Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Senior Citizens Village
Address: 504 West Canal Drive Dunn, NC 28334
County: Harnett
License Number: HAL-043-006

II. Date(s) of Visit(s): 1/16/25
Purpose of Visit(s): CI
Exit/Report Date: 3/12/25

Instructions to the Provider ***(please read carefully)*****:**

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could 3result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this CAR. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0902 (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	☐ POC Accepted _____ *DSS Initials*	____
Rule/Statutory Reference: Health Care		
Level of Non-Compliance: Type A1 Violation		
Findings: This Rule is not met as evidenced by: Type A1 Violation Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination and follow-up for 4 of 5 sampled residents (#1, #3, #4, #5) including failing to obtain a primary care provider (PCP) and a neurology referral for a resident (#1), failing to coordinate a referral for psychiatry (#3), failing to coordinate a referral for physical therapy (#4) and failing to coordinate a referral for dermatology services (#5). The findings are:		

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1. Review of Resident #1's current FL2 dated 11/18/24 revealed:
-Diagnoses included muscle wasting and atrophy, cognitive communication deficiency, unspecified dementia, type 2 diabetes mellitus, and anxiety disorder.
-The resident was intermittently disoriented, ambulatory, incontinent, and required assistance with bathing.

Review of Resident #1's Resident Register revealed the resident was admitted on 03/13/24.

a. Review of Resident #1's hospital record revealed:
-The resident was admitted to the hospital on 07/22/24 and discharged on 07/30/24.
-The resident's admission diagnoses were (urinary tract infection) UTI with pyuria (pus in the urine) and altered mental status.
-According to the facility the resident was normally active and constantly walking around at the facility however this morning he was found unable to stand and not arousable. His last known normal was last night.
-The resident had a febrile temperature of 102.8.
-The resident was administered intravenous antibiotics.
-The issues requiring follow-up were urinalysis (UA), dementia, peripheral artery disease (PAD), diabetes mellitus (DM), history of hypertension (HTN) and to follow-up with Primary Care Provider (PCP).
-The resident's discharge diagnosis was UTI with pyuria and was stable.
-The resident was started on Seroquel (an antipsychotic medication used to treat symptoms of schizophrenia, bipolar disorder, and depression) for intermittent agitation with good effects. He was continued on Seroquel at discharge with a recommendation of close outpatient follow-up.
-The resident resumed Metformin (a medication used to treat high blood sugar levels that was caused by a type of diabetes) at discharged and recommended that his PCP consider discontinuing.
-The resident had history of frequent falls and Hydrochlorothiazide (a medication used to treat hypertension) discontinued with instructions for outpatient blood pressure monitoring with a recommendation for a basic metabolic panel (BMP) outpatient follow-up.

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Review of Resident #1's hospital record revealed:
-The resident was admitted to the hospital on 08/8/24 and discharged on 08/10/24.
-The resident's admission diagnoses were acute cystitis with hematuria (blood in the urine) and sepsis (a life-threatening complication often infectious).
-The resident was intubated and sedated.
-The resident had past medical history of significant septic shock secondary to UTI (07/22/24).
-The facility staff reported that the resident had been more lethargic than his baseline.
-The resident had an elevated temperature of 102.9 at admission.
-The resident started actively seizing, he was unresponsive to verbal and physical stimuli, and only responsive to painful stimuli.
-The resident was intubated due to his inability to protect his airway and moved to the intensive care unit.
-The resident was transferred to a critical care hospital for neurology and continuous electroencephalogram (EEG).
-The resident was transferred to a neuro intensive care unit at another hospital.
-The resident's discharge diagnoses were acute cystitis with hematuria, seizures of unclear etiology, altered mental status, and acute respiratory failure secondary to inability to protect airway.

Review of Resident #1's hospital record revealed:
-The resident was admitted to the hospital on 08/16/24 and discharge on 08/26/24 after being transferred from a critical care hospital to a step-down unit for possible status epilepticus (continuous seizures).
-The resident's admission and discharge diagnosis was seizure disorder.
-The resident's issues that required follow-up upon discharge consisted of seizures, urinary complaints, fall risk, peripheral artery disease, urinary retention, poor bowel movement, and dementia.
-The resident was to follow-up with the PCP within 1 week due to being hospitalized for seizures.

Review of Resident #1's rehabilitation discharge summary revealed:
-The resident was admitted to a rehabilitation facility on 08/26/24 following discharge from the hospital.
-The resident was discharged on 11/13/24.

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-The nursing post discharge plan of care was to follow-up with the PCP.

Review of Resident #1's provider visit notes revealed:
-There was no documentation that the resident had been seen by a PCP from June 2024-December 2024.
-On 01/23/25, the resident was seen by the PCP for a post emergency department (ED) visit follow-up and noted on 01/15/25 the patient presented to the ED due to altered mental status. The PCP was not informed of the ED visit until 01/23/25 even though she saw him for a readmission on 01/16/25.
-During the ED encounter on 01/15/25 labs including UA and imaging were unremarkable and the resident was sent back the same day with no new orders.

Interview with the Administrator on 01/16/25 at 11:24am revealed:
-Resident #1 was not seen by the PCP when discharged from the hospital or the rehabilitation facility.
-All residents were supposed to be seen by a PCP after discharge.
-She was responsible for reviewing the discharge paperwork for the residents.
-She did not recall seeing that Resident #1 needed to follow-up with the PCP and the reasons follow-up was needed.
-She was not sure when Resident #1 was last seen by the PCP and would call to find out.
-Resident #1 had not been seen by the PCP because he was removed from the provider's system.
-She thought Resident #1 was being seen by the PCP but he was not.
-Resident #1 was "dropped" by the PCP because he was in the hospital and taken out of their system.
-She had to resubmit Resident #1's paperwork to get him put back in.

Telephone interview with the Administrator on 02/25/25 at 12:04pm revealed:
-Resident #1 did not follow-up with the PCP after he was discharged from the hospital in July when diagnosed with a UTI.
-The resident needed follow-up to ensure the UTI was "gone and cleared up."
-If Resident #1 did not follow-up with the PCP, he could get sepsis which was an infection in the blood.

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-She was unaware that the hospital recommended outpatient follow-up in July 2024 for Resident #1 due to being ordered Seroquel or why follow-up was needed.
-She did not know if Resident #1 was still ordered Seroquel.
-She was unaware that the hospital recommended outpatient follow-up in July 2024 for Resident #1 due to being ordered Metformin or why it may have needed to be discontinued.

Telephone interview with the PCP on 02/28/25 at 10:57am revealed:
-Resident #1 had never been her patient, she had been a provider at the facility since October 2024, and her colleague was the previous provider.
-She thought Resident #1 had a different provider when she would see him at the facility.
-Resident #1 was recently admitted for PCP services after the consents were signed.
-She was unaware of Resident #1's hospitalization in July 2024 and diagnosis of UTI with pyuria.
-Resident #1 required a follow-up with PCP for labs to ensure the UTI cleared up.
-Resident #1 needed the routine things that were not done after the diagnosis.
-She was unaware of Resident #1's hospitalization in August 2024 and diagnosis of acute cystitis with hematuria.
-Since Resident #1 did not have a follow-up, it could have caused him to be septic but she was unsure of what actually happened.
-She would order labs for Resident #1 and refer him to a psychologist for management of the Seroquel.
-She wanted psychiatry to follow-up with Resident #1 to ensure his moods were stabilized and due to his dementia diagnosis.
-She did not know Resident #1 had a seizure diagnosis.
-She had been "scrambling for information" as there had been no concrete information.
-Resident #1 was demented and she could not get the information from him.
-The facility was supposed to call the PCP when residents were being sent to the hospital.
-After a patient was discharged from the hospital, the facility was supposed to notify the provider, and the hospital discharge paperwork should be available for review.
-Resident #1 came back to the facility with no discharge paperwork, and he was just "hanging out."

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-All acute incidents were supposed to be reported and those incidents took precedents.

b. Review of Resident #1's PCP progress note dated 04/29/24 revealed:
-The resident was seen for an acute visit for a follow-up hospitalization.
-The resident was hospitalized from 04/21/24-04/22/24 following a fall. There was limited paperwork sent back with the resident from the hospital.
-Computed tomography (CT) completed showed no acute findings.
-The resident was discharged back to the facility with a physical therapy (PT) and a neurosurgery referral around 06/03/24.
-The resident medically required PT and occupational therapy (OT) due to generalized weakness secondary to hypertension and multiple falls.
-Staff were to schedule an appointment with neurosurgery.

Review of Resident #1's provider visits notes revealed there was no documentation that the resident had been seen by a neurosurgeon and no documentation regarding the reason for delay.

Review of Resident #1's hospital record dated 08/16/24 revealed:
-The resident was admitted to the hospital on 08/16/24 and discharged on 08/26/24 to a rehabilitation facility.
-The resident was initially admitted to the hospital for sepsis, UTI, and seizures.
-The resident was not responding, had recurrent seizures, and was intubated and transferred for evaluation with continuous electroencephalogram (EEG) and concerns for status epilepticus.
-The resident had episodes of seizures in his previous admission and received treatment in the coronary care unit (CCU).
-The resident's head CT showed no acute abnormality.
-Outpatient follow-up was recommended within 1 week due to hospitalization for seizures.

Review of Resident #1's rehabilitation discharge summary revealed:
-The resident was admitted to a rehabilitation facility on 08/26/24 following discharge from the hospital.

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-The resident was discharged on 11/13/24.
-The nursing post discharge plan of care was to follow-up with the PCP.

Interview with the Administrator on 01/16/25 at 11:24am revealed:
-She was responsible for sending referrals and scheduling the appointments.
-Resident #1 had an appointment with a neurologist but he was hospitalized again and missed it.
-She was unaware of when the appointment was scheduled and had to look it up.
-She may have rescheduled the neurology appointment due to the facility having transportation issues.
-None of the residents went to outside appointments with providers until June or July 2024.
-She did not see anything documented about Resident #1 seeing a neurosurgeon.
-She was unsure why the referral to a neurosurgeon was recommended but thought it was due to his diagnosis of dementia.
-If Resident #1 was not seen by a neurosurgeon it placed his health at risk.

Second interview with the Administrator on 01/16/25 at 1:47pm revealed:
-The providers left the orders at the facility when they were present.
-She faxed the orders and referrals.

Third interview with the Administrator on 01/16/25 at 3:00pm revealed:
-A referral should be sent as soon as received within 1-3 days.
-The referral should be sent and the appointments scheduled no later than a week later.

Telephone interview with the Administrator on 02/25/25 at 12:04pm revealed:
-She did not know if Resident #1 was seen by neurology.
-She was not aware of Resident #1 ever having seizures.
-She was not aware that Resident #1 was intubated.
-She did not recall reviewing the hospital discharge paperwork.
-She was responsible for reviewing hospital discharge summaries.
-She would follow-up.

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Telephone interview with the PCP on 2/28/25 at 10:57am revealed:
-She recently became Resident #1's provider (01/16/25).
-She was unaware of Resident #1's seizure disorder as she did not see anything in his record pertaining to him having seizures.
-She had been "scrambling to get information."
-Resident #1 had dementia and she could not get information from him.
-Resident #1 needed to see a neurologist if he had a seizure disorder.
-If Resident #1 continued to have seizures, he could "stroke out."

Review of Resident #1's incident report dated 03/04/25 revealed:
-The time of the incident was 5:03am.
-Resident #1 was on the front hall, yelled out, fell, and hit his head while actively seizing.
-Resident #1 had a gash at the bridge of his nose.
-Resident #1 would see the PCP on 03/06/25.

Review of Resident #1's hospital discharge summary dated 03/04/25 revealed:
-The reason for the visit were seizures.
-The diagnoses were fall, seizure, and laceration of the left eyebrow.
-The resident received 4 sutures.
-A PCP follow-up was recommended within 3 days around 03/07/25.

Telephone interview with the Administrator on 03/10/25 at 10:37am revealed:
-She was standing at the nursing station on 03/04/25, Resident #1 screamed, had tremors, fell, and hit his head on a chair injuring the bridge of his nose.
-She was unaware if Resident #1 was seen by the PCP on 03/06/25.

Review of an email received from the Administrator on 03/10/25 revealed Resident #1 was not seen by the PCP on 03/06/25 due to not being placed on the list to be seen.

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Review of Resident #1's PCP progress note dated 03/10/25 revealed:
-The resident had a telephone visit (televisit) per the facility's request post fall.
-The resident's hospital encounter diagnoses were seizures, fall, and a laceration to his left eyebrow.
-The physical exam was limited due to the televisit.
-The resident would be sent back to the hospital for the sutures to be removed on 03/11/25.
-The resident was to follow-up with neurology for seizures.

2. Review of Resident #3's FL2 current dated 10/31/24 revealed:
-Diagnoses included urinary tract infection (UTI), b12 deficiency, hypothyroid, hypertension, history of acoustic neuroma, history of anxiety disorder, constipation, and recurrent falls.
-The resident was intermittently disoriented and ambulatory.

Review of Resident #3's Resident Register revealed she was admitted 10/31/24.

Review of Resident #3's hospital record revealed:
-The resident was admitted to the hospital on 11/19/24 and discharged on 12/04/24.
-The resident presented to the hospital with syncopal episode and was found to have low blood pressure, dizziness, and currently having atrial fibrillation.
-Psychiatry was initially consulted due to the resident reporting worsening depression symptoms.
-The resident was found to have both grief over the loss of her husband and a major depressive disorder that was moderate to severe during the encounter.
-Psychiatry was re-engaged due to the patient refusing all medications and stating that she wanted to die.
-Psychiatry was asked to provide medication recommendations, re-evaluate need for an involuntary commitment due to possible suicidal ideations, and test for the resident's capacity to make medical decisions about treatment goals.
-The resident's diagnoses included major depressive disorder, single, severe, without psychotic features and grief.
-Other factors included malnutrition, history of failure to thrive, and cardiovascular side effects.
-The resident was alert and oriented x 2 during the conversation with psychiatry, she initially answered questions

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related to her presentation and soon after it was apparent that the resident was vehemently refusing medications and did not appear to understand which medications she was on.
-During the conversation the resident reported that she was absolutely not going to take any medications because "it's not a problem anymore, I don't feel there is any way out of this anymore. I don't want to live because of my husband's death."
-The psychiatrist further documented that "as this appears to indicate, while she is not suicidal and planning to kill herself actively, she was very much intent on killing herself by not taking part in her medical care anymore. It was discussed at length that not taking her medications could cause her death, and knowing this information she has made the choice to not take her medications."
-The resident did not have the capacity to make decisions regarding medical treatments at this time due to the delineated findings in the history of present illness section of this consultation report.
-The resident needed to be placed on an involuntary commitment (IVC) due to suicidal intent with a plan to not take her medications. Whether or not she needed a one-on-one sitter would be determined if she either attempted to leave the hospital or actively hurt herself in her room.
-Psychiatric recommendations were an IVC and to medically treat the resident for her medical needs even if it required forcing medications as she did not have the capacity to make medical decisions at this time.
-Issues requiring follow-up were outpatient with primary care provider (PCP) in 1-2 weeks for chronic medical management and follow-up with psychiatry for evaluating mood after undergoing grief.
-The resident's PCP signed off on the medical discharge paperwork on 01/02/25.

Review of Resident #3's provider visit notes revealed:
-The resident was seen by PCP on 01/02/25 as a new admission and referred to psychiatry.
-There was no documentation that the resident had been seen by PCP prior to 01/02/25.
-The PCP initialed the resident's hospital discharge summary from 11/19/24 indicating it was reviewed.
-There was no documentation that the resident had been seen by psychiatry and no documented reason for the delay.

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Review of Resident #3's psychiatry visit notes dated 02/25/25 revealed:
-The encounter type was an initial psychiatric assessment.
-The resident was started on Sertraline Hydrochloride (a medication used to treat depression) 20mg daily.

Interview with the Administrator on 01/16/25 at 11:24am revealed:
-She was responsible for sending referrals.
-Resident #3 was taken out of the PCP's system due to being hospitalized and she had to resend the paperwork to get her back in the system (initial consult 01/02/25).
-Resident #3 was put back in the system the end of last month (December 2024).
-All residents were supposed to be seen by the PCP after discharge from the hospital.
-Resident #3 was not seen by the PCP when she was discharged from the hospital.

Second interview with the Administrator on 01/16/25 at 3:00pm revealed:
-She was not aware that Resident #3 was involuntarily committed.
-She did not recall reviewing Resident #3's hospital discharge paperwork.
-The PCP referred Resident #3 to psychiatry because of her mental health diagnoses and she told the PCP Resident #3 had not been seen by psychiatry.
-A referral should be sent as soon as they were received within 1-3 days.
-The referral should be sent and the appointments scheduled no later than a week later.
Telephone interview with the PCP on 02/28/25 at 10:57am revealed:
-Resident #3 had mental disorders.
-She did not recall Resident #3 being involuntarily committed.
-She likely referred her to psychiatry because she has not been seen.
-Resident #3 had an episode within the last 3 weeks and she told the facility to follow-up with psychiatry.
-The lapse in Resident #3 seeing psychiatry after IVC could have resulted in suicide.
-Resident #3 had a dementia diagnosis and psychiatry would be able to follow through with monitoring that diagnosis.

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Telephone interview with Resident #1's mental health provider on 02/28/25 at 1:42pm revealed:
-She completed Resident #3's initial psychiatric assessment yesterday.
-She had not seen Resident #3 prior to yesterday (02/27/25) and the resident had not been seen by anyone else in the practice.
-Resident #3 had not received psychotherapy.
-Resident #3 was very depressed when she saw her but stated she was not suicidal.
-Resident #3 stated "she wanted God to take her so she could be with her husband."
-She would see Resident #3 twice per month as opposed to monthly.
-She was not aware that Resident #3 had been involuntarily committed due to suicidal ideation in November 2024.

Telephone interview with Resident #3's guardian on 02/28/25 at 1:48pm revealed:
-She had no concerns regarding the resident's care.
-She was unaware that Resident #3 was involuntarily committed due to suicidal ideation in November 2024.
-She told the Administrator when Resident #4 was admitted (10/31/24) that she needed to see psychiatry because of her sadness.
-She signed the paperwork for Resident #3 to receive psychiatric treatment when she was admitted.
-Resident #3 had always been depressed and cried since she had been at the facility.
-Resident #3 had not been seen by psychiatry.

3. Review of Resident #4's current FL2 dated 08/15/24 revealed:
-Diagnoses included dementia, anxiety, heart failure, muscle weakness, and unsteady gait.
-The resident was intermittently disoriented and semi-ambulatory with a wheelchair.

Review of Resident #4's primary care provider (PCP) progress notes revealed:
- The resident was seen on 10/17/24 for a referral for a physical therapy (PT) evaluation for range of motion, joint mobility, and muscle tone.
-The resident was seen on 11/14/24 due to a hospital visit follow-up due to a fall on 11/13/24.

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-The resident was seen on 12/06/24 post hospital follow-up due to a fall. The resident had a closed head injury.
-The resident was seen on 01/2/25 for a monthly evaluation "no reported behaviors other than patient continued to be found getting up and out of wheelchair trying to walk. The resident's family brought in a rolling walker. The resident did not know how to operate it properly, she was a fall risk, and the family took it out.

Review of Resident #4's hospital records revealed:
-The resident was seen on 11/13/24 for a fall with an injury to her head.
-The resident was seen on 11/27/24 for a fall with a closed head injury, follow-up with PCP in 1-2 days for reassessment.
-The resident was seen on 12/21/24 for back pain due to being in a wheelchair all the time. "We suspect that your lower back pain is due to being seated in a wheelchair for an extended period of time. You should be up and walking more often, we are putting an order in for a rolling walker so that you are able to ambulate around the facility more. You should tell your facility that the reason you are having lower back pain is because they are keeping you in a chair all the time. Follow-up with PCP for a PT referral."

Review of Resident #4's provider visits notes revealed the resident was evaluated for PT on 01/27/25 and occupational therapy (OT) on 02/18/25.

Interview with the Administrator on 01/16/25 at 1:35pm revealed:
-She spoke with the PCP about PT for Resident #4 and "we don't know if she will be able to do it [PT] due to her cognition."
-She had not received PT because "it fell through the cracks."
-Insurance would not cover a rolling walker for Resident #4 so her family brought her one, she did not know how to use it properly, it was a hazard, and the family took it back out.

Interview with the PCP on 01/16/25 at 1:40pm revealed:
-She observed Resident #4's gait to be unstable so she ordered PT to evaluate Resident #4 to see what was recommended.
-She believed Resident #4 was more safe utilizing a wheelchair until PT could assess her and work with her.

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Observation of Resident #4 on 01/16/25 at 3:00pm revealed:
-Resident #4 was sitting outside the Administrator's office waiting to speak with her stating she wanted to see when she was getting her a walker so "she could get up out of here."
-Resident #4 stood up out of her wheelchair.
-The Administrator asked Resident #4 to sit down in her wheelchair so she would not fall.
-Resident #4 did not sit down and the Administrator assisted her back in her wheelchair.
-Resident #4 stated "my tail is still hurting me. My doctor said I need to get off of it. You keep putting me off."

Telephone interview with the PCP on 02/28/25 at 10:57am revealed:
-If there was a delay in Resident #4 receiving PT, it could make her physical condition more debilitating due to no exercise.
-Resident #4 needed PT to strengthen her because she had been complaining about pain.

Telephone interview with Resident #4's family member on 02/28/25 at 2:43pm revealed:
-Resident #4 had dementia.
-Resident #4 complained about not wanting to sit in her wheelchair but it was needed for her safety.
-Resident #4 complained that her back was hurting and the facility would not let her stand up.
-She explained to Resident #4 that she could not get out of her wheelchair for her safety as she was not stable.
-Resident #4 started PT (January 2025).
-She was aware that the referral for PT was made in October 2024, she kept asking about the referral, she was told the agency the referral was sent to was short staffed, and there was no one to come out.

4. Review of Resident #5's current FL2 dated 10/08/24 revealed:
-Diagnoses included anemia, chronic pain, hypertension, asthma, lupus, osteoarthritis, history of deep vein thrombosis, and malignant neoplasm.
-The resident was intermittently disoriented, semi-ambulatory, and required assistance with bathing and dressing.

Review of Resident #5's primary care provider (PCP) progress note dated 12/19/24 revealed the resident had a nodule crusting to the right the temporomandibular (TM) area.

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Review of PCP order dated 12/19/24 revealed a dermatology referral due to a nodule on the right side of her face -- basal cell carcinoma (BCC), squamous cell carcinoma (SCC), and melanoma.

Interview with the Administrator on 01/16/25 at 1:28pm revealed:
-The dermatologist office was called today and the facility was waiting for a call back with an appointment.
-She was aware that Resident #5 had a "place on her face."
-She was auditing every resident's chart to get appointments scheduled.
-The facility had transportation now.

Interview with the PCP on 01/16/25 at 1:30pm revealed Resident #5 appeared to have some type of cancer and the nodule may need to be frozen off.

Interview with Resident #5 on 1/16/25 at 1:37pm revealed:
-Her appointment with a dermatologist had not been scheduled.
-The PCP told her a month ago that an appointment would be scheduled.
-The Administrator was the person that was supposed to schedule the appointment but she had not scheduled it.

Interview with the Administrator on 1/16/25 at 1:47pm revealed:
-The providers left the orders at the facility when they were present.
-She faxed the orders and referrals.
-She called and would try to get the appointments scheduled.
-The PCP printed the progress notes and orders while at the facility and she reviewed the notes.
-She was aware that Resident #5 was referred to dermatology but she "hadn't gotten to her yet because she was working on scheduling other appointments."
-She was the only one "doing it all."
-She was aware that Resident #5 needed to be seen to check to see if she had cancer.
-She was aware that it was an urgent appointment that needed to be scheduled.
-She was trying to get the appointments scheduled as quickly as she could.

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Telephone interview with the Administrator on 02/25/25 at 12:04pm revealed:
-She was unaware if Resident #5 had been seen by dermatology.
-The transportation person was out today so she was not sure if Resident #5 went to the appointment.
-She would find out if Resident #5 went to the appointment but it would "take a minute for the transportation person to get back to her."

Telephone interview with the PCP on 02/28/25 at 10:57am revealed:
-She had been out for two weeks however prior to her being out Resident #5 had not been seen by dermatology.
-Transportation was the reason why Resident #5 has not been to the dermatologist, the facility could not take her.
-If there was a delay in Resident #5 being seen by a dermatologist and she was diagnosed with skin cancer, it could get worse and cause some issues, the longer the delay the worse Resident #5's prognosis could be.

Attempted telephone interview with Resident #5's family member on 02/28/25 was unsuccessful.

The facility failed to coordinate appointments with the primary care provider and neurology (#1), psychiatry (#3), physical therapy (#4), and dermatology (#5). Resident #1 was discharged from the hospital with a diagnosis of a urinary tract infection with pyuria that required close monitoring to ensure it was cleared. Resident #1 was hospitalized again with worsening symptoms and was diagnosed with acute cystitis with hematuria and sepsis and required intubation. Resident #1 was referred to neurology in April 2024 due to falls, was never seen, and when hospitalized in August 2024 he was diagnosed with a seizure disorder. Resident #1 had a seizure at the facility on 03/04/25 that resulted in a fall. Resident #1 hit his head on a chair and he obtained a laceration above his left eyebrow that required 4 sutures. Resident #3's guardian requested psychiatry services for the resident upon admission in October 2024 for depression and crying spells, the services were never coordinated, and the resident was involuntarily committed in November 2024 for suicidal ideation. The facility did not coordinate psychiatry services for Resident #3 upon discharge, she remained depressed, and the services remained delayed until February 2025 putting the resident at risk for suicide.

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Resident #4, who was experiencing pain, was referred to physical therapy in October 2024. There was a delay in her receiving therapy until January 2025. Resident #5's primary care provider referred her to a dermatologist in December 2024 due to nodule crusting to the right temporomandibular area which was believed to be cancerous. The facility failed to coordinate dermatology care which could worsen Resident #5's prognosis if diagnosed with cancer. The failure of the facility to provide health care referral and follow-up resulted in serious physical harm and serious neglect and constitutes a Type A1 Violation.

The facility provided a plan of protection in accordance with G.S.131D-34 on 1/16/25 for this violation.

THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 11, 2025.

Rule/Statute Number: 10A NCAC 13F .0906 (b)(1)
(b) Mail.
(1) Residents shall receive their mail promptly and it shall be unopened unless there is a written, witnessed request authorizing management staff to open and read mail to the resident. This request shall be recorded on Form DSS-1865, the Resident Register or the equivalent

Rule/Statutory Reference: Other Resident Care and Services
Level of Non-Compliance: Standard Deficiency
Findings:

This Rule is not met as evidenced by:
Standard Deficiency
Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 sampled resident's mail was opened in their presence and read to them when opened after being unaware that they gave the facility written authorization to open their mail.

The findings are:

1.Review of Resident #6's FL2 dated 8/14/24 revealed:
-Diagnoses included type 2 diabetes, intellectual disability, chronic pain syndrome, restless leg syndrome, obesity, vertigo, and glaucoma.
-The resident was intermittently disoriented.

Review of Resident #6's Resident Register dated 8/14/24 revealed a highlighted area that the resident signed indicating the facility could open her personal mail in her presence to read and explain the contents to her and the facility could assist in handling her mail that pertains to her financial or medical affairs.

Observation of Resident #6's opened mail on the office manager's desk with no addressed envelop attached.

Interview with Resident #6 on 1/16/25 at 2:04pm revealed:
-She had not received her mail that she was expecting.
-The facility always opened everyone's mail and she knew that they were not supposed to.
-She denied that the facility opened her mail in her presence, read her the mail, and explained it.
-She asked the office manager this morning if she had any mail and she was told she did not have any.
-She stated the office manager told her "if there was any mail I would have given it to you."
-She did not give the facility permission to open her mail.

Interview with the Office Manager on 1/16/25 at 2:14pm revealed:
-She was responsible for the facility mail.
-Resident #6 gave the facility permission to open her mail when the resident register was signed.
-She was unaware that if a resident gave the facility permission to open their mail that the facility was required to open and read the mail to the resident.
-Resident #6 had mail but she did not have time to give her the mail yet.
-She threw away all of the addressed envelops unless there was a return envelop included.
-She denied that Resident #6 asked her for her mail this morning.
-She forgot that Resident #6 had mail.
-She would open the residents mail in their presence moving forward.
-She would have Resident #6 to sign a new resident register since she did not want the facility to open her mail.

Interview with the Administrator on 1/16/25 at 2:19pm revealed:
-The office manager was responsible for the facility mail.

-She discussed the resident registers with the residents when admitted and included a discussion about whether the facility could open the resident's mail.
-Resident #6 gave the facility permission to open her mail.
-She reviewed the resident register and stated she did not realize the resident was giving the facility permission to open their mail in their presence, have the mail read to them, and explained.

Review of Resident #6's revised Resident Register dated 1/16/25 revealed the resident did not give the facility permission to open her mail in her presence.

2. Review of Resident #7's FL2 dated 8/14/24 revealed:
-Diagnoses included hypertension, anxiety, depression, insomnia, chronic pain, cerebral vascular disease, arthritis, benign prostatic hyperplasia.
-The resident was intermittently disoriented.

Review of Resident #7's Resident Register dated 8/14/24 revealed a highlighted area that the resident signed indicating the facility could open his personal mail in his presence to read and explain the contents to him and the facility could assist in handling his mail that pertains to his financial or medical affairs.

Interview with Resident #7 on 1/16/25 at 2:05pm revealed:
-He did not give the facility permission to open his mail.
-He did not think the facility was supposed to open his mail.
-He had been waiting on his insurance card and was told it was sent 3 times.

Refer to interview with the office manager on 1/16/25 at 2:14pm.

Refer to interview with the Administrator on 1/16/25 at 2:19pm.

Review of Resident #7's revised Resident Register dated 1/16/25 revealed the resident did not give the facility permission to open her mail in her presence.

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* The Plan of Protection should be completed and returned to Harnett County Department of Social Services by April 8, 2025.

Facility Name:

IV. Delivered Via:	Hand delivered	Date: 3/18/25
DSS Signature:	Angel Fuentes, APS	Return to DSS By: 4/8/25

V. CAR Received by:	Administrator/Designee (print name): Erika White	
	Signature: Erika White	Date: 3/18/25
	Title: office manager	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*		