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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 10/02/24 - 10/04/24.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 2 of 5 sampled residents related to not receiving urology care and dental care as ordered (#1) and not reporting weight loss to the primary care provider (PCP) (#2) . The findings are: 1. Review of Resident #1's current FL2 dated 01/01/24 revealed diagnoses included dementia, essential hypertension, epilepsy, chronic kidney disease stage 4, presence of cardiac and vascular implants, Diabetes Mellitus II, atherosclerotic heart disease of native coronary artery, atrial fibrillation, atrial flutter and hyperlipidemia. Review of Resident #1's care plan dated 02/27/24 revealed Resident #1 required limited assistance with toileting and supervision/set up assistance with eating. a. Review of Resident #1's Urologist orders dated 03/26/24 revealed: -There was an order to obtain a kidney, ureter,	D 273	Facility shall ensure that for each and every resident in the facility that is made a referral and or appointment pertaining to their health will be made on their behalf by arranging the appointment , the transportation and any other needs to be able to appropriately treat the resident. Correspondence shall be kept between primary referring physician and attending physician of treatment until no longer needed. This duty is the responsibility of the Memory Care Manager, RCC or the Executive Director in her absence as to prohibit delays of care. Memory Care Manager shall not only carry out this process but also document in the resident's chart and report to the Executive Director daily at morning meetings and or as the need is written by the provider. Audits of resident records shall take place weekly and be ongoing.	11/01/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Y. Evans	Executive Director/Administrator	10/28/24

REVIEWED AND ACKNOWLEDGED ON 10/31/24 BY NURSE CONSULTANT

Tina B Nielsen

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and bladder (KUB) in 4 months (an X-ray study that allowed the doctor to assess the organs of the urinary system and can locate kidney stones which can be very painful and may need surgery).
-The reason for the KUB was for conservatism (ideal approach to patient care) for bilateral kidney stones.

Review of Resident #1's record revealed no results for a KUB and no documentation in the progress notes that Resident #1 had been sent out to obtain the KUB.

Review of Resident #1's Urologist orders dated 08/21/24 revealed:
-There was an order for lithotripsy (a non-invasive medical procedure to break down kidney stones using shock waves to break the stones into smaller pieces, making them easier to pass through urine).
-The phone number to call to schedule the lithotripsy was listed on the order form.
-There was an order to follow up in 6 weeks.

Review of Resident #1's record revealed no results for the lithotripsy and no documentation in the progress notes that Resident #1 had been sent out to have lithotripsy performed.

Review of Resident #1's progress notes dated 08/21/24 at 7:16pm revealed:
-There was an entry for a health status note by the Resident Care Coordinator (RCC).
-Resident #1 had an appointment with the Urologist and the facility received a phone number to call to schedule lithotripsy.
-The follow up appointment was scheduled for 10/02/24 at 1:30pm (the entry did not designate with whom the appointment was made).
-The facility would send the information to the

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guardian for Resident #1.

Interview with the staff from Resident #1's Urologist office on 10/04/24 at 8:50am and 9:47am revealed:
-Her office had received numerous calls from the facility on 10/03/24 regarding resident #1 and several calls on 10/02/24.
-The last message the office received from the facility prior to the calls on 10/02/24 and 10/03/24 was from the RCC on 03/27/24.
-Resident #1 had seen the Urologist on 03/26/24 and a KUB was ordered for him in order to consider lithotripsy.
-There had been a delay in care because the facility did not get the KUB done as ordered.
-The resident's kidney stones were actually inside the kidney and were not blocking anything.
-The kidney stones could possibly cause damage to the kidneys.
-The Certified Medical Assistant (CMA) in the local urology office assisted the Urologist when the resident was seen and then the information was forwarded to the main office in which the procedure would be done.
-The Urologist had considered performing lithotripsy more as a comfort measure for the resident, more than medically necessary or the possibility of damage to the kidney.
-The X-rays dated 12/28/22 from the urology office, noted renal stones.
-There were bilateral stones at the time of the x-ray but were not obstructive and were not causing hydronephrosis (a condition of excess urine accumulation in kidney that causes swelling of kidneys which causes pain during urination, nausea and vomiting).
-There was a KUB done on 01/18/23 where calcifications (kidney stones) had been seen.
-Kidney stones of this size were unable to be

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passed through the urine without some medical intervention, lithotripsy to reduce the size of the stones or through surgery to remove the stones.

Interview with the RCC on 10/04/24 at 1:58pm revealed:
-She was responsible for scheduling appointments for residents.
-Resident #1's last urology appointment was in August 2024.
-There was not a following up appointment scheduled during the August 2024 appointment.
-Resident #1 had several different guardians appointed since he was admitted to the facility.
-The guardian needed to complete consent paperwork for the Urologist and the hospital in order for the lithotripsy to be done.
-She may have missed the order about the x-ray (KUB) as she thought the Urologist office was to schedule it.

Interview with the Administrator on 10/04/24 at 2:21pm revealed:
-The RCC was responsible for scheduling appointments for residents.
-There had been some delays in appointments due to the changes in guardianship for Resident #1.
-Resident #1 was not able to sign consents for his care and his guardian changes caused some delays.
-She had thought the RCC had been trying to contact the Urologist office in order to get Resident #1's appointments made.
-She had called the Urologist office herself yesterday (10/03/24) and left a message.

Attempted telephone interview with Resident #1's legal guardian on 10/04/24 at 2:30pm was unsuccessful.

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D 273	Continued From page 4 Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. b. Review of Resident #1's records revealed: -On 06/17/24, Resident #1 had been evaluated as a new patient and had panoramic radiographic image done. -On 08/22/24, Resident #1 had impressions done and fitted for dentures. -There were no other dates of services documented and no future appointments were notated in Resident #1's records. Interview with the Resident Care Coordinator (RCC) on 10/04/24 1:58pm revealed: -She was responsible for scheduling appointments for residents. -Resident #1's last dental appointment was in August 2024. -There was not a follow up appointment scheduled during the August 2024 appointment. -Resident #1 had several different guardians appointed since he was admitted to the facility. -She notified Resident #1's guardian on 10/03/24, that the facility had reached out to the dental office regarding the status of Resident #1 dentures. -The RCC did not say whether the facility was supposed to make the follow up appointment or if the dental office would contact the facility when the dentures were ready. Interview with the Administrator on 10/04/24 at 2:21pm revealed: -The RCC was responsible for scheduling appointments for residents. -There had been some delays in appointments due to the changes in guardianship for Resident	D 273		

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D 273	Continued From page 5 #1. -Resident #1 was not able to sign consents for his care and his guardian changes caused some delays. -Resident #1's dentist had not given the facility a follow up appointment date to return for his dentures, but the RCC had contacted them today to set up an appointment to get that done. Attempted telephone interview with Resident #1's primary dental provider on 10/04/24 at 2:30pm was unsuccessful. Attempted telephone interview with Resident #1's legal guardian on 10/04/24 at 2:30pm was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. 2. Review of Resident #2's current FL2 dated 08/05/24 revealed: -Diagnoses included dementia, essential hypertension, schizophrenia, muscle weakness, seborrheic dermatitis, urge incontinence, and asthma. -There was an order to complete weekly weights. Review of Resident #2's August 2024 electronic medication administration record (eMAR) revealed: -There was an electronic entry dated 08/05/24 for house supplements three times a day for nutrition at 7:30am, 12:00pm and 5:30pm. -There was documentation that Resident #2 had received house supplements starting on 08/05/24 at 5:30pm through 08/31/24 at 5:30pm. -Weight was documented as 144 pounds (lbs.) on 08/05/24.	D 273		

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-Weight was documented as 145 lbs. on 08/12/24.
-Weight was documented as 144 lbs. on 08/19/24.
-Weight was documented as 143.8 lbs. on 08/26/24.

Review of Resident #2's September 2024 eMAR revealed:
-There was an electronic entry for house supplements three times a day for nutrition at 7:30am, 12:00pm and 5:30pm.
-There was documentation that Resident #2 had received house supplements three times a day at 7:30am, 12:00pm and 5:30pm 09/01/24 through 09/30/24.
-Weight was documented as 142.3 lbs. on 09/02/24.
-Weight was documented as 135.8 lbs. on 09/09/24.
-Weight was documented as 134.2 lbs. on 09/16/24.
-Weight was documented as 133.6 lbs. on 09/23/24.
-Weight was documented as 133.6 lbs. on 09/23/24.

Review of Resident #2's October 2024 eMAR revealed:
-There was an electronic entry for house supplements three times a day for nutrition at 7:30am, 12:00pm and 5:30pm.
-There was documentation that Resident #2 had received house supplements three times a day at 7:30am, 12:00pm and 5:30pm 10/01/24 through 10/02/24 and at 7:30am on 10/04/24 .

Interview with the Resident Care Coordinator (RCC) on 10/04/24 at 1:30pm revealed:
-The facility had just purchased a new scale.

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-Resident #2 was known to wear several layers of clothing and that could be part of the weight loss.
-The medication aides (MAs) were expected to follow the orders and notify her or the primary care provider (PCP) if the resident lost weight.
-She was not aware that Resident #2 had lost 6. 5 lbs. between the first and second week in September.
-He was receiving nutritional supplements.

Interview with the Administrator on 10/04/24 at 2:21pm revealed:
-She was made aware of the need for a new scale and the facility had purchased one around the middle of September.
-The MAs did the monthly weights around the 15th of the month and weekly weights were done on the day the weight was ordered for the resident.
-She expected the RCC or MAs to notify the PCP of any weight loss but there was nothing in place as to what amount of weight loss for which the PCP was to be notified.

Telephone interview with Resident #2's PCP on 10/04/24 at 9:50am revealed:
-She was not aware that Resident #2 had lost any weight.
-She expected MAs to follow her orders and notify her if the resident lost weight.
-The MAs were able to reach her and should have notified her of Resident #2's weight loss.
-She would want to weigh herself on the scales and then have Resident #2 weighed to make sure the scales were accurate.

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

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D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of orders for 1 of 5 sampled residents (#4) related to fingerstick blood sugars (FSBS) outside of parameters (#4). The findings are: Review of Resident #4's current FL-2 dated 08/27/24 revealed: -Diagnosis included type 2 diabetes and dementia. -There was an order to check fingerstick blood sugar (FSBS) before meals and at bedtime, notify the primary care provider (PCP) if FSBS is greater than 400. Review of Resident #4's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS before meals and at bedtime, scheduled at 8:00am, 11:00am, 5:00pm, and 8:00pm, notify the PCP if FSBS is greater than 400. -FSBS was documented as 405 at 8:00pm on 08/28/24.	D 276	10/24/24 Facility shall ensure that the appropriate staff, Med Aides, Memory Care Manger are following the orders written by the provider. This includes training and reeducation of processes performed and on gaining clarification if needed. Orders shall be read, followed, to include contacting the provider as directed in the order for further instruction or for new orders given. The staff shall document the order specifications and communications and instructions in the resident's chart. Memory Care Manager and Executive Director shall conduct audits weekly on EMARS and records. Staff training on 10/23/24 and will be ongoing.	

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D 276	Continued From page 9 -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 400. Review of Resident #4's September 2024 eMAR revealed: -There was an entry to check FSBS before meals and at bedtime, notify the PCP if FSBS is greater than 400. -FSBS was documented as 526 at 5:00pm on 09/10/24. -FSBS was documented as 430 at 5:00pm on 09/13/24. -FSBS was documented as 417 at 5:00pm on 09/16/24. -FSBS was documented as 435 at 5:00pm on 09/19/24. -FSBS was documented as 406 at 11:00am on 09/22/24. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 400. Review of Resident #4's electronic progress notes revealed there was no documentation that Resident #4's PCP was notified of FSBSs greater than 400 in August 2024 and September 2024. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable. Interview with a medication aide (MA) on 10/03/24 at 1:20pm revealed: -Resident #4 had orders to notify her PCP if her FSBS was greater than 400. -Resident #4 had her FSBS checked four times a day, before meals and at bedtime. -MAs were expected notify Resident #4's PCP when her FSBS was greater than 400.	D 276		

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-When she notified the PCP that Resident #4's FSBS were greater than 400 she documented in the electronic progress note.
-She was not sure why there was no documentation that Resident #4's PCP had been notified that her FSBS was greater than 400.
-She probably forgot to document in the resident's electronic progress note that she notified the resident's PCP.
-She knew that continued FSBSs over 400 could cause health risks including damage to organs, hospitalization, and the resident fainting.
-She should have documented that she notified Resident #4's PCP of FSBSs great than 400 so the PCP could instruct her what to do.

Interview with the Special Care Unit Coordinator (SCUC) on 10/04/24 at 1:30pm revealed:
-She was not aware that MAs had not notified Resident #4's PCP when her FSBSs were over 400.
-MAs were expected to follow PCP orders and notify Resident #4's PCP when her FSBSs were over 400.
-There were specific directions on the eMAR to contact Resident #4's PCP if her FSBSs were over 400.
-The PCP needed to be notified because that was her order and the PCP may provide directions to the MA on what steps to take next when the resident's FSBSs were over 400, or if the resident needed to go to the local Emergency Department (ED).
-MAs should document communication with the resident's PCP in the electronic progress note.
-She supervised the MAs, and they knew that they were expected to follow the PCP parameters for Resident #4.
-FSBSs over 400 placed the resident at risk of damage to her kidneys and heart, she was placed

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D 276	Continued From page 11 at an increased risk of falling which could lead to injury. Interview with the Administrator on 10/04/24 at 2:21pm revealed: -MAs were expected to read orders on the eMAR, follow the PCP orders and understand the orders. -MAs should have notified the resident's PCP immediately to notify her that Resident #4 had FSBSs greater than 400. -The MAs were able to also notify the SCUC of FSBSs great than 400 and the SCUC would contact the PCP. -The MAs should have documented communication with the PCP in the electronic progress notes. -The MAs were aware that they needed to keep her and the SCUC aware of any time they need to notify any resident's PCP. Telephone interview with Resident #4's PCP on 10/04/24 at 9:50am revealed: -She was not aware that Resident #4 had FSBSs greater than 400 in August 2024 and September 2024. -She expected MAs to follow her orders and notify her if Resident #4's FSBSs were greater than 400 so she could direct staff what action to take. -The MAs were able to reach her and should have notified her immediately when Resident #4's FSBS was over 400. -Uncontrolled diabetes over time placed the resident at risk of long term effect such as organ damage to all organs.	D 276		