the report was reviewed and signed by the ED and completed by the facility's contracted LHPS RN.

Review of Resident #2's local hospital ER discharge summary report dated 03/15/24 revealed:
-Resident #2 was admitted to the local hospital ER on 02/26/24 with a complaint of right foot injury and foul smelling drainage, and was discharged on 03/14/24 to a SNF.
-Resident #2 was admitted to the local hospital ER with a diagnosis of gas gangrene (a highly lethal soft tissue infection that produces foul smelling gas) and osteomyelitis. (Osteomyelitis is an infection of bone).
-On physical exam, the right foot showed gangrenous changes, blistering and drainage from the right great toe with cellulitis (serious bacterial skin infection) extending up to the ankle.
-Vitals on admission on 02/26/24 at 11:27am were blood pressure 160/97 (normal 120/80), pulse 110 beats per minutes (normal 60-100), respiration 20 breaths per minute (normal 12-18), and temperature 98.2 Fahrenheit; at 12:15pm pulse was 130 beats per minute; at 2:39pm blood pressure was 145/87, and at 3:17pm blood

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pressure was 152/75, pulse was 113 beats per minute, and respiration was 20 breaths per minute.
-Resident #2's POA stated the resident was brought to the local hospital ER due to confusion and altered mental status with right foot pain and swelling after a recent fall 5 days ago.
-Skin assessment noted soft tissue swelling and concern for wet gangrene.
-Hospital course of treatment was guillotine amputation on 02/26/24 followed by below right knee amputation (BKA) on 02/29/24. (A guillotine amputation is performed when the presence of severe infection or death of the tissue is present in an effort to eliminate the bacteria and provide a safer wound environment for a definitive amputation at a later date).

Interview with a lead medication aide (MA) on 05/08/24 at 9:30am revealed she did not perform any duties related to the LHPS reviews and evaluations and was never instructed to do so.

Telephone interview with the facilty's LHPS Registered Nurse (RN) who completed the assessment in February 2024 on 04/12/24 at 2:39pm revealed:
-She completed the LHPS review and evaluation for the Resident #2 on 02/15/24.
-She did not perform a physical assessment on the resident and was not trained or told to conduct a physical assessment.
-She was trained to review orders for LHPS tasks that were to be provided to the resident related to their diagnoses and ensure those tasks were listed on the LHPS form.
-She was also responsible to ensure staff were trained to perform the LHPS tasks.
-If there was "anything going on with the resident," it was the facility's responsibility to

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report those concerns to the Primary Care Provider (PCP).
-She did not inspect the resident's feet during the review and evaluation on 02/15/24.

Telephone interview with the facility's LHPS RN who completed the assessment in September and November 2024 on 05/08/24 at 11:30am revealed:
-She completed the LHPS reviews and evaluations for Resident #2 on 09/01/23 and 11/20/23.
-She conducted LHPS reviews and evaluations and trained other LHPS RNs.
-She performed a "focused assessment" of a resident based on the 28 state identified tasks related to the resident's diagnosis and a review of the resident's tasks that were ordered.
-She would not have necessarily looked at a resident's feet unless a review of the record review indicated there was a concern with the feet.

Telephone interview with the faciliy's in-house Podiatrist on 05/07/24 at 8:34am revealed:
-She provided foot care to residents at the facility on 02/01/24 and did not recall providing care to Resident #2.
-Generally, a resident with diabetes should have routine podiatry support due to being at high risk for falls and a foot wound that may lead to an infection and subsequently an amputation.
-A person with a Hgb A1C level of 7.2% was high, and the person's feet should be monitored at least every 90 days if no injury to the feet was observed by a trained professional.

Interview with the Executive Director (ED) on 04/11/24 at 5:07pm revealed:
-The facility had a RN that completed the LHPS

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D 280	Continued From page 55 reviews and evaluations for the residents. -The Care Managers or designee (Memory Care Coordinator (MCC)/Resident Care Coordinator (RCC) who was out on leave) were responsible for ensuring LHPS reviews and evaluations was completed for residents. -While the MCC/RCC was out on leave, she and the lead medications aides (MAs) were responsible. -She thought a physical assessment was performed on the resident during the LHPS review and evaluation. A second interview with the ED on 05/08/24 at 10:30am revealed: -The LHPS RN was contracted to provide physical assessments and make recommendation regarding the care of residents when admitted, quarterly, or when there was a change in a resident's tasks. -She or the Care Manager were responsible for reviewing LHPS reviews and evaluations reports. -The LHPS RN came to the facility once a month. -The LHPS RN also trained personal care aides (PCAs) and medication aides (MAs) on personal care tasks provided. -She did not expect the LHPS RN to look at Resident #2's feet during the review and evaluation on 02/15/24. -She expected the LHPS RN to follow the instructions on the LHPS review and evaluation form. ______________________ The facility failed to ensure the LHPS Registered Nurse performed a physcial assessment of Resident #2 related to his diagnosis of diabetes with suboptimal blood sugar control, and a history of stroke. The LHPS review and evaluation, which did not include an assessment of Resident #2's feet, was completed 11 days prior to Resident #2	D 280		

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D 280	Continued From page 56 being sent to the emergency room for a severe infection in his right foot which subsequently resulted in a below the knee amputation. This failure resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. _______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/12/24. CORRECTION DATE OF THE TYPE A2 VIOLATION SHALL NOT EXCEED 06/07/24.	D 280		
D 281	10A NCAC 13F .0903 (d) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (d) The facility shall assure action is taken in response to the licensed health professional review and documented, and that the physician or appropriate health professional is informed of the recommendations when necessary. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to implement recommendations for 1 of 5 sampled residents related to a podiatry referral made by the Licensed Health Professional Support Nurse for a resident with a diagnosis of diabetes and a history of stroke, who was sent to the emergency room for a severe foot infection (#2).	D 281		

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The findings are:

Review of Resident #2's current FL-2 dated 03/05/23 revealed:
-Diagnoses included a stroke, diabetes, hypertension, and expressive aphasia related to a stroke. (Expressive aphasia is a condition where a person may understand speech but have difficulty speaking).
-The resident was ambulatory and required assistance with bathing and dressing.
-The resident resided on the assisted living (AL) unit.

Review of Resident #2's Resident Register revealed an admission date of 04/27/23 and a discharge date of 03/14/24 to a skilled nursing facility (SNF).

Review of Resident #2's recent diagnostic laboratory report dated 02/06/24 revealed:
-There was a blood sugar level of 123mg/dl which was noted to be high (normal is 66-99mg/dl).
-There was a Hemoglobin (Hgb) A1C value of 7.2% (normal is less than 5.7%). (Hgb AIC is a blood test that measures the average blood sugar levels over a period of 3 months and monitors how well a person's blood sugar is being controlled).
-For someone with known diabetes, a Hgb AIC greater than or equal to 7% indicated suboptimal (not at the best possible level) control.

Review of Resident #2's Licensed Health Professional Support (LHPS) review and evaluation report dated 05/11/23 revealed:
-The resident was a recent admission to the facility.
-He was independent in both ambulation and transfers.

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-His had finger stick blood sugars (FSBS) done twice daily with a recent range of 113-252.
-He was prescribed Metformin 500mg twice daily. (Metformin is a medication used to control high blood sugar).
-There was a recommendation to place the resident on the podiatry list.
-There was documentation the report was reviewed and signed by the Executive Director and completed by the facility's contracted LHPS Registered Nurse.

Review of Resident #2's Podiatry Services Authorization form revealed:
-There was a signed agreement dated 09/07/23 by Resident #2's Power of Attorney (POA) authorizing the facility's in-house Podiatry Service to provide foot care to the resident.
-This agreement was also signed by the Executive Director (ED).

Review of Resident #2's progress note dated 02/26/24 revealed:
-The lead MA noticed the resident was not acting normal and did not want breakfast.
-She went to check on the resident after the personal care aide (PCA) informed the MA that she noticed his right foot "did not look right."
-The resident's breathing was abnormal.
-A picture of the swollen foot was sent to the Primary Care Provider (PCP).
-The PCP gave instructions to send Resident #2 to the local hospital emergency room (ER).
-Resident #2's Power of Attorney (POA) was notified.

Review of Resident #2's local hospital ER discharge summary report dated 03/15/24 revealed:
-Resident #2 was admitted to the local hospital

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ER on 02/26/24 with a complaint of right foot injury and foul smelling drainage, and was discharged on 03/14/24 to a SNF.
-Resident #2 was admitted to the local hospital ER with a diagnosis of gas gangrene (a highly lethal soft tissue infection that produces foul smelling gas) and osteomyelitis. (Osteomyelitis is an infection of bone).
-On physical exam, the right foot showed gangrenous changes, blistering and drainage from the right great toe with cellulitis (serious bacterial skin infection) extending up to the ankle.
-Resident #2's POA stated the resident was brought to the local hospital ER due to confusion and altered mental status with right foot pain and swelling after a recent fall 5 days ago.
-Skin assessment noted soft tissue swelling and concern for wet gangrene.
-Hospital course of treatment was guillotine amputation on 02/26/24 followed by below right knee amputation (BKA) on 02/29/24. (A guillotine amputation is performed when the presence of severe infection or death of the tissue is present in an effort to eliminate the bacteria and provide a safer wound environment for a definitive amputation at a later date).

Telephone interview with Resident #2's POA on 04/12/24 at 9:10am revealed:
-He was not aware of the resident ever being seen by a podiatrist during the time he resided at the facility, which was about a year.
-He remembered the Business Office Manager (BOM) sending him a consent form to sign giving the facility the authority to provide foot care to the resident by their in-house Podiatry Service.
-He signed the form on 09/07/23 and sent it back to the facility via email after checking to make sure the resident's insurance would cover the foot care.

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-He did not hear anything further from the facility regarding podiatry services for the resident.

Interview with a personal care aide (PCA) on 0/10/24 at 9:40am revealed:
-Staff were not allowed to cut Resident #2's fingernails or toenails because he was diabetic.
-She did not know the last time his fingernails and toenails were trimmed or who trimmed them.
-She thought the resident's toenails were cut by an outside provider that came to the facility on a routine basis.

Telephone interview with the facility's in-house Podiatrist's Assistant on 04/12/24 at 10:08am revealed:
-The Podiatry Service provided foot care to residents at the facility every 90 days.
-The Podiatry Service required authorization from the resident or resident's legal representative before the resident could be entered in their system and services could be provided.
-There was no documentation that an authorization was received from the facility for the resident to receive foot care.
-The Podiatry Service last provided foot care at the facility on 02/01/24.
-Resident #2 was not in their system to receive services, therefore foot care was not provided to the resident on that date.
-It was standard of care for a any resident residing in an assisted living facility to receive podiatry services at least every 90 days.

Telephone interview with the Business Office Manager (BOM) on 04/12/24 at 11:34am revealed:
-The ED and the Care Managers (Memory Care Coordinator/Resident Care Coordinator who was currently on leave) were responsible for ensuring

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the authorization for podiatry services was completed for residents and submitted to the Podiatry Service.
-She may have assisted with getting the podiatry consent form signed if asked.
-She did not remember speaking to Resident #2's POA regarding completing the authorization form, but may have.
-She did not know why the authorization form was not sent to the facility's in-house Podiatry Service.
-She was not aware of any podiatry appointments being made for Resident #2.

Telephone interview with the facility's in-house Podiatrist on 05/07/24 at 8:34am revealed:
-She provided foot care to residents at the facility on 02/01/24 and did not recall providing care to Resident #2.
-Generally, a resident with diabetes should have routine podiatry support due to being at high risk for falls and a foot wound that may lead to an infection and subsequently an amputation.
-Podiatry support included inspecting and monitoring the feet for cuts, rashes, sores, calluses, possible infection and cutting toenails.
-A small cut of the skin surrounding the toenail could turn into a sore, a sore could turn into cellulitis (bacterial skin infection), and cellulitis could lead to an amputation.
-A person with diabetes with consistent elevated blood sugar levels may experience damage to blood vessels resulting in the person's circulatory system to be compromised (lack of blood flow to toes and feet) which could cause a wound not to heal and the tissue to die.
-Also, a person with diabetes with high blood sugar levels over time could experience nerve damage (neuropathy), which can cause numbness in the feet and prevent the person from feeling foot pain or even knowing there was

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a wound on the foot due to loss of sensation.
-This loss of sensation in the foot could cause a wound to progress quickly to a serious infection because the person did not have the the "normal pain alert system" to know something was wrong.
-If a person had a A1C of 7.2% with a cut or sore on the foot, she would recommend monitoring the foot every 1-2 weeks by a home health nurse because there may be a need for the person to be referred to a wound clinic or to the hospital for management and treatment in that an infection could progress quickly in a couple days to two weeks.
-After an amputation, a person's life expectancy was decreased significantly and typically was less than 5 years.
-Routine foot care was the "key" in preventing a toe infection that may lead to an amputation of a foot.

Telephone interview with Resident #2's PCP on 04/12/24 at 1:20pm revealed:
-She did not know who trimmed Resident #2's fingernails and toenails.
-The facilty never requested a referral from her for podiatry services for the resident.
-A referral was not needed unless the Podiatry Service or the resident's insurance company required it.
-Routine foot care would have been beneficial for Resident #2, but there was no way of knowing whether this would have prevented the outcome.

Interview the Executive Director on 05/08/24 at 10:30am revealed:
-She did not recall reviewing the LHPS review and evaluation report dated 05/11/23 and was not aware of the recommendation for Resident #2 to be placed on the podiatry list.
-She or the Care Manager were responsible for

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D 281	Continued From page 63 reviewing LHPS reports and ensuring the implementation of any recommendations. -She did know why Resident #2 was not placed on the podiatry list. -She did not know why the authorization form for Resident #2 to receive foot care, signed by the resident's POA and her, was not sent to the in-house Podiatry Service. -Resident #2 should have been receiving foot care from a podiatrist on a routine basis to ensure there were no cuts or bruises on his feet that could lead to an infection since he was diabetic. ________________________ The facility failed to ensure the recommendation by the LHPS Registered Nurse for podiatry support (foot care) was implemented for a resident with a diagnosis of diabetes, suboptimal blood sugar control and a history of stroke. . Despite the consent for treatment form being signed and the podiatrist visiting the facility quarterly, the resident never received any podiatry care during the 11 months he resided at the facility. The resident was sent to the emergency room for a severe infection in his right foot which subsequently resulted in a below the knee amputation. This failure resulted in serious physical harm and neglect to the resident and constitutes and Type A1 Violation. ________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/08/24. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 06/07/24.	D 281		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights	D 338		

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An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
FOLLOW-UP TO CONTINUING TYPE B VIOLATION

Based on these findings, the Previously Unabated Type B Violation was abated. Non-compliance continues.

Based on observations and interviews the facility failed to provide care and services residents' rights by not providing meals based on residents' preferences and in a timely manner, and adequate options to meet their nutritional needs.

The findings are:

Observation of the lunch meal on 04/09/24 at 12:09pm revealed:
-The residents in both the Special Care Unit (SCU) and the Assisted Living (AL) dining hall were seated and ready to eat lunch.
-The menu was pot roast, tater tots, coleslaw, white bread, mixed fruit, water, and tea.
-The cook began plating the food at 12:12pm and served the SCU dining hall first.
-The cook began plating the food for the AL dining hall at 12:38pm.
-Plates were served to the residents on the AL dining hall at 12:40pm.
-The residents in the AL dining hall voiced to the wait staff that they were angry that their food was late.

Observation of the breakfast meal on 04/10/24 at

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7:25am revealed:
-The menu was eggs, oatmeal, toast, breakfast meat of choice (sausage and bacon prepared), cereal, mixed fruit, water, cranberry juice, OJ, and coffee.
-There was 1 cook and 1 wait staff preparing and serving the meal for both the SCU and AL dining hall.
-The residents on the AL dining hall were seated at approximately 7:45am.
-The cook began plating the food at 7:53am and served at 8:02am in the SCU dining hall and began plating the food at 8:16am and served at 8:16am in the AL dining hall.
-The cook plated sausage meat and not bacon.

Interview with the cook on 04/10/24 at 8:25am revealed:
-She cooked the bacon to be sure there was enough meat to go around.
-She did not give out bacon on the first go around and planned to ask if anyone wanted bacon on the second go around.
-The cook asked if anyone wanted bacon and four out of eight residents on the SCU, and three out of seven residents on the AL said yes.

Interview with a resident on 04/10/24 at 11:20am revealed:
-He ate the same foods repeatedly (mac and cheese, baked chicken, and pot roast).
-He ate breakfast on 04/10/24 then left the dining room.
-He was not aware bacon was being served, he was not offered bacon.
-He waited for meals at least 40 minutes a few times and it was close to 1pm when he ate the day before (04/09/24).
-He left the dining hall at least twice in the last month and did not eat because it was taking too

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long to be served.
-He reported his concerns about repetitive meals and late service during resident rights meetings and nothing changed.
-He did not report his concerns to the Executive Director (ED).

Interview with a second resident on 04/10/24 at 11:30am revealed:
-There were two good cooks in the kitchen but not enough workers to help get the food to the table.
-The office manager ordered the food, and he ate the same foods "over and over again" (pot roast at least 3 times a week, mixed vegetables, and liquid eggs).
-They did not serve chicken often unless it was chicken tenders, and he never got pancakes, French toast, or real eggs.
-He was not aware that there was bacon in the kitchen until the cook asked him, close to the end of the breakfast, if anyone wanted bacon and he asked for 2 pieces of bacon.
-He had to wait for his meal almost every day for at least 30 minutes.

Interview with a third resident on 04/10/24 at 11:45am revealed:
-She never knew when she would be served a meal once she was sitting at the dining hall table.
-She ate the same foods "over and over again" (sausage and eggs and a lot of pork).
-They did not serve pancakes and she got bacon sometimes.
-The knew bacon was often prepared but it went to the employees.
-She knew this because she could smell the bacon being cooked, not being served to residents and she saw staff come out with plates of food covered in foil.

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-She told the ED, but it made no difference.

Second interview with the cook on 04/10/24 at 4:10pm revealed:
-She cooked and plated the food, and the wait staff served the meal to the residents in both the SCU and AL dining halls.
-The cook and the wait staff were the only two working in the kitchen.
-She cooked the bacon because the sausage links were taking too long to cook, and she was trying to get the food out in a timely manner.
-She cooked more sausage meat than bacon because less bacon was ordered.

Interview with the wait staff on 04/11/24 at 2:10pm revealed:
-The residents complained they did not get the food they wanted to eat.
-Often, there was not enough food for a second serving.
-Staff would come in and grab food before the residents were served.

Interview with the Executive Director (ED) on 04/11/24 at 3:15pm revealed:
-The dining experience was to be in a restaurant style and the cook was to plate the food as the residents came into the dining hall.
-No more than 3 to 5 plates at a time should be plated and placed on the resident's table.
-Dietary staff placed the facility's food order on the computer and the office manager ensured the order matched the menu then placed the order.
-She would work with dietary on getting the residents' plates out a sooner.
-She was unaware that employees were eating food out of the kitchen prior to residents being served first.

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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: TYPE B VIOLATION. Based on interviews, and record reviews, the facility failed to administer medication as ordered for 2 of 7 sampled residents (#5, #6) related to a scheduled medication used to treat moderate to severe pain (#5), medications used to treat pain, fever, inflammation, reduce the risk of heart attack, high blood pressure, infection, blood clots, heart failure, high blood sugar, fluid retention, an overactive bladder, low potassium blood level, and vitamins (#6). The findings are: Review of the facility's undated medication policy on 04/10/24 revealed medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders. 1. Review of Resident #5's current FL-2 dated 01/18/24 revealed: -Diagnoses included malignant neoplasm of the prostate and pathological fracture in neoplastic	D 358		

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disease, other specified site.
-There was an order for oxycodone 5mg (oxycodone is an opioid analgesic used to treat moderate to severe pain) tablets, take one tablet every eight hours.

Review of Resident #5's current signed physicians order sheet dated 02/08/24 revealed an order for oxycodone 5mg tablets, take 1 tablet every eight hours.

Review of Resident #5's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxycodone 5mg tablets, take 1 tablet every eight hours, scheduled for 6:00am, 2:00pm, and 10:00pm.
-There was documentation that oxycodone 5mg was not administered on 04/01/24 at 2:00pm and documented as missed dose.
-There was documentation that oxycodone 5mg was not administered on 04/01/24 at 10:00pm and documented as discontinued.
-There was documentation that oxycodone 5mg was not administered on 04/02/24 at 6:00am and 2:00pm and documented as patient unable to take medication.
-There was documentation that oxycodone 5mg was not administered on 04/02/24 at 10:00pm and documented as awaiting refill order.
-There was documentation that oxycodone 5mg was not administered on 04/03/24 at 6:00am and documented as patient unable to take medication.
-There was documentation that oxycodone 5mg was not administered on 04/03/24 at 2:00pm and documented as missed dose.
-There was documentation that oxycodone 5mg was not administered on 04/03/24 at 10:00pm and documented at awaiting refill order.

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-There was documentation that oxycodone 5mg was not administered on 04/04/24 at 6:00am and documented as patient unable to take medication.

Review of Resident #5's medication of hand on 04/10/24 at 9:52am revealed:
-There were 3 bubble packages of oxycodone 5mg, 1 package was empty with 30 slots punched, 1 package with 30 tablets remaining and one package with 11 tablets remaining.
-The 3 bubble packages were labeled noting oxycodone 5mg tablets, take 1 tablet every eight hours, 90 tablets were dispensed on 04/02/24.

Telephone interview with a representative from the facility's contracted pharmacy provider on 04/10/24 at 4:25pm revealed:
-A prescription for oxycodone 5mg was received from the provider on 04/02/24.
-Oxycodone 5mg tablets, take one tablet every 8 hours were dispensed and delivered to the facility on 04/03/24 for a quantity of 90 tablets for a 30-day supply.
-Oxycodone 5mg tablets, take one every 8 hours were previously dispensed on 03/01/24 for a quantity of 90 tablets for a 30-day supply.

Interview with Resident #5 on 04/10/24 at 10:12am revealed:
-He took oxycodone three times a day for hip and shoulder pain.
-The facility had run out of oxycodone for a few days earlier this month.
-He was told at that time by the medication aide (MA) that a prescription had been requested from the provider and they were waiting on the prescription to be sent to the pharmacy.
-He described his pain level as 3-4 out of 10 (with 10 being the highest level of pain) when he took

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the oxycodone.
-He described his pain level as 6-7 out of 10 on the days the oxycodone was not available.
-He denied symptoms of nausea, diarrhea, or gastric upset when he did not receive the oxycodone earlier this month.

Interview with the MA on 04/10/24 at 9:11am revealed:
-The MAs performed weekly cart audits, to check for needed refills, expired medications, and order changes.
-The residents' medications were on a 28-day cycle fill except for narcotics.
-The MAs requested refills for the residents from the pharmacy.
-If a resident needed a narcotic filled, the MA contacted the provider's office to request a prescription be sent to the pharmacy.
-She requested medications when the residents had 3-4 days remaining on their current prescription.
-Resident #5's oncologist prescribed the oxycodone 5mg for him.
-She remembered calling Resident #5's oncologist and spoke with the nurse at the office to request an oxycodone refill for the resident.
-She was told by the nurse, that the oncologist was out of the office for the next 2 days but she would give him the prescription request when he returned.
-She could not remember exactly when she placed the call to the oncology office to request the oxycodone prescription for Resident #5.
-She requested an emergency prescription from the facility's contracted pharmacy provider but was told a signed prescription was required since oxycodone was a schedule II narcotic.
-She did not think to contact Resident #5's primary care provider (PCP) for a temporary

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oxycodone prescription until the oncologist returned to issue a prescription.
-The residents' medications should be requested at least 3-4 days prior to running out, especially if it was narcotic that required a prescription.
-The residents should not be without their medications.

Interview with the Executive Director (ED) on 04/11/24 at 2:33pm revealed:
-The MAs ordered refills for the residents.
-The MAs did weekly cart audits to make sure medications were available to the residents, order refills if needed, check for expired medications and if there were any order changes for medications.
-Medications were to be requested within 7 days of running out and should be requested at least 3-5 days in advance of the last dose to avoid running out of medications.
-She had documentation the MA had requested an oxycodone prescription from Resident #5's oncology office on 04/01/24 at 2:32pm and was told the physician had to sign the prescription and it could take 48 to 72 hours and Resident #5 had an appointment with his oncologist on 04/02/24 and an oxycodone prescription was sent to the pharmacy the same day.
-She expected medications to be ordered in advance so the residents would not be out of medications.
-She expected the residents' medications to be available and to be administered as ordered.

Telephone interview with Resident #5's PCP on 04/11/24 at 9:38am revealed:
-Resident #5's oncologist prescribed oxycodone for pain related to metastatic prostate cancer.
-She was not aware that Resident #5 had been without the oxycodone for 9 consecutive doses.

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-Resident #5 could have experienced inadequate pain relief without the oxycodone.
-Resident #5 could have possibly experienced gastric upset and diarrhea related to possible withdrawal symptoms if he has been on oxycodone long term.

Telephone interview Resident's #5's oncologist's nurse on 04/11/24 at 11:32am revealed:
-Resident #5 diagnosis was prostate cancer with metastasis to the bones.
-Resident #5 was prescribed oxycodone 5mg, three times per day for pain related to bone metastasis.
-The facility contacted their office on 04/01/24 at 2:34pm for an oxycodone refill for Resident #5.
-The oxycodone refill was sent to the pharmacy for Resident #5 on 04/02/24 at 2:41pm.
-Without oxycodone, the resident could be uncomfortable and experience pain related to bone metastasis

2. Review of Resident #6's current FL-2 dated 06/29/23 revealed diagnoses included dementia, hypertension, hypokalemia, congestive heart failure, and atrial fibrillation.

a. Review of Resident #6's physician order dated 02/29/24 revealed an order foot Acetaminophen 500mg, 2 tablets every 8 hours for pain three times a day. (Acetaminophen was a medication used to treat pain, fever, inflammation, and reduce the risk of a heart attack).

Review of Resident #6's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Acetaminophen 500mg, 2 tablets every 8 hours for pain at 6:00am, 2:00pm and 10:00pm.

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-There was documentation Acetaminophen 500mg, 2 tablets was not not administered at 10:00pm on 04/02/24, 04/03/24, and 04/04/24 with the notation missed dose.

Observation of Resident #6's medication on hand on 04/11/24 at 11:00am revealed there was a bubble card containing 28 Acetaminophen 500mg tablets with a dispense date of 03/21/24 for a quantity of 168 tablets.

b. Review of Resident #6's physician order dated 02/29/24 revealed an order for Biofreeze cream 10%, apply topically to bilateral knees three times a day for discomfort. (Biofreeze is a medications use to treat muscle pain).

Review of Resident #6's April 2024 eMAR revealed:
-There was an entry for Biofreeze cream 10%, apply topically to bilateral knees three times a day for discomfort three times a day at 8:00am, 2:00pm, and 8:00pm.
-There was documentation Biofreeze cream 10% was not administered at 2:00pm on 04/01/24 and at 8:00am on 04/02/24 with the notation missed dose.

Observation of Resident #6's medication on hand on 04/11/24 at 11:00pm revealed there was one tube of Biofreeze cream 10% with a dispensed date of 03/21/24 for one tube.

c. Review of Resident #6's physician order dated 02/29/24 revealed an order for Carvedilol 3.125mg, 1 tablet two times a day with meals. (Carvedilol was a medication used to treat high blood pressure and heart failure).

Review of Resident #6's April 2024 eMAR

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revealed:
-There was an entry for Carvedilol 3.125mg, 1 tablet two times a day with meals at 8:00am and 8:00pm.
-There was documentation Carvedilol 3.125, 1 tablet was not administered at 8:00am on 04/02/24, 5:00pm on 04/04/24, and 5:00pm on 04/06/24 with the notation missed dose.

Observation of Resident #6's medication on hand on 04/11/24 at 11:00pm revealed there were two bubble cards containing 37 Carvedilol 3.125mg tablets with a dispensed dated of 03/21/24 for a quantity of 56 tablets.

d. Review of Resident #6's physician order dated 02/29/24 revealed an order for Cephalexin 250mg, 1 tablet daily for recurrent urinary tract infection (UTI). (Cephalexin was a medication used to treat infections).

Review of Resident #6's April 2024 eMAR revealed:
-There was an entry for Cephalexin 250mg, 1 tablet at 8:00am.
-There was documentation Cephalexin 250mg, 1 tablet was not administered at 8:00am on 04/02/24 with the notation missed dose.

Observation of Resident #6's medication on hand on 04/11/24 at 11:00am revealed there was a bubble card containing 9 Cephalexin 250mg tablets with a dispensed date of 03/21/24 for a quantity of 28 tablets.

e. Review of Resident #6's physician order dated 02/29/24 revealed an order for Eliquis 2.5mg, 1 tablet two times day. (Eliquis was a medication used to treat and prevent blood clots).

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D 358	Continued From page 76 Review of Resident #6's April 2024 eMAR revealed: -There was an entry for Eliquis 2.5mg, 1 tablet at 8:00am and 8:00pm. -There was documentation Eliquis 2.5mg, 1 tablet was not administered at 8:00am on 04/02/24 with the notation missed dose. Observation of Resident #6's medication on hand on 04/11/24 at 11:00am revealed there was a bubble card containing 16 Eliquis 2.5mg tablets with a dispensed date of 03/21/24 for a quantity of 56 tablets. f. Review of Resident #6's physician order dated 02/29/24 revealed an order for Entresto 49 mg-51 mg, 1 tablet two times a day. (Entresto is a medication used to treat heart failure). Review of Resident #6's April 2024 eMAR revealed: -There was an entry for Entresto 49mg-51mg, 1 tablet two times a day. -There was documentation Entresto 49mg-51mg, 1 tablet was not administered at 8:00am on 04/02/24 with the notation missed dose. Review of Resident #6's medication on hand on 04/11/24 at 11:00am revealed there was a bubble card containing 16 Entresto 49mg-51mg tablets with a dispense date of 03/21/24 for a quantity of 56 tablets. g. Review of Resident #6's physician order dated 02/29/24 revealed an order for Farxiga 10mg, 1 tablet daily. (Farxiga is a medication used to treat chronic kidney failure, heart failure, and type 2 diabetes). Review of Resident #6's April 2024 eMAR	D 358		

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revealed:
-There was an entry for Farxiga 10mg, 1 tablet daily at 8:00am.
-There was documentation Farxiga 10mg, 1 tablet was not administered at 8:00am on 04/02/24 with the notation missed dose.

Observation of Resident #6's medication on hand on 04/11/24 at 11:00am revealed there was a bubble card containing 9 Farxiga 10mg, tablets with a dispense date of 03/21/24 for a quantity of 28 tablets.

h. Review of Resident #'6's physician order dated 02/29/24 revealed an order for Furosemide 20mg, 1 tablet daily at 3:00pm and Furosemide 20mg, 2 tablets every morning. (Furosemide is a medication used to treat fluid retention).

Review of Resident #6's April 2024 eMAR) revealed:
-There was an entry for Furosemide 20mg, 1 tablet daisy at 3:00pm and Furosemide 20mg, 2 tablets at 8:00am.
-There was documentation Furosemide was not administered at 3:00pm on 04/01/24 and 8:00am on 04/02/24 with the notation missed dose.

Observation of Resident #6's medication on hand on 04/11/24 at 11:00am revealed there was a bubble card containing 6 Furosemide 20mg tablets with a dispense date of 03/21/24 and quantity of 84 tablets, and a bubble card containing 12 Furosemide 20mg tablets with a dispensed date of 03/21/24 for a quantity of 84 tablets.

i. Review of Resident #6's physician order dated 02/29/24 revealed an order for Levothyroxine 25mcg, 1 tablet daily. (Levothyroxine is a

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medication used to treat hypothyroidism).

Review of Resident #6's April 2024 eMAR revealed:
-There was an entry for Levothyroxine 25mcg, 1 tablet daily at at 8:00am.
-There was documentation Levothyroxine 25mcg, 1 tablet was not administered at 8:00am 0n 04/02/24 with the notation missed dose.

Observation of Resident #6's medication on hand on 04/11/24 at 11:00am revealed there was a bubble card containing 7 Levothyroxine 25mcg tablets with a dispensed date of 03/21/24 for a quantity of 28 tablets.

j. Review of Resident #6's physician order dated 02/29/24 revealed an order for Myrbetriq 50mg, 1 tablet every day for overactive bladder. (Myrbetriq is a medication used to treat overactive bladder).

Review of Resident #6's April 2024 eMAR revealed:
-There was an entry for Myrbetriq 50mg, 1 tablet at 8:00am.
-There was documentation Myrbetriq 50mg, 1 tablet was not administered at 8:00am on 04/02/24 with the notation missed dose.

Observation of Resident #6's medication on hand on 04/11/24 at 11:00am revealed there was a bubble card containing 9 Myrbetriq 50mg tablets with a dispense date of 03/21/24 for a quantity of 28 tablets.

k. Review of Resident #'6's physician order dated 02/29/24 revealed an order for Potassium Chloride ER 10meq, 1 tablet daily. (Potassium Chloride is a medication used to treat and prevent low blood potassium levels).

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D 358	Continued From page 79 Review of Resident #6's April 2024 eMAR revealed: -There was an entry for Potassium Chloride ER 10meq, 1 tablet at 8:00am. -There was documentation Potassium Chloride ER 10meq, 1 tablet was not administered at 8:00am on 04/02/24 with the notation missed dose. Observation of Resident #6's medication on hand on 04/11/24 at 11:00am revealed there was a bubble card containing 9 Potassium Chloride ER 10meq tablets with a dispense date of 03/21/24 for a quantity of 28 tablets. l. Review of Resident #6's physician order dated 02/29/24 revealed Tab-A-Vite, 1 tablet daily. (Tab-A-Vite is a supplement). Review of Resident #6's April 2024 eMAR revealed: -There was an entry for Tab-A-Vite, 1 tablet at 8:00am -There was documentation Tab-A-Vite, 1 tablet was not administered at 8:00am on 04/02/24 with the notation missed dose. Observation of Resident #6's medication on hand on 04/11/24 at 11:00am revealed there was a bubble card containing 9 Tab-A-Vite tablets with a dispense date of 03/21/24 for a quantity of 28 tablets. m. Review of Resident #6's physician order dated 02/29/24 revealed an order for Vitamin B-12 250 mcg, 1 tablet daily. (Vitamin B-12 is a vitamin). Review of Resident #6's April 2024 eMAR	D 358		

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revealed:
-There was an entry for Vitamin B-12 250mcg, 1 tablet at 8:00am.
-There was documentation Vitamin B-12 250mcg, 1 tablet was not administered at 8:00am on 04/02/24 with the notation missed dose.

Observation of Resident #6's medication on hand on 04/11/24 at 11:00am revealed there was a bubble card containing 9 Vitamin B-12 250mcg tablets with a dispense date of 03/21/24 for a quantity of 28 tablets.

n. Review of Resident #6's physician order dated 02/29/24 revealed an order for Vitamin D2 2000U 50mcg, 1 tablet every day. (Vitamin D2 is vitamin).

Review of Resident #6's April 2024 eMAR revealed:
-There was an entry for Vitamin D2 2000U 50mcg, 1 tablet at 8:00am.
-There was documentation Vitamin D2 2000U 50mcg, 1 tablet was not administered at 8:00am on 04/02/24 with the notation missed dose.

Observation of Resident #6's medication on hand on 04/11/24 at 11:00am revealed there was a bubble card containing 10 Vitamin D2 50mcg tablets with a dispense date of 03/21/24 for a quantity of 28 tablets.

Interview with the medication aide (MA) on 04/11/24 at 4:00pm revealed:
-She was the MA working on 04/02/24 at 8:00am.
-She thought she administered Resident #6's medication at that time and must have failed to document on the computer after administering the medication.
-The computer program would generate a missed

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dose notation on the eMAR if the MA did not click off administered the medication or did not administer the medication at all.

Interview with the second MA on 04/11/24 at 4:40pm revealed:
-She was the MA working at 10:00pm at night on 04/02/24, 04/03/24, and 04/04/24.
-She was sure she administered Resident #4's medication at that time.
-She must have forgotten to document on the computer after administering the resident medication and a missed dose notation was generated on the eMAR.

Interview with the Executive Director (ED) on 04/12/24 at 11:30am revealed:
-The computer system would generate a missed dose notation if the MA forgot to document that the medication was administered.
-She expected medications to be administered as ordered and to be documented when administered on the eMAR.
____
The facility's failure to ensure Resident #5's oxycodone was available in the facility for administration, resulted in the resident missing 9 consecutive doses of this scheduled medication to treat pain related to metastatic cancer, causing him to experience a significant increase in his pain level. This failure was detrimental to the health and welfare of the resident and constitutes a Type B violation.
____

The facility provided a plan of protection in accordance with G.S. 131-34 on 04/11/24 for this violation.

CORRECTION DATE FOR THE TYPE B

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D 358	Continued From page 82 VIOLATION SHALL NOT EXCEED JUNE 22, 2024.	D 358		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure a care coordinator was on duty in the Special Care Unit (SCU) at least eight hours a day, five days a week to oversee resident care to ensure each resident received care and services appropriate to each resident's needs. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of 122 beds including 72 beds for Assisted Living (AL) and 50 beds for the Special Care Unit (SCU). Review of the facility's resident census list provided on 04/09/24 revealed: -The facility had a total of 47 residents. -27 residents resided on AL. -20 residents resided on the SCU.	D 466		

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Observation of the SCU on 05/07/24 from 8:36am to 8:42am revealed:
-The SCU was secured, and a coded keypad was used by staff for secure entrance.
-The was an office on the SCU labeled Resident Care Coordinator (RCC) across the hall from the medication preparation room.
-There was no one present in the RCC office.

Interview with a lead medication aide (MA) on 05/07/27 at 8:32am revealed:
-She worked at the facility for about one and a half years.
-She worked on the AL and the SCU.
-She was not sure how many hours she worked on the AL versus the SCU but said she mainly worked the AL.
-She was considered a lead MA.
-The facility had an RCC but she had been on leave for over a month.
-The facility had not had a Special Care Unit Coordinator (SCUC) since she had been employed there.
-She thought a SCUC and RCC were the same position.
-The RCC covered both the AL and the SCU.
-She was not sure how many hours the RCC spent in the AL and the SCU.
-The Executive Director (ED) currently covered the RCC duties, and she assisted the ED with these duties when she could.
-The ED was in the SCU a lot, but she was not sure exactly how many hours per week.

Second interview with a lead MA on 05/07/24 at 10:18am revealed:
-She administered medications to the residents.
-She currently supervised the personal care aides (PCAs) and made sure they performed their

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duties such as bathing, incontinence care and other activities of daily living (ADLs).
-She worked shifts in the AL and SCU.
-She did medication cart audits and processed physicians' orders when the facility's contracted primary care provider (PCP) came or if a resident went out to see PCP or returned from the hospital or emergency department (ED).
-She was the acting RCC from January 2023 to about June of 2023 and she covered both the AL and the SCU.
-She could not say how many hours per week she spent on either unit while she was the acting RCC during that time.
-There was another RCC employed, she thought during July 2023 and August of 2023 but she was no longer employed at the facility.
-The current RCC started in either October 2023 or November 2023 and covered both the AL and the SCU.
-The RCC office was in the SCU.
-She was not told of any additional responsibilities since the current RCC had been out on leave but tried to help the ED when she could.

Interview with a second lead MA on 05/07/24 at 10:03am revealed:
-She started work at the facility in April 2024 but had worked there previously.
-She worked on the AL and the SCU.
-She did not how many hours per week she worked on the AL versus the SCU.
-As a lead MA, she made sure everything ran smoothly on the unit.
-She administered medications.
-She made sure the PCAs took care of the residents' needs such as bathing, grooming, incontinent care, and assistance with meals if needed.
-She assisted the PCAs with resident care when

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she was not administering medications.
-There was an RCC, that covered the AL unit and the SCU, but she had been on leave since April 2024.
-There was not a SCUC.
-She had not been assigned any additional duties in the absence of the RCC.
-She did not know what the duties of the RCC were.

Interview with the ED on 05/08/24 at 12:06pm revealed:
-There was not a paid position of SCUC for the facility.
-The last time the facility had a SCUC was November 2022.
-A lead MA functioned as the RCC in the SCU and AL since November 2023 but had been on leave since 03/12/24.
-There was not an interim RCC, she and the other lead MAs covered the role.
-The RCC's duties included reviewing and updating FL2s, reviewing and updating care plans, reviewing the residents' records for physicians' orders, performing medication cart audits and medication reviews for the AL and SCU, and performing quarterly reviews for the SCU.
-The RCC worked 40 hours per week with overtime.
-She felt the RCC devoted most of her time in the SCU if not 100%.
-The ED now covered the RCC's responsibilities with assistance from the lead MAs.
-She could not say how many hours were spent coordinating care for the AL versus the SCU but probably 80 to 85% of her time was spent in the SCU.
-Two of the lead MAs assisted her with the RCC's duties and alternated their time between the AL

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D 466	Continued From page 86 unit and the SCU. -She could not say exactly how many hours the lead MAs spent on the AL and the SCU. -A SCUC was being hired in the near future. Refer to Tag 105, 10 NCAC 13F .0311(a) Other Requirements Refer to Tag 270, 10 NCAC 13F .0901(b) Personal Care and Supervision ______________________________ The facility failed to ensure a special care coordinator was on the special care unit 40 hours per week to meet the needs of the 20 special care unit residents. This failure was detrimental to the safety and welfare of the special care unit residents and constitutes a Type B violation. ______________________________ The facility provided a plan of protection in accordance with G.S. 131-34 on 5/15/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 22, 2024.	D 466		