STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051041	A. BUILDING: _____ B. WING _____	R 07/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON HOUSE	145 DAIRY ROAD CLAYTON, NC 27520

(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
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on July 25, 2017 through July 27, 2017.	{D 000}		
{D 074}	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure the walls were kept clean and in good repair for the dining room, the Quiet Room on the C Hall, the hallways, residents' bedrooms, and restrooms on the A, B, and C Halls and the floor of a private bathroom on the B Hall. The findings are: Observation of the Quiet Room on the C Hall on 7/25/17 at 4:00 p.m. revealed 3 of 4 walls had several black marks and scraped wall areas. Observation of Room 304 on the C Hall on 7/25/17 at 4:05 p.m. revealed: -The door and the door frame had several areas of peeling paint along its bottom. -The lower wall area to the right of the door entrance inside the room had several areas of peeling paint and numerous black marks with scraped areas.	{D 074}		

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{D 074}	Continued From page 1 -The lower third of the wall between the 2 closet doors had several areas of chipped, peeling paint. -The lower wall area between the bathroom door and the first closet door had a scraped peeling paint area that measured approximately 6 inches wide and 3 feet long. Based on observations, interviews, and record reviews the resident in Room 304 was not interviewable. Observation of the ceiling surrounding a light fixture in the hallway in front of Room 304 on 7/25/17 at 4:10 p.m. revealed the ceiling areas was cracked along the left side of the light fixture and measured approximately 3 feet long. Observation of the C Hall on 7/25/17 at 4:15 p.m. revealed: -All of the baseboards of hallway on the C Hall were dusty and had several black and brown stains. -The lower wall area located between the employee breakroom down the entire length of the hallway back toward the nurse's station had long gray and black scrape marks with peeling paint in some areas. -The lower half of the door frame of the first dining room entrance had several areas of scraped and chipped peeling paint. -The door located to the left of the activity calendar had several areas of scraped and chipped peeling paint. -The wall area underneath the activity calendar had several scraped paint areas and various black and brown stains to the baseboard under the activity calendar. -The lower wall corner located to the right of the business office door had several areas of chipped	{D 074}		

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{D 074}	Continued From page 2	{D 074}		

paint with exposed white sheetrock and measured approximately 2 feet high from the floor.

Interview with a housekeeper on 7/25/17 at 4:15 p.m. revealed:
-She had not really noticed any of the peeling paint in the hallway or in any of the residents' rooms.
-The black marks on the walls in the hallway were from the wheels of the wheelchairs that scraped the walls.
-She cleaned the marks whenever she saw them but it was an ongoing job to keep the walls clean.
-She was not sure when walls in the facility had last been painted.

Observation of the dining room on 7/25/17 at 4:20 p.m. revealed three of four walls had several black scraped marks and chipped wall paint.

Interview with the dietary manager on 7/25/17 at 4:20 p.m. revealed:
-The scraped areas were a result of the residents' wheelchairs hit the walls in the dining room.
-He was not sure how long the scraped areas had been on the walls or how long the face plate had been bent.
-He was not sure if he had ever reported the scraped walls to the Administrator.

Interview with the Administrator and the Regional Director of Operations on 7/25/17 at 4:30pm revealed they would follow up with the concerns related to the walls in the dining room and the hallway of the C Hall.

Observation of a housekeeper on 7/26/17 at 9:45 a.m. revealed the housekeeper was cleaning the walls on the C Hall with a mop.

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{D 074}	Continued From page 3 Interview with two staff members on 7/26/17 at 10:30 a.m. revealed: -There were several walls throughout the facility that needed painting because they were scraped or had peeling paint. -The walls of the facility were last painted about 6 months ago. -No painting or wall repairs had been done in the facility since April 2017. Interview with the Administrator on 7/26/17 at 10:40 a.m. revealed: -The walls were going to be painted in the hallways and the baseboards soon but she could not specify how soon the painting would be done. -She had not noticed the scraped areas on the wall in the dining room. -It was hard to keep the walls from being scraped by the residents' wheelchairs in the facility. -The housekeeping staff cleaned the walls and baseboards whenever it was needed. -The walls were going to be repainted with washable paint. Observation of the A Hall on 07/26/17 at 11:05 a.m. revealed: -There was an area of white plaster on the wall near the business office that was about 2 ½ feet wide and 4 feet in height. -There was a hole near the bottom of the plastered area that was about 12 squared inches and had visible pipes, insulation, and wooden boards. Interview with the Vice President of Quality Assurance and Regulatory Compliance on 07/26/17 at 1:30 p.m. revealed: -The water fountain was going to be repaired but since the residents did not use it; it was removed	{D 074}		

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{D 074}	Continued From page 4	{D 074}		

from the wall last week.
-The maintenance staff would finish cutting off the pipes in the wall where the water fountain used to be.

Observation on the A Hall on 07/27/17 at 1:38 p.m. revealed:
-The maintenance staff was working on the area of the wall where the water fountain had been removed.
-There pieces of plaster on the floor and some of the pipes in the hole of the plastered area had been removed.

Interview with a medication aide on 07/27/17 at 3:42 p.m. revealed:
-The water fountain was removed from the wall on the A Hall a few weeks ago.
-She did not know how long the water fountain had been broken.
-The residents did not usually use the water fountain.

Observation on the A Hall on 07/27/17 at 3:44 p.m. revealed:
-The hole in the wall with pipes exposed where the water fountain had been removed was patched with plaster.
-The wall had white plaster and needed painting.

Observation of the nurses' station near the main entrance on 07/26/17 at 11:07 a.m. revealed:
-The top of the half wall around the nurses' station had missing and peeling paint exposing the wood material underneath the paint.
-The half was around the nurses' station was approximately 4 feet long on the B Hall side and 8 feet long on the side near the main entrance.
-The missing and peeling paint covered the majority of the top of the wall on both sides of the

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{D 074}	Continued From page 5 half wall. Interview with the Vice President of Quality Assurance and Regulatory Compliance on 07/26/17 at 1:30 p.m. revealed: -The whole facility was repainted on 02/10/17 and the front common area was touched up on 03/13/17. -The half wall around the nurses' station needed a different type of finish on top of it because the paint would continue to peel off. Interview with maintenance staff from the facility's contracted Maintenance Company on 07/27/17 at 3:19 p.m. revealed: -He had been assigned to work as maintenance staff at this facility for two months. -He usually worked on-site at the facility 2 days per week. -He had a repair order for the water fountain on A Hall a few weeks ago but he did not know how to repair it. -His supervisor discussed it with facility management and it was decided not to replace the water fountain since the residents did not use it. -The Administrator asked the maintenance staff to remove the broken water fountain from the wall so he removed it about 2 weeks ago. -He patched part of the wall area where he removed the water fountain but he needed additional supplies to be able to finish the area where the drain pipes in the wall were connected to the water fountain. -He fixed the drain pipes today (07/27/17) and capped them and there was no leaking. -He put drywall back up on the wall today (07/27/17). -He would sand and paint the drywall once it had dried.	{D 074}		

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{D 074}	Continued From page 6 -The top of the half wall around the nurses' station needed painting because the paint was peeling and chipping. -It was in "pretty bad shape". Interview with a medication aide on 07/27/17 at 3:42 p.m. revealed: -The top of the half wall around the nurses' station was repainted about 6 months ago. -The paint started peeling off the top of the half wall about a month after it was repainted. The findings are: Observation on 7/26/17 at 11:33 a.m. of room 211 revealed: -The grab bar in the private bathroom was wrapped in black electrical tape. -There was also approximately two inches of rust on the shower bar adjacent to the taped area. -There was another grab bar in the shower where both ends are rusted. -The non-slip shower appliques are peeling up from the floor in the private bathroom. -The baseboard was coming undone from the wall in the private bathroom. Observation on 7/26/17 at 11:36 a.m. of room 206 revealed there was a three foot scratch, scraped paint on the bedroom wall of room 206. Observation on 7/26/17 at 11:39 a.m. of room 202 revealed the electrical outlet faceplate was not secured to the outlet. Observation on 7/26/17 at 11:41 a.m. of room 201 revealed there was a golf ball sized spackled, unpainted hole behind the door. Observation on 7/26/17 at 11:42 a.m. of the B hallway revealed there was a basketball sized	{D 074}		

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{D 074}	Continued From page 7 spackled, unpainted hole beside the activity room door sign. Observation on 7/26/17 at 11:43 a.m. of the women's bathroom revealed -The shower hot water nozzle was separating from the wall. -There was a chip to the bottom left of the porcelain sink approximately the size of a golf ball.	{D 074}		
{D 076}	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to have furniture in good repair in the residents' living areas which included chairs in the Quiet Room on the C Hall, nightstands and chests in residents' rooms on the A, B, and C Halls. The findings are: Observation of the Quiet Room on the C Hall on 7/25/17 at 4:00 p.m. revealed: -There were 4 vinyl chairs with scarred, worn wooden armrests and numerous chips to the wood finish of the legs. -There was a blue loveseat with cracked finish to the front and an orange stain to the lower left front side of the loveseat.	{D 076}		

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{D 076}	Continued From page 8 Observation of Room 304 on the C Hall on 7/25/17 at 4:05 p.m. revealed: -The laminate on the top of the nightstand by the room entrance was peeling on all 4 sides and exposed the wood underneath. -The handle to the top drawer of the nightstand was missing -Both handles were missing on the nightstand next to the window. -Three of eight handles were missing on the 4 drawer chest and one handle was broken to the 3rd drawer. Interview with a housekeeper on 7/25/17 at 4:15 p.m. revealed she had not really noticed any problems with the furniture in any of the residents' rooms or the Quiet Room on the C Hall. Observation of the dining room on 7/25/17 at 4:20 p.m. revealed: -There were 32 dining room chairs with numerous chips to the wooden armrests and legs of all the chairs and various stains to the cloth seating of the chairs. -Nine of fifteen wooden tables in the dining room were chipped and had worn areas of the legs of the tables. Interview with the dietary manager on 7/25/17 at 4:20 p.m. revealed: -He did not like the condition of the furniture in the dining room. -He had reported any problems with the condition of the dining room furniture to the Administrator. Observation of Room 313 on the C Hall on 7/26/17 at 9:37 a.m. revealed: -The handle was missing from the left side of the second drawer of the 4 drawer chest that sat next	{D 076}		

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{D 076}	Continued From page 9	{D 076}		

to the closet door.
-The laminate on the top of the chest was peeling on all 4 sides.

Interview with a personal care aide on 7/26/17 at 10:25 a.m. revealed:
-Two newer cloth chairs had been placed in the Quiet Room on the C Hall but the other vinyl chairs were really old and "beat up" on the wooden armrests and chair legs.
-She had reported the worn condition of the chairs in the Quiet Room to a previous Administrator but she had not reported any problems with the furniture to the new Administrator.

Interview with a staff members on 7/26/17 at 11:00 a.m. revealed:
-The dining room furniture was at least seven years old.
-Most of the furniture was old throughout the facility and needed to be updated.
-She could not recall if any residents had ever complained about the condition of the furniture in their rooms.
-Staff reported any furniture that needed repairs to the Administrator.
-She did not recall if she had ever reported any problems with the furniture in the facility to the Administrator.

Observation on 7/26/17 at 11:38 a.m. of room 206 revealed the laminate was peeling from the side and top of the dresser.

Observation on 7/26/17 at 11:35 a.m. of room 208 revealed the tops of both dressers were buckling and laminate was peeling.

Observation on 7/26/17 at 11:37 a.m. of room 204

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{D 076}	Continued From page 10 revealed there was an eight inch strip of plastic with staples extending from the bed. Observation on 7/26/17 at 11:40 a.m. of room 203 revealed the top of the dresser was buckling and raised. Observation on 7/25/17 at 10:23 a.m. of room 115 on A Hall revealed the headboard of the bed by the door had an area that had multiple scratches approximately ½-2 inches long and ¼ inch wide exposing wood. Observation on 7/25/17 at 10:40 a.m. of room 107 on A Hall revealed: -The nightstand top had broken laminate on the right side top edge that was approximately 1 inch wide and 2-3 inches long exposing wood. -The dresser had a broken knob on the right hand side of the top drawer. -The closet door had a cracked area approximately 4 inches in length and 1 inch wide. Interview on 7/25/17 at 10:40 a.m. with resident of room 107 revealed he did not know what happened to the closet door or dresser knob, "It has been like that." Observation on 7/25/17 at 10:47 a.m. of room 105 on A Hall revealed: -There were two dressers in the room and both had torn laminate on the top left hand side approximately 1 inch wide by 1 inch long. -There were two nightstands in the room and both had torn laminate on the top left hand side approximately 2 inches wide and 5-6 inches long. Observation on 7/25/17 at 11:00 a.m. of room 101 revealed the dresser had laminate that was buckled with a piece of laminate missing	{D 076}		

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{D 076}	Continued From page 11 exposing wood below. Observation on 7/27/17 at 3:40 p.m. of room 101 on A Hall revealed the buckled laminate tops on the dresser and nightstand had been removed. Observation on 7/27/17 at 3:41 p.m. of room 105 on A Hall revealed the torn laminate tops had been removed. Interview on 7/26/17 at 1:30 p.m. with the Vice President of Quality Assurance and Regulatory Compliance revealed: -Heat treatments caused the laminate to separate from the furniture. -She would get a count of furniture peeling and order new furniture today. -The facility's contracted maintenance company was responsible for replacing knobs on furniture. Interview on 7/27/17 at 3:20 p.m. with a Maintenance Worker with the contracted maintenance company revealed: -He had been assigned to this building for two months. -The housekeeper reported problems to the Administrator. -The Administrator did a walk through of the facility and would report to his supervisor what needed to be done. -The Maintenance Worker's supervisor would tell him what needed to be repaired. -The Administrator entered any needed repairs into a computer software system. -His supervisor reviewed the information, created work orders and forwarded the work orders to him for repairs. -He sometimes started repairs and if he saw something else that needed to be done he would create his own work order and go ahead and do	{D 076}		

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{D 076}	Continued From page 12 it. -The Administrator decided the priority level of the repairs needed. -He usually did not know what was going on in a resident's room unless he was in the room to make repairs. -He had not noticed the laminate peeling from furniture.	{D 076}		
{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: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up to meet the health care needs of 1 of 5 residents sampled (#2) as related to failure to notify the primary care provider of skin breakdown resulting in a referral for specialized wound care. The findings are: Review of Resident #2's current FL-2 dated 3/3/17 revealed: -Diagnoses included Vascular Dementia, Vitamin	{D 273}		

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{D 273}	Continued From page 13 B12 Deficiency Anemias, Essential Hypertension, and Coronary Artery Atherosclerosis. -Resident #2 was intermittently disoriented, ambulatory with a wheelchair, and incontinent of bowel and bladder. Review of Resident #2's Assessment & Care Plan dated 5/22/17 revealed: - Resident #2 was last seen by his primary care physician (PCP) on 4/7/17. -Resident #2 required extensive assistance bathing, dressing, and toileting. -Resident #2 could be verbally abusive when being redirected. Interview with a personal care aide (PCA) on 07/25/17 at 10:56 a.m. revealed: -Resident #2 was total care and required assistance with all activities of daily living. -She noticed Resident #2 had redness and an open sore on his buttocks about a week ago when she was providing care to the resident. -She reported it to the supervisor on duty that day but she could not recall which supervisor. Interview with a Medication Aide /Supervisor (MA) on 07/25/17 at 11:08 a.m. revealed: -She was not aware of any skin issues with Resident #2. -She did not recall any staff reporting any skin breakdown or other skin issues about Resident #2. Review of Shower Assessments for Resident #2 revealed: -Extreme redness in the groin and buttock area was documented on the shower assessment for 6/12/17. -Redness in the groin and buttock area was documented on the shower assessment for	{D 273}		

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{D 273}	Continued From page 14 6/30/17. -Extreme redness in the buttock area was documented on the shower assessment for 7/3/17. -Redness in the groin and buttock area was documented on the shower assessment for 7/5/17. -Resident #2's buttocks was documented as pink on the shower assessment for 7/10/17. -Redness in the groin and extreme redness and an open area on the bottom was documented on the shower assessment for 7/17/17. This was signed by the Supervisor. -Redness and an open area on the buttocks are documented on the shower assessment for 7/19/17. This was signed by the Supervisor. -An open sore on the buttock was documented on the shower assessment for 7/21/17. This was signed by the Supervisor. -A sore on the buttock was documented on the shower assessment for 7/24/17. This was signed by the Supervisor. Observation of the resident on 7/26/17 at 9:50 a.m. revealed: -Resident #2 was sitting in his wheelchair in the shower room. -Resident #2 was assisted to a standing position by two personal care aides for skin assessment. -Redness was observed on both sides of Resident #2's buttocks with more redness observed on Resident #2's left buttock when compared to the right buttock. -There were two lines of scraped skin areas to Resident #2's upper, left buttock that measured approximately two inches long. -There were two open circular areas on Resident #2's lower, left lower buttock that had an approximate diameter of one centimeter. -The interior of the two open areas were dark	{D 273}		

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{D 273}	Continued From page 15 pink in color and had no drainage or odors. Based on observations, interviews and record reviews Resident #2 was not interviewable. Interview with two PCA's on 7/26/17 at 9:51 a.m. revealed: -Resident #2 had redness on his buttocks last week. -The PCA's documented this on the shower assessment last week. -The PCA had told the Executive Director (ED) and she came down and saw the area. -The PCA's had been using barrier cream on the area. -The resident was showered three times a week on Monday, Wednesday, and Friday. -A shower assessment was completed for each day a shower was given. Interview with a MA/ Supervisor on 7/26/17 at 10:05 a.m. revealed: -The MA/Supervisor had not noticed anything out of the ordinary with Resident #2's skin. -The MA/Supervisor confirmed she had signed the shower assessment sheet dated 7/17/17 documenting extreme redness and an open area on the bottom. -The MA/Supervisor recalled the PCA taking the ED to the shower room to see Resident #2's open sore. -Staff had been applying barrier cream to the open areas. -The resident's skin is evaluated when changed or showered. -Any problems with the resident's skin are documented on the shower assessment forms. -MA's/ Supervisors have to review the shower assessment sheets and sign them. -If a problem was noted, the MA/S should consult	{D 273}		

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{D 273}	Continued From page 16 with the Resident Care Coordinator (RCC) or the ED. -The shower assessment forms were then given to the ED. -The doctor may also be called for home health to do wound care or the resident will be placed on the list to see the doctor. -Calls to the doctor would be documented in the Quick Medication Administration Record (MAR). Review of the Quick MAR revealed a call to the doctor on 7/26/17 at 10:24 a.m. by the ED to report a small area of skin breakdown on the left buttock, to obtain a home health order and an order for a gel cushion. Interview with a PCA on 7/26/17 at 10:18 a.m. revealed: -The PCA had noticed the skin tear on Resident #2 about a week ago. -The PCA then told the ED about the skin on Resident #2's bottom. -The ED came into the room and removed Resident #2's pants to see the area. -There were two red areas at that time. -The ED asked the PCA to complete the shower assessment. Interview with another PCA on 7/26/17 at 12:00 p.m. revealed: -The PCA had noticed a spot on Resident #2 buttocks last Monday. -The area was open, red, and bleeding. -The PCA notified the MA/Supervisor on shift that day. -She applied barrier cream to the area and then completed a shower assessment sheet. -The shower assessment sheets used to be filed in a book by date after the MA/Supervisor signed them.	{D 273}		

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{D 273}	Continued From page 17 -This book was overflowing so on Monday (07/24/17) the ED asked that shower assessments be placed in her mailbox or under her door. Interview with a MA on 7/26/17 at 12:31 p.m. revealed: -Resident #2 tended to have redness of the skin. -The PCA came to get ointment from the MA last week. -The MA saw Resident #2's bottom last week while assisting with a diaper change. -The MA remembered the left buttock being red but not open. -Resident #2 was incontinent at all times. -The MA signed the shower assessment that documented that the shower was given and any skin tears or bandages. -The MA used ointment on simple skin tears and called the doctor for more serious skin tears. -She was not clear on whether she should contact anyone else. -The ED now handles everything with shower assessments and follow up as of Monday 7/24/17. -The shower assessments used to be filed in a book but the book became full and was overflowing. -As of Monday, 7/24/17, shower assessments were to be put into the ED's box Interview with the ED on 7/26/17 at 10:40 a.m. revealed: -The ED was unaware of any open areas on Resident #2 until earlier today. -She observed a small breakdown on the resident's left buttock. -She called the doctor this morning requesting an order for home health and a gel cushion for Resident #2's wheelchair.	{D 273}		

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{D 273}	Continued From page 18	{D 273}		

-Shower assessments are signed by the MA/S.
-The ED expected MA/S to bring the shower assessments of concern to her attention.
-The MA/S's were asked to call the doctor.
-The ED would like to be notified first due to being on call 24 hours a day and seven days a week.
-The facility doctors were also available around the clock.
-The ED confirmed that Resident #2 had a private physician.
-Previously, shower assessments were filed in a book for the RCC to review.
-As of Monday, shower assessments were now put into the ED's mailbox.

Telephone interview with Resident #2's Primary Care Provider's nurse on 7/27/17 at 9:30 a.m. revealed:
-Resident #2 was last seen on 4/18/17 for a hospital follow up due to pneumonia.
-The resident was seen for his dementia, cholesterol, and diabetes on an ongoing basis.
-The resident had no skin redness when he was seen on April 18, 2017.
-The facility had not notified the doctor of any skin breakdown on Resident #2's buttock until they called on 7/26/17 asking for an order for home health.
-The doctor was now referring Resident #2 to the wound clinic for a stage 2 wound.
-The location of the wound would hinder the dressing in addition to the exposure to urine and bowel.

Interview with the home health Registered Nurse on 7/27/17 at 9:38 a.m. revealed:
-Resident #2 had a stage 2 wound on the left buttock
-The RN had contacted the resident's PCP this morning 7/27/17 to explain it would be difficult to

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{D 273}	Continued From page 19	{D 273}		

dress the wound due to the location.
-The RN was unable to say how long the wound had been there.
-Redness without an open area usually indicates a stage one wound.
-A stage two wound was defined by the open skin.
-The facility should practice skin pressure techniques making sure the resident is not constantly on his bottom to prevent future wounds.
-The resident should also be kept clean and dry.
-A gel cushion would also help the wound,
-Resident #2 was dry last night when the RN arrived and he was seated in his wheelchair.
-There was barrier cream on the wound as well.

Telephone interview with Resident #2's family on 7/27/17 at 9:25 a.m. revealed:
-Resident #2's care was going well.
-The staff at the facility were very good to the resident.
-The home health nurse came last night to do wound care on Resident #2.
-Resident #2 was in good hands and the facility was meeting his needs.

Interview with the ED on 7/27/17 at 1:35 p.m. revealed:
-The ED did not recall Resident #2 having any broken skin on the buttocks.
-The ED could not recall the color of the skin when she saw it.
-The resident did not complain of any pain.
-The ED instructed staff to keep an eye on the area.
-The ED had contacted Resident #2's PCP to get the referral to the wound clinic so that the facility could coordinate that appointment.
-The facility would be scheduling an appointment

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{D 273}	Continued From page 20 with Resident #2's PCP on 7/27/17 in order to get a diagnosis and order for the gel cushion. -A standard wheelchair cushion had been ordered in the interim. The facility failed to provide referral and follow-up to meet the acute health care skin needs of Resident #2 who experienced skin breakdown documented since 06/12/17 that progressed to [2] stage two wounds on 07/17/17. The facility did not notify the physician of Resident #2's wounds. The facility's failure to notify the physician was detrimental to the health of 1 of 5 residents sampled and constitutes a Type B violation. Review of the facility's plan of protection dated 7/27/17 revealed: -Staff would be in-serviced on the shower sheets and reporting responsibilities immediately. -Body assessments would be completed on all residents to use as a baseline immediately. -The RCC/ED would review all assessments. -The shower assessments would now be reviewed daily by the RCC/ED. -The RCC/ED would notify the doctor with any issues immediately. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 10, 2017.	{D 273}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	{D912}		

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{D912}	Continued From page 21 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up to meet the health care needs of 1 of 5 residents sampled (#2) as related to failure to notify the primary care provider of skin breakdown resulting in a referral for specialized wound care. [Refer to Tag 0273, 10A NCAC 13F .0902 (b) Health Care (Type B Violation)].	{D912}		