| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| SEVEN LAKES ASSISTED LIVING | 292 MCDOUGALL DRIVE SEVEN LAKES, NC 27376 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a complaint investigation on 12/29/2014 through 12/31/2014. | D 000 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>PAST CORRECTED TYPE A2 VIOLATION<br><br>Based on record review and interview the facility failed to assure referral to the physician for poor appetite, medication refusal, and wound care in a timely manner for 1 of 3 residents sampled (#2) resulting in continued decline in health and worsening of a decubitus ulcer. The findings are:<br><br>Review of a closed record revealed a Resident Register with an admission date of 12/12/2013 for Resident #2.<br><br>Review of Resident #2's FL-2 dated 12/12/2013 revealed:<br>-Diagnoses included: Dementia, Rheumatoid Arthritis, Chronic Pain, Anemia, Hypertension, Osteoporosis, Chronic Renal insufficiency and Hyperlipidemia.<br>-Resident #2 was ambulatory.<br>-Resident #2 required total care assistance in bathing, feeding, and dressing.<br>-Resident #2 was intermittently disoriented.<br>-Resident #2's skin was normal.<br>-Resident #2 was on a regular diet with Ensure | D 273 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SEVEN LAKES ASSISTED LIVING | 292 MCDOUGALL DRIVE SEVEN LAKES, NC 27376 |

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| D 273 | Continued From page 1 | D 273 | | |

supplement.
-Medications included: Gingko biloba 60 mg daily (Gingko biloba is a supplement used to improve blood flow to the brain and acts as an antioxidant), Aspirin 81 mg daily, Hydralazine 25 mg three times daily (Hydralazine is a medication used to treat high blood pressure), Prednisone 5 mg daily (Prednisone is a medication used to treat arthritis), Calcium Carbonate/Vitamin D 600 mg/400 mg daily, Prednisolone ophthalmic 1% drops (Prednisolone is used to reduce irritation, redness, burning, and swelling of eye inflammation), one drop to the left eye three times daily, Simbrinza 1%/0.2% ophthalmic (Simbrinza is used to treat glaucoma or ocular hypertension), one drop to both eyes three times daily, Latanoprost 0.005% ophthalmic, one drop to both eyes at bedtime (Latanoprost is used to treat glaucoma or ocular hypertension), Vitamin B complex one tablet daily, Vitamin C 1000 mg one tablet daily, and Vitamin E 400 units once daily.

Review of documentation in Resident #2's facility record revealed:
-Resident #2 had been brought to the hospital emergency room on 12/12/2013 by the department of social services requesting medical clearance for placement to a memory care facility and did not return home.
- On admission to the facility Resident #2 had a Body Evaluation and Observation assessment done on 12/12/2013 which indicated a "bed sore" with a round circle drawn on the sacrum of a body image with no further descriptive comments.
-Physician's orders on the FL-2 did not include wound care instructions on 12/12/2013.
-There was no documentation the physician was contacted for wound care orders.

Review of Resident #2's hospital records from

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| SEVEN LAKES ASSISTED LIVING | 292 MCDOUGALL DRIVE SEVEN LAKES, NC 27376 |

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| D 273 | Continued From page 2<br><br>12/8/2013 to 12/12/2013 revealed:<br>-Resident #2 was admitted to the hospital on 12/08/2013 for syncope and was found to have a preexisting decubitus ulcer of the buttocks which was being treated.<br>-A hospital consult was done on 12/9/2013 for assisting with skin care for the sacral decubitus described as "irregularly shaped ulceration, almost like a cluster of grapes that measures in gross dimension 3 cm in vertical length x 5 cm width."<br>-The hospital consult stated, "Most of the area is stage II, but 1 portion is stage III. It does not look grossly infected."<br>-Examination of her extremities revealed no pressure sites on her toes, heels or malleoli (ankle).<br>-The plan included a nutrition consult, a pressure relieving heel protector, an air mattress, an antimicrobial wound gel and a foam dressing to the sacrum.<br>-Discharge medications did not include wound care instructions.<br><br>Review of the physician documentation in Resident #2's record revealed:<br>-The facility's house physician did an new resident assessment at 10:00 a.m. on 12/16/2013, four days after admission to the facility.<br>-The physician's assessment indicated Resident #2 had a wound on her buttocks that needed evaluation.<br>-Staff reported Resident #2 came with the wound from the Emergency Department and she had not been eating or taking her medications for 3 days since admission.<br>-The sacral decubitus measured 3.5 cm X 3.5 cm.<br>-The physician cleansed the wound and a 4 cm X | D 273 | | |

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| SEVEN LAKES ASSISTED LIVING | 292 MCDOUGALL DRIVE SEVEN LAKES, NC 27376 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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4 cm dry dressing was applied.
-Resident #2 was agitated with an abnormal affect, disoriented to time, place and person and attempted to scratch the physician's face.
-On 12/16/2013 orders included: Home Health for wound care, mighty shake supplements three times daily, a regular pureed diet, staff to encourage Resident #2 to eat, or get up with family about possible feeding tube placement, incontinent supplies, and a wheelchair.
-On 12/17/2013 a hospital bed and pressure reduction mattress was ordered.
-There was no documentation the facility had contacted the physician prior to 12/16/2013 for orders for wound treatment, not consuming any solid meals since being admitted on 12/12/2013 or medication refusal.
-On 12/19/2013 a physical therapy evaluation was ordered per facility request.

Review of Resident #2's progress notes from 12/12/2013 to 12/16/2013 revealed:
-On 12/14/2013 at 7:11 p.m. Resident #2 refused to eat her meals.
-On 12/14/2013 at 9:10 p.m. Resident #2's family brought food but Resident #2 still refused to eat.
-On 12/15/2013 Resident #2 refused some of her medication in the morning, refused to eat breakfast, lunch, and dinner, but drank a whole glass of milk for breakfast, a glass of tea and 2 health shakes for lunch, and 2 health shakes for dinner.
-On 12/16/2013 at 1:10 p.m. the facility staff sent Resident #2 out to the Emergency Department due to not eating or consuming food after she had been seen by the house physician in the morning.

Review of the incident report for Resident #2 dated 12/16/2013 at 1:10 p.m. revealed:

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| SEVEN LAKES ASSISTED LIVING | 292 MCDOUGALL DRIVE SEVEN LAKES, NC 27376 |

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| D 273 | Continued From page 4<br>-Resident #2 was sent out to the Emergency Department for medical reasons, refusing to eat or drink with small amounts consumed.<br>-The physician's office was notified and the department of social services.<br><br>Review of the Resident #2's hospital records for 12/16/2013 and 12/17/2013 revealed:<br>-Diagnoses: Dehydration, Poor oral intake, and Stage II sacral decubiti.<br>- On 12/17/2013 a physician consultation was done for the sacral pressure sore.<br>-The physician's notes indicated Resident #2's sacrum had an open ulcer measuring approximately 5 cm x 3 cm x 0.3 cm with adherent coverage of necrotic yellow slough.<br>-The physician's notes further identified 3 new skin areas from the previous consultation done in the hospital on 12/9/2013 which included: the tip of the great toe had a very small and intact dry eschar measuring approximately 0.3 cm x 0.3 cm.; the right heal had a small dry scab measuring approximately 0.5 cm x 0.5 cm x 0.1 cm; and the left lateral ankle had a small dry scab measuring approximately 0.5 cm x 0.5 cm x 0.1 cm.<br>-The plan of care included: dressing changes with Santyl ointment (Santyl is a medication used in the healing of ulcers and works by breaking up and removing dead skin) daily with Vaseline gauze, dry cover dressing, an air mattress at the facility, continued nutritional support and vitamin therapy, and to follow up next week at the outpatient wound clinic.<br>-Discharge instructions on 12/17/2013 included a follow up appointment at the Wound care clinic on 01/07/2014 at 2:00 p.m. and a follow up appointment on 12/19/2013 at 12:00 p.m. with her former outpatient primary care physician who was also her hospital attending physician. | D 273 | | |

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| D 273 | Continued From page 5<br><br>Interview with the receptionist at the former primary care physician's office on 12/31/2014 at 9:00 a.m. revealed:<br>-Resident #2 had 2 scheduled appointments on 12/19/2013 and 12/24/2013 which were cancelled by the facility staff due to having a new physician at the assisted living facility.<br>-Resident #2 was last seen by the physician on 12/2/2013 for follow-up after hospital discharge on 11/25/2013.<br><br>Review of the progress notes from Home Health revealed:<br>-On 12/18/2013 the Home Health nurse visited for an admission evaluation.<br>-It was noted Resident #2 had an unstageable pressure ulcer to her right buttock due to greater than 75% slough to the wound bed and Santyl ointment was applied to the wound and covered with foam dressing.<br>-On 12/20/2013 the Home Health nurse visited for wound assessment and dressing change as ordered with a plan to continue dressing changes 3 times weekly per progress note.<br>-There were no further progress notes from the Home Health Nurse after 12/20/2013 in Resident #2's record.<br><br>Interview with the Home Health agency receptionist on 12/30/2014 at 11:30 a.m. revealed:<br>-Resident #2 was not seen after 12/20/2013 because the nurse who saw Resident #2 on 12/18/2013 and 12/20/2013 did not update the chart with Resident #2's new service address at the facility.<br>-Resident #2 had received physical therapy at her residence in October 2013 from their agency.<br>-On 12/23/2013 and 12/24/2013 the Home Health | D 273 | | |

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| SEVEN LAKES ASSISTED LIVING | 292 MCDOUGALL DRIVE SEVEN LAKES, NC 27376 |

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| D 273 | Continued From page 6<br>nurse noted she was unable to locate the patient.<br><br>Review of the Home Health notes faxed to the facility on 12/30/2014 revealed:<br>-On 12/23/2013 the nurse attempted several times to contact the patient by phone to arrange for in home visit for assessment and wound care, visited the address on file, and attempted to call the referring physician for which there was no office number available.<br>-On 12/24/2013 the nurse attempted to call several times but there was no answer and no answering machine to be able to leave a message.<br>-The next documented attempt to locate Resident #2 was on 12/30/2013 when a call was placed to the patient's home twice with no answer and the primary physician on file was called who did not have a record of Resident #2.<br><br>Review of Resident #2's Medication Administration Record (MAR) from 12/12/2013 through 12/25/2013 revealed:<br>-Resident #2 refused 9 of 10 doses of Gingko bilob ordered daily.<br>-Resident #2 refused 8 of 20 doses of Hydralazine ordered three times daily.<br>-Resident #2 refused 2 of 10 doses of Latanoprost ophthalmic 0.005% ordered every evening.<br>-Resident #2 refused 7 of 11 doses of Prednisone ordered daily.<br>-Resident #2 refused 9 of 16 doses of Prednisolone ophthalmic solution ordered until it was discontinued on 12/20/2013.<br>-Resident #2 refused 12 of 31 doses of Simbrinza ophthalmic solution ordered 3 times daily.<br>-Resident #2 refused 10 of 11 doses of Vitamin B complex ordered daily.<br>-Resident #2 refused 10 of 11 doses of Vitamin C | D 273 | | |

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ordered daily.
-Resident #2 refused 9 of 11 doses of Vitamin E ordered daily.
-Resident #2 refused 11 of 23 shakes offered three times daily.

Review of progress notes in Resident #2's record from 12/17/2013 to 12/25/2013 revealed:
-On 12/17/2013 Resident #2 at 10% of her supper, drank 1 health shake and refused her evening medications.
-On 12/19/2013 at 6:30 p.m. Resident #2 refused to eat breakfast and supper, drank a shake in the morning and refused her eye drops at the evening medication pass.
-On 12/20/2013 at 6:50 a.m. Resident #2 took all medication but still refused to eat and drank most of her shakes.
-On 12/20/2013 at 6:40 p.m. Resident #2 refused some of her medication.
-On 12/22/2013 at 3:17 p.m. Resident #2 refused some of her medication and ate about 25% of her breakfast and 15% of her lunch.
-On 12/23/2013 at 6:30 a.m. Resident #2 refused medication during the shift.
-On 12/23/2013 at 8:00 p.m. Resident #2 refused medication.
-On 12/25/2013 at 2:07 p.m. Resident #2 was sent out for change in mental status.

Review of the incident report dated 12/25/2013 revealed "change in mental status", temperature 99.1 degrees Fahrenheit, blood pressure 180/70, pulse 110, respirations 22, blood sugar 90 and the physician and the department of social services were notified.

Review of Resident #2's hospital records from admission on 12/25/2013 to discharge on 1/13/2014 revealed:

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| D 273 | Continued From page 8<br>-The history and physical on 12/25/2013 documents the reason for admission, "Pyrexia, I believe multifactorial in origin secondary to a urinary tract infection as well as an infected stage IV sacral decubitus ulcer."<br>-Resident #2 had a temperature of 101.6 degrees Fahrenheit, blood pressure 187/87, pulse 92, respirations 12 on admission.<br>-On 12/25/2013 the Stage IV decubitus ulcer measured 6 cm x 3 cm with a depth of 3 cm and had a foul smelling odor, mild pus draining from the area, with tunneling anteriorly.<br>-Resident #2 had altered mental status, dehydration, and hypokalemia.<br>-On 12/26/2013 consultation notes for the sacral pressure sore revealed her "stage II pressure sore had progressed and gotten worse since her previous admission" on 12/16/2013 - 12/17/2013.<br>-The discharge and transfer summary on 1/13/2014 listed diagnoses including Stage IV decubitus ulcer, Urinary tract infection with both bacteria and yeast, and protein calorie malnutrition, severe.<br>-Resident #2 was discharged to a health and rehabilitation facility to manage continued wound care, eye care, and physical therapy.<br><br>Interview with a Medication Aide on 12/30/2014 at 12:30 p.m. revealed:<br>-She started employment in October 2013.<br>-She remembers Resident #2's "wound was bad but Home Health was caring for it."<br><br>Interview with a Personal Care Aide on 12/30/2014 at 12:45 p.m. revealed:<br>-She washed and bathed Resident #2.<br>-Resident #2 "would always drink liquids and would eat if she was having a good day."<br>-She encouraged her to get up from bed and turn off of her buttocks. | D 273 | | |

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| D 273 | Continued From page 9<br><br>Interview with a Personal Care Aide on 12/30/2014 at 2:30 p.m. revealed:<br>-She remembers Resident #2 was a 2-3 person assist.<br>-Resident #2 was combative.<br>-She remembers Home Health was responsible for treating the wound on her buttocks.<br>-The wound had an odor.<br><br>Interview with the Executive Director on 12/29/2014 at 4:45 p.m. revealed:<br>-She had taken the job of Executive Director in December 2013 replacing the previous Executive Director who remained employed at the facility as the Resident Care Coordinator of the Memory Care Unit until January 2014.<br>-The Resident Care Coordinator was responsible for assuring resident care needs were met and for monitoring Home Health Services were provided as ordered.<br>-Resident #2 had a wound when she came from the hospital for admission.<br>-Resident #2 wasn't eating and staff sent her to the hospital.<br>-Resident #2 was only at the facility for several weeks and then went to skilled care.<br>-There was no documentation the physician was notified by the facility of Resident #2's poor appetite, medication refusal, or sacral wound prior to being seen for an initial assessment on 12/16/2013.<br>-There was no documentation the physician was notified by the facility of continued poor appetite, medication refusal, or the wound developing an odor between 12/17/2013 and 12/25/2013 when she was admitted to the hospital.<br>-There was no documentation Home Health Services provided wound care after 12/20/2013 or the facility contacted Home Health when | D 273 | | |

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| D 273 | Continued From page 10<br>wound care was not provided as scheduled on 12/23/2013.<br><br>Interview with the physician's receptionist on 12/31/2014 at 10:30 a.m. revealed:<br>-The facility contacted the physician regarding Resident #2 on 12/16/2013, 12/17/2013 and 12/20/2013.<br>-On 12/16/2013 there was a request for a billing code for a wheelchair and they were informed the resident had not been eating for 4 - 5 days and they were sending her to the hospital.<br>-On 12/17/2013 there was a request for an order for a hospital bed and air mattress.<br>-On 12/20/2013 there was a request for a face to face form to be filled out for Home Health Services. | D 273 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>This Rule was not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care.<br><br>The findings are: | D912 | | |

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| D912 | Continued From page 11<br><br>Based on record review and interview the facility failed to assure referral to the physician for poor appetite, medication refusal, and wound care in a timely manner for 1 of 3 residents sampled (#2) resulting in continued decline in health and worsening of a decubitus ulcer. [Refer to Tag D273, 10A NCAC 13F .0902(b) (Past corrected Type A2)] | D912 | | |