Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Sunrise on Providence
Address: 5114 Providence Rd. Charlotte, NC 28226
County: Mecklenburg
License Number: HAL-060-165
II. Date(s) of Visit(s): 03/27/25, 04/01/25, 04/07/25, 04/29/25, 05/14/25
Purpose of Visit(s): Complaint Investigation

Instructions to the Provider *(please read carefully)*:
Exit/Report Date: 05/15/25

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 result 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) Healthcare	☐ POC Accepted _____ *DSS Initials*	____
Rule/Statutory Reference: (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.		
Level of Non-Compliance: Type A1 Violation		
Findings: Based on interviews and record reviews, the facility failed to meet the acute healthcare needs for 1 of 5 sampled residents (Resident #1) which resulted in an unstageable gluteal fold (area of skin below the buttocks separating the upper thigh from the buttocks) wound. Review of facility's Skin Care and Pressure Injury Management Program training policy dated January 2019 revealed: -During resident care, if a possible pressure injury was identified, a Personal Care Aid (PCA) is to notify a licensed nurse.		

-The licensed nurse validates the observation by examining the resident and evaluating the area of concern. -Notify the healthcare provider and collaborate on a treatment order. -Notify the home health agency to institute the healthcare provider- ordered treatment plan; validate the staging and measurement of the wound. -Complete the Pressure Injury Investigation Form. -Educate and train care staff on any new treatment or interventions. -If a deep tissue pressure injury (DTPI) evolves and the level of injury becomes apparent, not the observed stage and proceed with notification and treatment per this guideline. Review of Resident #1's current FL-2 dated 09/20/24 revealed: -Diagnoses included hypertension, severe dementia, hyperlipidemia (a medical condition related to excess lipids in the blood), and impaired fasting glucose. -A Special Care Unit (SCU) was the recommended level of care. Review of Resident #1's Resident Register revealed: -Resident #1 was admitted on 09/14/24. -Date of discharge was unavailable. Review of Resident #1's current Care Plan dated 02/11/25 revealed: -Resident #1 required total care with toileting and ambulation; two-person assistance with transfers, dressing, and bathing. -Resident #1 had a pressure ulcer on his right gluteal fold. Review of Resident #1's Licensed Health Professional Support (LPHS) assessment dated 02/05/25 revealed: -Home health was treating a wound to Resident #1's buttocks. -Resident #1 required two-person with transfers. -Recommendations included monitor right buttocks for healing, dressing changes, and signs and symptoms of infection. Review of Resident #1's January 2025 Progress Notes revealed: -On 01/07/25, a Health and Wellness Licensed Practical Nurse (LPN) documented Resident #1 sustained a closed pinpoint size abrasion to the back of thigh crease from his brief with no signs or symptoms of infection. -On 01/10/25 a Health and Wellness LPN documented a wellness visit assessment of Resident #1 with no documentation of his skin integrity.		

-On 01/17/25, the Special Care Coordinator (SCC) documented notification to Resident #1's Power of Attorney (POA) of "a pressure sore to his right lower hip", Resident #1's NP had been notified, and a referral for home health skilled nursing had been ordered.
-On 01/20/25, a Health and Wellness LPN documented she had cleaned and applied a dressing to Resident #1's wound, the wound was wet with a pink middle which looked like slough.
-There was no documentation Resident #1's contracted NP had been notified of Resident #1's right gluteal fold wound between 01/18/25 and 01/21/25.
-On 01/21/25, a Health and Wellness LPN documented notification to Resident #1's POA about his gluteal fold wound getting larger.
-On 01/21/25, a Health and Wellness LPN documented Resident #1 was evaluated by a palliative care NP for admission to palliative care. Resident #1's contracted NP was notified of palliative care admission.
-On 01/23/25, a Health and Wellness LPN documented Resident #1 was evaluated by his NP with instructions to continue home health skilled nursing for wound care.
-There was documentation between 01/24/25 and 01/31/25 with Resident #1's NP for treatment of his right gluteal fold wound.

Review of the facility's January 2025 Pressure Injury Investigation Form for Resident #1's was unavailable for review.

Review of Resident #1's January 2025 contracted Nurse Practitioner (NP) visit notes revealed:
-On 01/07/25, a facsimile notification indicated Resident #1 sustained an intact, closed pinpoint abrasion from adult brief friction at crease of thigh near buttocks with no signs or symptoms of infection, there was a request for barrier cream to be applied during incontinence care.
-On 01/17/25, a facsimile notification indicated Resident #1 had an area of his thigh that was dark around the edges that were drying and when pressed bone could be felt, there was a request for home health to begin wound care.
-On 01/17/25 at 11:48am the NP responded asking if barrier cream was being applied, asking which thigh the wound was located on and an order for home health would be sent.
-On 01/17/25 at 2:24pm a facsimile order with instructions to provide basic first aid to gluteal fold; clean with soap and water, pat dry, cover with border dressing daily and as needed; take photograph daily and fax or send to NP until home health begins.

-A visit note dated 01/21/25 documented the NP had been notified on 01/17/25 of a wound to Resident #1's right gluteal fold and facility could manage the wound until home health skilled nursing started. -There were instructions to "watch area carefully and avoid prolong sitting and moisture." -The facility did not offer a photograph of the wound and was aware the NP ordered home health skilled nursing as soon as possible (ASAP). Home health reported Resident #1's right gluteal fold is unstageable. -A visit note dated 01/23/25, electronically signed on 01/30/25 by the NP documented the NP and home health skilled nursing had requested facility to leave Resident #1 in bed, reposition him and avoid prolonged moisture to skin. "Wound started as redness on 01/08/25 and barrier cream ordered three times daily, unsure how (the wound) worsened to this stage despite resident needing total care and (wound) should have been noted. -Resident #1 had been evaluated at the ED for (bowel) impaction on 01/11/25 with no indication of a wound". Review of Resident #1's January 2025 electronic Medication Administration Record (eMAR) revealed: -An order dated 01/08/25 for miconazole nitrate (a barrier cream medication used to treat fungal growth) topical antifungal 2% cream with instructions to apply to red areas three times daily. -Miconazole nitrate 2% cream was documented as administered on once opportunity between 7:00pm and 9:00pm on 01/08/25. -Miconazole nitrate 2% cream was documented as administered three times daily between 01/09/25 and 01/31/25 with one resident refusal exception and one hospitalization exception. -An order dated 01/18/25 for basic first aid to gluteal fold with instructions to clean with soap and water, pat dry and cover with a border dressing daily and as needed. Take picture and fax to Nurse Practitioner (NP) daily until home health starts. -Basic first aide and facsimile of a picture of Resident #1's gluteal fold was documented as administered on 01/18/25, 01/19/25, and 01/20/25 with no exceptions. -There were no copies of pictures of Resident #1's right gluteal fold in the eMAR for review on 01/18/25, 01/19/25, and 01/20/25. Review of Resident #1's January 2025 facility contracted home health visit notes revealed:		

-On 01/21/25, home health skilled nursing care for Resident #1 began care twice weekly. -On 01/21/25, Resident #1 sustained a right lower buttock unstageable wound with necrotic (dead) tissue measured 3cm in length, 2cm in width, and 0.1cm in depth. 90% soft eschar (dead tissue), small amount of serosanguineous (blood and serous fluid) drainage with foul odor. -On 01/23/25, Resident #1's right lower buttock wound was unstageable (depth could not be determined) with necrotic tissue without measurement. 90% slough (dead yellow or white tissue), faint odor with moderate serosanguineous drainage and surrounding areas with granulating (new) tissue. -On 01/27/25, Resident #1's right lower buttock wound was unstageable with necrotic tissue measured 3cm in length, 3cm in width, and 0.5cm depth. 100% necrotic slough with small amount of foul odor serosanguineous drainage. -On 01/29/25, Resident #1's right buttock wound was unstageable with 100% soft necrotic tissue without measurements. Moderate serosanguineous drainage with odor. -On 01/31/25, Resident #1's right buttock wound was unstageable with 100% necrotic slough tissue without measurement. Small serosanguineous drainage and odor. -There was no documentation that Resident #1's NP was notified of Resident #1's right gluteal fold wound by home health skilled nursing. Review of the facility's January 2025 Weekly Wound Evaluation documentation revealed: -On 01/21/25, Resident #1's NP was notified resident began Home Health treatment for an acquired right lower buttock suspected deep tissue pressure ulcer injury with odor present, small amount of serosanguinous drainage measuring 3cm length by 2cm width by 0.1cm depth without infection. -On 01/28/25, Resident #1 treated by Home Health for a right lower buttock suspected deep tissue pressure ulcer injury with slough, necrotic tissue, odor present, small amount of serosanguinous drainage measuring 3cm length by 3cm width by 0.5cm depth without infection. Review of Resident #1's February 2025 facility contracted home health visit notes revealed: -On 02/03/25, Resident #1's right buttock unstageable wound with necrotic tissue measured 3cm in length, 3cm in width, and 1cm in depth. 100% soft adhering black slough with moderate odor and small amount of serosanguineous drainage. -On 02/05/25, Resident #1's right buttock unstageable wound with 100% soft necrotic slough without measurement. Wound		

edges with mixed yellow slough and granulated tissue, small amount of bleeding to wound edges.
-On 02/07/25, Resident #1's right buttock unstageable wound measured 4cm in length, 3cm in width, and 1cm in depth with 100% soft necrotic tissue. Edge of wound had mixed yellow and granulated tissue. Foul odor subsided with cleansing.
-On 02/10/25, Resident #1's right buttock unstageable wound with necrotic tissue measured 4cm in length, 4cm in width, and 1cm in depth. Wound had 100% necrotic slough with a small amount of serosanguineous drainage with foul odor. Resident #1 had non-productive cough and low-grade fever.
-There was no documentation that Resident #1's NP was notified of Resident #1's right gluteal fold wound by home health skilled nursing.

Review of the facility's February 2025 Pressure Injury Investigation Form for Resident #1 was unavailable for review.

Review of the facility's February 2025 Weekly Wound Evaluation documentation revealed:
-On 02/04/25, Resident #'s NP was notified resident continuation of treatment by Home Health for a right lower buttock suspected deep tissue pressure ulcer injury with slough, necrotic tissue, odor present, small amount of serosanguinous drainage measuring 3cm length by 3cm width by 0.5cm depth without infection.
-On 02/11/25, Resident #1 treated by Home Health for a right lower buttock suspected deep tissue pressure ulcer injury with slough, necrotic tissue, odor present, small amount of serosanguinous drainage measuring 3cm length by 3cm width by 0.5cm depth without infection.

Telephone interview with Resident #1's Power of Attorney (POA) on 04/04/25 at 3:40pm revealed:
-Resident #1 was admitted to the SCU in September 2024.
-Resident #1 utilized the facility's contracted Nurse Practitioner (NP).
-In early January 2025, she was notified Resident #1 had a very small skin problem on his buttocks.
-In late January 2025, the facility and Resident #1's NP notified her that he had sustained a pressure ulcer to his buttocks.
-In January 2025, home health skilled nursing assessed and began treatment of Resident #1's pressure ulcer.
-Between late January 2025 and February 2025, Resident #1's wound on his buttocks "smelled horrible."

Interview with Resident #1's contracted Nurse Practitioner (NP) on 04/29/25 at 11:10am revealed:

-Resident #1 was admitted to the SCU in September 2024. -In December 2024, Resident #1exhibited significant decline with cognitive impairment, ambulation, transfers, food and liquid intake. -On 01/07/25, she was notified Resident #1 had a "pinpoint closed abrasion to his right gluteal fold." -On 01/08/25, she ordered a barrier cream to be applied daily to Resident #1's buttocks. -On Friday, 01/17/25, she was notified Resident #1 had an "an area on his thigh with darkness around edges while cleaning, resident grimaced with pain" and may need a referral for home health wound care. -Based on the facility's notification and telephone discussion with a facility LPN on Friday, 01/17/25, she determined Resident #1's right gluteal fold skin integrity was closed and intact without signs of infection but could develop into a stageable wound treated by skilled nursing home health. -On 01/17/25 at 2:24pm she ordered basic first aid to Resident #1's right gluteal fold, clean with soap and water, pat dry, apply border dressing daily and as needed; and take a photograph daily and fax or send to the NP until home health assessed the resident. -She expected her order dated 01/17/25 for basic first aid, wound dressing, and photograph notification to be implemented immediately because she was unaware what Resident #1's right gluteal fold skin presented visually. -She initiated a home health skilled nursing referral on 01/17/25. -Home health began care with Resident #1 on 01/21/25. -Between 01/17/25 and 01/21/25, the facility did not send her any photographs of Resident #1's right gluteal fold or any other method of wound progression notification. -If the facility was unable to take photographs of Resident #1's right gluteal fold wound, she expected the facility clinical nurse notify her daily between 01/18/25 and 01/21/25 by telephone, facsimile, or video-chat with an update of the wound. -On 01/21/25, the home health Registered Nurse (RN) assessed Resident #1's right gluteal fold and immediately notified her the wound was unstageable with necrotic tissue. -She was concerned Resident #1's right gluteal fold wound notification on 01/17/25 which did not indicate an unstageable wound resulted in a significant open, unstageable wound with necrotic tissue on 01/21/25. -If the facility had implemented and followed her order for a daily photograph notification between 01/17/25 and 01/21/25, she may have determined Resident #1's right gluteal fold		

wound required referral for Emergency Department (ED) evaluation and treatment.
-Because she was not notified of Resident #1's right gluteal fold wound progression between 01/17/25 and 01/21/25, once home health skilled nursing-initiated treatment, the degree of wound injury significantly decreased the ability to treat and heal the area in addition to his decreased mobility and protein intake.
-The facility utilized a RN and two Licensed Practical Nurses (LPNs) she would have expected frequent documented assessment of Resident #1's skin, specifically buttocks area between 01/07/25 and 01/17/25, and daily between 01/18/25 and 01/21/25 due to Resident #1's general health decline and identified right gluteal fold skin integrity.

Interview with the home health Registered Nurse (RN) on 04/29/25 at 1:22pm revealed:
-She was contracted by Resident #1's NP for his right gluteal fold wound assessment and treatment.
-On 01/17/25, Resident #1's NP submitted a referral for Resident #1's to be evaluated and treated for a possible right gluteal fold wound.
-Between 01/17/25 and 01/20/25, she was unaware of Resident #1's right gluteal fold wound stage.
-On 01/21/25 during first shift she initiated an assessment of Resident #1's right gluteal fold wound and determined the wound was unstageable with necrotic tissue measuring 3cm in length by 2cm in width and 0.1cm in depth with minimal serosanguinous drainage and odor.
-Prior to 01/21/25, she did not anticipate Resident #1's right gluteal skin fold wound to be as significantly progressed as it presented on 01/21/25.
-She would have expected facility staff to immediately notify Resident #1's NP between 01/17/25 and 01/21/25 of Resident #1's right gluteal fold wound prior to her assessment due to the wound's presentation on 01/21/25 when she initiated removal of his border dressing.
-Due to Resident #1's immobility and protein intake decline, once his right gluteal fold wound was assessed as an unstageable wound with necrotic tissue on 01/21/25, wound improvement was difficult to treat and continued to worsen prior to his death.

Interview with a first shift Medication Aide (MA) on 04/07/25 at 12:20pm revealed:
-Resident #1 had been known to resist staff assistance with personal care.
-Resident #1 was incontinent of bladder and bowel.

-In December 2024, Resident #1 had a significant decline from independent ambulation to constant use of a wheelchair. -In December 2024, Resident #1 required prompting for food and liquid intake. -In early January 2025, staff were aware Resident #1 had a very small, closed skin irritation to his right gluteal fold. -In early January 2025, Resident #1's NP ordered a barrier cream to be applied to his buttocks three times daily during incontinence care. -In early January 2025, she assisted Personal Care Aides (PCAs) with applying Resident #1's barrier cream during each incontinence brief change. -In January 2025, on her shift she documented administration of Resident #1's miconazole nitrate 2% barrier cream daily during incontinence care. -She did not work on 01/18/25 and 01/19/25. -On 01/20/25, she documented administration of basic first aid for Resident #1's right gluteal fold performed by a Health and Wellness LPN but did not recall photographing the wound area. -On 01/20/25, she did not recall what Resident #1's right gluteal fold wound looked like. -On or about 01/21/25, Resident #1 required home health skilled nursing for his right gluteal skin wound which "smelled terrible." -The Health and Wellness LPNs were responsible for all notifications to residents' providers. Attempted telephone interview with a MA scheduled to work on 01/18/25 and 01/19/25, on 05/02/25 at 1:27pm was unsuccessful. Telephone interview with a facility Health and Wellness Licensed Practical Nurse (LPN) on 04/08/25 at 10:18am revealed: -PCAs and MAs were expected to notify LPNs for any changes in residents' conditions. -LPNs were responsible for communicating with residents' providers of any changes in healthcare needs and request medication and treatment orders. -On 01/07/25, she was notified by care staff about Resident #1's right gluteal fold skin integrity. -On 01/07/25, she assessed Resident #1's right gluteal fold which sustained a pinpoint size, very small red closed skin abrasion where his incontinence brief seam touched the skin. -On 01/07/25, she notified Resident #1's NP about his right gluteal fold skin assessment and the facility obtained an order		

for skin barrier cream to the affected area to be administered three times daily.
-In late January 2025, she requested Resident #1's NP order home health skilled nursing care for a pressure ulcer.

Second telephone interview with a Health and Wellness LPN on 04/28/25 at 9:50am revealed:
-LPNs were expected to complete a monthly skin assessment on each resident and as needed if notified by care staff.
-LPNs were expected to complete weekly wound care assessment documentation after home health skilled nursing assessment and treatment started.
-On 01/17/25, she completed a skin assessment of Resident #1's right gluteal fold by removing the barrier cream applied by care staff and observed a small closed, round pinkish area with darkened skin along the edges of the affected area and noted boney prominence and Resident #1 grimaced in pain.
-On 01/17/25, she notified Resident #1's NP about his right gluteal skin assessment and requested a referral for home health skilled nursing because of a possible pressure ulcer beginning.
-On 01/17/25, she flushed the area with saline and applied a gauze dressing to Resident #1's right gluteal fold to prevent soiling.
-Between 01/18/25 and 01/21/25, she was unaware if Resident #1's NP was notified of any changes to Resident #1's right gluteal fold wound.
-MAs were expected to apply border dressings "similar to a large band-aid", LPNs were expected to apply gauze-type dressings.
-She was unaware how Resident #1's right gluteal fold was treated on 01/18/25 and 01/19/25.
-On 01/20/25, she cleaned Resident #1's right gluteal fold dressing and observed the area had pink slough with some foul odor.
-On 01/21/25, the facility's contracted home health skilled nurse assessed Resident #1 right gluteal fold wound and notified Resident #1's NP of the assessment and treatment plan.
-After 01/21/25, Resident #1's right gluteal fold wound worsened.

Interview with a second Health and Wellness LPN on 04/29/25 at 12:10pm revealed:
-Resident #1 had a significant decline in December 2024 with ambulation, mobility, and food intake.
-On 01/07/25, Resident #1 had sustained a very small, pinpoint size pink skin fiction irritation to his right gluteal fold where his incontinent brief seam covered his buttocks.

-She was unaware if clinical nursing staff assessed Resident #1's right gluteal fold skin integrity between 01/08/25 and 01/16/25. -On 01/17/25, a Health and Wellness LPN assessed Resident #1's right gluteal fold and notified Resident #1's contracted NP. -On 01/17/25, Resident #1's NP ordered basic first aid, border dressing along with a daily photograph notification to the NP until home health skilled nursing began on 01/21/25. -Staff were expected to follow physician's orders as prescribed. -She was unaware if the facility had ever received a physician's order prior to 01/17/25 with a request for daily photographs of a residents wound. -Between 01/18/25 and 01/19/25, she assisted a MA with Resident #1's bowel incontinence care. -Between 01/18/25 and 01/19/25 while attempting to assist with Resident #1's bedside incontinence care and change the right gluteal fold dressing, she was unable to photograph the wound area due to Resident #1's behaviors. -She did not recall how frequently Resident #1's right gluteal fold wound dressing was ordered to be changed. -Between 01/18/25 and 01/19/25, Resident #1's right gluteal fold wound was a dime-sized intact and closed pink colored skin area with no odor. -Between 01/18/25 and 01/19/25, she did not notify Resident #1's NP of the right gluteal fold wound visual assessment because the area was closed with no wound progression. -Between 01/18/25 and 01/19/25, she determined Resident #1's right gluteal fold wound did not require referral to the ED. Interview with the Resident Care Director on 04/29/25 at 12:45pm revealed: -She was a Registered Nurse (RN) and responsible for oversite of the facility's two LPNs and all MAs. -Between 01/09/25 and 01/25/25 she was not working. -On 01/07/25, she was aware Resident #1 sustained a very small, pinpoint size closed skin irritation to his right gluteal fold and his NP ordered miconazole nitrate 2% barrier cream three times daily to Resident #1's buttocks skin folds. -She would have expected her Health and Wellness LPNs to re-assess Resident #1's right gluteal fold on or about 01/10/25 and as needed thereafter. -On 01/17/25, a Health and Wellness LPN assessed Resident #1's right gluteal fold to have an area of intact, closed soft tissue and requested a referral for home health skilled nursing to treat the area for a possible pressure ulcer. -Until April 2025, she was unaware on 01/17/25 Resident #1's NP had ordered daily pictures of his right gluteal fold until		

home health skilled nursing assessed and began treatment of the affected area.
-The facility had never taken photographs of residents' skin integrity and send to providers prior to 01/17/25.
-On 01/17/25, the Health and Wellness LPN should have notified Resident #1's NP that the facility was unable to implement an order for daily photographs of Resident #1's right gluteal fold.
-If the facility was expected to photograph a residents wound, she expected the Health and Wellness LPNs to photograph and submit the photographs to Resident #1's right gluteal fold wound NP as ordered and/or call, electronic message, or facsimile the NP daily.
-Until April 2025, she was unaware the Health and Wellness LPNs never photographed or notified Resident #1's NP of Resident #1's right gluteal fold wound between 01/18/25 and 01/21/25.
-Between 01/07/25 and 02/14/25, she never assessed Resident #1's right gluteal fold wound.

Interview with the Administrator on 04/29/25 at 3:45pm revealed:
-She was unable to locate a facility policy and procedure for resident healthcare and wound services.
-Resident #1 was admitted to the facility in September 2024 to the SCU.
-Resident #1 was known to exhibit disruptive, aggressive and resistance to care behaviors towards staff between September 2024 and February 2025.
-In December 2024, Resident #1exhibited a significant decline with mobility and required prompting for meals.
-On 01/17/25, a Health and Wellness LPN notified Resident #1's NP of the beginning of a possible pressure ulcer.
-Until April 2025, she was unaware Resident #1's NP had ordered daily photographs of Resident #1's right gluteal fold on 01/17/25 until home health skilled nursing assessment on 01/21/25.
-On 01/17/25, the Health and Wellness LPN should have clarified Resident #1's NP order for daily photographs because facility staff were not able to take photographs of residents.
-If Health and Wellness LPNs were unable to photograph Resident #1's right gluteal fold wound between 01/18/25 and 01/21/25, she would have expected them to notify the NP by facsimile, telephone, or electronic phone or mail.
-Between 01/18/25 and 01/21/25, she would have expected Health and Wellness LPNs to notify Resident #1's NP of his right gluteal fold wound if the wound had opened prior to home health skilled nursing assessment on 01/21/25.

-On or about 01/21/25, after Resident #1's home health skilled nursing assessment of his right gluteal fold wound, she became aware the wound was determined to be unstageable. -Between 01/17/25 and 01/21/25, she did not know how, why, or when Resident #1's right gluteal fold wound developed to an unstageable pressure ulcer with necrotic tissue. --- The facility failed to provide healthcare referral and follow-up in accordance with a physician's order for Resident #1, and they failed to update the provider of changes in the appearance of the wound during a three-day period. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. --- CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED 06/14/25. The facility provided a plan of protection in accordance with G.S. 131-34 on 04/29/25.		

Sunrise on Providence

5/15/25 (AH)

IV. Delivered Via:	(1) Hand-delivered, email, certified	Date: ~~5/14/25~~
DSS Signature:		Return to DSS By: 6/6/25

V. CAR Received by:	Administrator/Designee (print name):		
	Signature:		Date:
	Title:	Administrator	5/15/25

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.*