STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068024	A. BUILDING: _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT GREEN OF CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

(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 complaint investigation and a COVID-19 focused Infection Control Survey with onsite visits on 09/17/20, 09/21/20 and 09/23/20 and a desk review survey on 09/18/20, 09/22/20 and a telephone exit on 09/24/20.	D 000	The facility scheduled the podiatrist And all residents received services On 10/5 and 10/6. The facility assigned The Quality Administrator to do hair, skin And nail assessments to obtain a baseline Of each residents needs. This assessment Will be completed quarterly thereafter And reported to the physician by the Quality Administrator on an as needed Basis. Any additional needs will be Addressed immediately upon assessment And observation. The facility in serviced All care aides on assessing residents nails During showers and when assisting the Resident to bed. Care aides are aware Of the importance of reporting Findings to the Resident Care Coordinator And the Quality Administrator for continued Follow through and to ensure that all care Needs are met. The facility completed all Assessments and nail care with the next Podiatrist visit scheduled timely to meet all Residents needs.	11/9/20
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: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure physician notification for 3 of 7 sampled residents (#2. #6, and #7) related to podiatry and nailcare with one of the residents diagnosed with diabetes (#2). The findings are: 1. Review of Resident #2's current FL-2 dated 6/10/20 revealed: -Diagnoses included depression, hypertension (HTN), diabetes mellitus, dysphagia, muscle spasms, quadriplegia, urinary tract infection, abdominal pain, myasthenia, muscle spasticity, neurogenic bladder, sepsis, multiple sclerosis, major depressive disorder and hyperlipidemia. -Resident #2 was ambulatory with the aid of a wheelchair. Review of Resident #2's assessment and care plan dated 10/04/19 revealed:	D 273		

Yolanda Mayo administrator 10/30/2020

Reviewed & Accepted Edwards 11/9/2020

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D 273	Continued From page 1 -The resident was oriented, and he had adequate memory. -Resident #2 was ambulatory with the aid of a motorized wheelchair. -Resident #2 was totally dependent with grooming and personal hygiene. Review of Resident #2's activity of daily living (ADL) log for 09/01-09/20/20 revealed the staff must cut the resident's nail. Review of Resident #2's Family Nurse Practitioner (FNP) visit dated 01/28/20 revealed: -Resident #2's nails were debrided with manual clippers without incident. -Nails were debrided for length and thickness. (Debridement is the act of removing any unwanted tissue or substance from the toenail.) Observation of Resident #2's toenails on 09/21/20 at 1:00 pm revealed: -The great toenail on the left foot extended about 1/4 inch from the end of the toe. -The toenail on the little toe on the left foot curved less than 1/4 of inch, but the nail did not touch the skin of the toe. -The great toe on the right foot extended less 1/4 inch from the end of the toe. Interview with Resident #2 on 09/21/20 at 10:40 am revealed: -His toenails were long because the podiatrist stopped coming to the facility because of COVID-19. -He had not notified the staff of his toenails being long. -He had numbness in his feet, but that was normal. -The podiatrist usually came to the facility three to four times per year.	D 273		

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D 273	Continued From page 2 -He had not been seen by a Podiatrist since March 2020 or longer due to COVID-19. Telephone interview with Resident #2's primary care physician (PCP) on 09/22/20 at 2:02 pm revealed: -He was not notified that Resident #2's toenails were long, and podiatry care had not been provided since March 2020 or longer. -He would have documented the information. -Lack of podiatry care could lead to nerve damage and poor circulation. Telephone interview on 09/24/20 at 1:48 pm with the Director of Specialty Services reporting dictated information from the Podiatrist revealed: -Non-routine podiatry care for diabetes residents could cause nail beds to be vulnerable to lacerations, skin breaks and susceptibility to infection -Nerve sensation was a common loss in residents who had diabetes. Telephone Interview with a personal care aide (PCA) on 09/24/20 at 12:38 pm revealed: -She had not noticed Resident #2's toenails being long. -Staff were not allowed to trim or cut diabetic residents' toenails. -If the PCA had known, she would have reported to her supervisor. Telephone interview with a medication aide (MA) on 09/24/20 at 11:27 am revealed: -She did not know that Resident #2's toenails were long. -The PCA had not reported to her that Resident #2's toenails were long. -She helped put Resident #2 in bed the previous night, but she did not see his toes because the	D 273		

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D 273	Continued From page 3 resident wanted to keep his socks on. -Staff were not allowed to trim or cut diabetic residents' toenails. -If the MA had known, she would have reported to her supervisor. Telephone interview with the previous Resident Care Coordinator (RCC) on 09/22/20 at 5:08 pm revealed: -She did not know Resident #2's toenails were long. -If she had known, she would have contacted the Administrator. -The Administrator would be able to cut Resident #2's toenails because she was a nurse, and the resident had diabetes. Interview with the current RCC on 09/23/20 at 1:00 pm revealed -He did not know Resident #2's toenails were long. -Staff were not allowed to trim or cut diabetic residents' toenails. -Since Resident #2 had diabetes, he would have contacted Resident #2's PCP for a podiatry consult. Telephone interview with the Administrator on 09/24/20 at 1:48 pm revealed she had not been notified by staff that Resident #2's toenails needed to be cut. Refer to the two letters from the podiatry services provider. Refer to the interview with the Resident Care Coordinator (RCC) on 09/21/20 at 11:29 am. Refer to the second interview with the RCC on 09/23/20 at 11:50am and 1:00 pm.	D 273		

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D 273	Continued From page 4 Refer to the telephone interview with the previous RCC on 09/22/20 at 1:52pm and 5:08 pm. Refer to the interview with the Administrator on 09/21/20 at 2:09pm and 09/23/20 at 12:57 pm. Refer to the telephone interview with the Administrator on 09/24/20 at 1:48 pm. Refer to the telephone interview with the Director of Specialty Services for the podiatry provider on 09/21/20 at 12:26 pm and 2:19 pm. Refer to the telephone interview with the Director of Specialty Services for the podiatry provider on 09/23/20 at 12:18 pm and 09/24/20 at 11:39 am. Refer to the telephone interview with the for Director of Specialty Services the podiatry provider on 09/24/20 at 11:39 am. 2. Review of Resident #7's current FL-2 dated 06/10/20 revealed: -Diagnoses included edema, hypertension, congestive heart disease, acute myocardial infarction, glaucoma, Alzheimer's, abnormal gait, and major depressive disorder. -Resident #7 used a wheelchair for ambulation. Review of Resident #7's assessment and care plan dated 07/01/20 revealed Resident #7 required extensive assistance with dressing, grooming and personal hygiene. Review of Resident #7's podiatry services summary dated 01/28/20 revealed: -Resident #7's toenails were debrided (significant reduction in the thickness and length of the	D 273		

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D 273	Continued From page 5 toenail) using manual clippers. -Resident #7 had peripheral vascular disease (PVD), poor circulation and onychomycosis (fungal infection of the nail). -Resident #7's feet should be kept clean and dry. -Plan was for nail debridement greater than every 61 days to minimize pain, pressure, and risk of infection. Observation of Resident #7's fingernails on 09/21/20 at 10:46 am revealed all five fingernails on his right hand were approximately one-fourth to one-half inches long. Interview with Resident #7 on 09/21/20 at 10:46 am revealed: -His fingernails on his right hand needed to be cut; he did not recall when his fingernails had last been cut. -His "toenails needed to be cut too." -He did not know who cut his fingernails and toenails, but he could not do it himself. -He did not tell anyone his fingernails or toenails needed to be cut because he did not know who to tell. -His fingernails and toenails did not hurt, but he would like to have them cut. Interview with a personal care aide (PCA) on 09/21/20 at 10:57 am revealed: -She assisted residents with personal care, including bathing, dressing and incontinence care. -She did not trim the resident's fingernails. -She did not have access to fingernail clippers. Interview with a second PCA on 09/21/20 at 11:07 am revealed: -She assisted residents with personal care, including hygiene, baths, buttons, zippers,	D 273		

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D 273	Continued From page 6 brushing teeth, shaving, and transfers. -She did not cut the resident's fingernails. -The MAs were responsible for cutting nails. Second interview with the first PCA on 09/21/20 at 11:21 am and 12:27 pm revealed: -Resident #7 had asked her a couple of months ago to cut his fingernails. -She told Resident #7 she could not cut his fingernails, but she would tell a supervisor. -She told a named supervisor; the supervisor no longer worked at the facility. -She had noticed Resident #7's toenails needed to be cut and had told the named supervisor. -She had not thought to tell anyone else that Resident #7's fingernails or toenails needed to be cut. Interview with a medication aide (MA) on 09/21/20 at 11:24 am revealed: -The PCA's were responsible for cutting fingernails. -He had not cut any resident fingernails lately; he may have cut a resident's fingernails about three weeks ago. -No one had told him Resident #7's fingernails needed to be cut. -A PCA should have told him Resident #7's fingernails needed to be cut. -The PCA's had more direct contact with the residents and would have seen that Resident #7's fingernails needed to be cut. -During the interview he observed Resident #7's fingernails and felt Resident #7's fingernails needed to be cut. Observation of Resident #7's toenails on 09/21/20 at 12:20 pm revealed: -On Resident #7's right foot, the first toenail was broken and jagged and the other four toes had	D 273		

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D 273	Continued From page 7 toenails that were between one-fourth to one-half inch in length. -On Resident #7's left foot, five of five toes had toenails that were between one-fourth to one-half inch in length. Second interview with the MA on 09/21/20 at 12:29 pm revealed: -He had not seen Resident #7's toenails. -Resident #7 was "up" and dressed when he arrived. -No one had reported to him Resident #7's toenails needed to be cut. Interview with the Administrator on 09/21/20 at 2:09 pm revealed: -She knew there was a resident whose toenails needed to be cut but she could not recall if it was Resident #7. -She was not aware Resident #7's toenails or fingernails needed to be cut. -She would have expected staff to cut Resident #7's nails if the nails needed to be cut. Telephone interview with Resident #7's Primary Care Provider (PCP) on 09/22/20 at 3:36 pm revealed: -He had not been notified Resident #7's fingernails or toenails needed to be cut. -He was concerned Resident #7's nail care had not been done for hygiene reasons. -Resident #7's fingernails and toenails should have been cared for. Interview with the Resident Care Coordinator (RCC) on 09/23/20 at 12:00 pm revealed: -He was not aware of Resident #7's toenails or fingernails needed to be cut. -No one had brought it to his attention nail care was not being provided.	D 273		

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D 273	Continued From page 8 Interview with a third PCA on 09/23/20 at 12:04 pm revealed: -She worked multiple shifts but usually worked third shift. -She worked with Resident #7 "about 2-weeks ago." -She had noticed Resident #7's fingernails needed cutting. -She did not cut the resident fingernails; the MAs cut resident fingernails. -She did not tell a MA Resident #7's fingernails needed cutting. -She had not seen Resident #7's toenails because Resident #7 was already dressed when she worked with him. -She "just forgot" to tell a MA Resident #7's fingernails needed to be cut. Attempted telephone interview with the named supervisor on 09/23/20 at 3:59 pm was unsuccessful. Refer to the two letters from the podiatry services provider. Refer to the interview with the Resident Care Coordinator (RCC) on 09/21/20 at 11:29 am. Refer to the second interview with the RCC on 09/23/20 at 11:50 am and 1:00 pm. Refer to the telephone interview with the previous RCC on 09/22/20 at 1:52 pm and 5:08 pm. Refer to the interview with the Administrator on 09/21/20 at 2:09 pm and 09/23/20 at 12:57 pm. Refer to the telephone interview with the Administrator on 09/24/20 at 1:48 pm.	D 273		

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D 273	Continued From page 9 Refer to the telephone interview with the Director of Specialty Services for the podiatry provider on 09/21/20 at 12:26 pm and 2:19 pm. Refer to the additional telephone interviews with the Director of Specialty Services for the podiatry provider on 09/23/20 at 12:18 pm and 09/24/20 at 11:39 am. 3. Review of Resident #6's current FL-2 dated 07/13/20 revealed diagnoses of dementia, osteoarthritis, hypertension and depression. Observation on 09/21/20 at 1:51 pm of Resident #6 revealed: -Resident #6 was seated in a wheelchair with her legs hanging down in front with the left foot was slightly crossed over the right foot. -Resident #6's feet, toes and ankles were edematous and the skin on the top of her feet was dry, yellow in color and crusty. -The toenails on Resident #6's right foot, smaller toes, were cut in an angle across the top, had sharp edges at the corners with jagged edges,and extended one third to one half inch beyond the end of the toes. -The right big toenail was thick, rounded in shape with scratch marks across the top of the nail and was cut a quarter of an inch below the end of the toe. -The toenails on Resident #6's left foot, smaller toes were cut in an angle across the top with a pointed or jagged edge extending one third to one half inch beyond the end of the toes. -The left big toe was thick and had a yellow-white dry substance under the top edge of the nail. -All of the toenails except for the big toes, were curving upward at the ends.	D 273		

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D 273	Continued From page 10 Interview on 09/23/20 at 9:50 am with Resident #6 revealed: -No one looked at or asked her about trimming her toe nails. -She had not had a Podiatry appointment to trim her toenails since being at the facility -She kept socks on her feet to cover her toes. Review of Resident #6's Progress/Provider notes for 07/06/20 to 09/17/20 revealed there was no documentation of podiatry nail care being done or an appointment being made for nail care services for the resident. Interview on 09/21/20 at 12:30 pm with a first shift personal care aide (PCA) revealed: -She gave Resident #6 a bed bath in the mornings but had not noticed her toe nails being long. -PCAs did not trim residents' toenails. -The facility used to have a podiatrist come every 3 months for residents' nail care. -Resident #6 would need to see a podiatrist for trimming her toenails. -Visitors had been restricted from the facility beginning in February, 2020 due to COVID-19 and there had been no resident podiatry appointments scheduled since. -Observing residents' feet for nailcare was not listed on the personal care logs. Interview on 09/23/20 at 10:00 am with a first shift Medication aide (MA) revealed: -Residents were already dressed when he came to work and he did not see their feet. -He did not check residents' toenails unless a problem was reported to him. -If there were problems reported, he would look at the residents' feet.	D 273		

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D 273	Continued From page 11 -The MA did not know of a protocol for podiatry services for reaidents. Telephone interview on 09/24/20 at 9:35 am with the Supervisor revealed: -The PCAs provided personal care to the residents and were responsible for reporting concerns to a MA or himself. -He was not aware Resident #6's toenails were long and needed podiatry services. -Resident #6's feet should be looked at when she had her bath. - "(We) used to have podiatry services consistently, but when COVID-19 came in January 2020, a hold was put on podiatry services and they have not been back." -"Resident #6 had fragile skin and rubbing one foot over another with jagged toenails could cut her skin and cause an infection." -If he had been told Resident #6's toenails were long, he could have trimmed them himself. Telephone interview on 09 24/20 at 2:08 pm with Resident #6's Power of Attorney (POA) revealed: -Visitation was not allowed at the facility due to COVID-19 in January 2020 and he had been in contact with, but not seen, Resident #6. -Prior to the COVID-19 outbreak, Resident #6 had regular podiatry services. -He was not aware Resident #6 was not having regular podiatry services, no one at the facility let him know. Telephone interview on 09/21/20 at 12:26 pm and 09/24/20 at 11:39 am with the Director of Specialty Services for the podiatry provider revealed: -Resident #6 was admitted for services on 02/28/20 and had an appointment to start podiatry services on 03/11/20.	D 273		

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D 273	Continued From page 12 -The facility did not follow-up on the 03/11/20 appointment for Resident #6. Telephone interview on 09/24/20 with the Director of Specialty Services reporting dictated information from the Podiatrist revealed: -The danger of Resident #6 having long toenails causes pressure on her fragile skin and the nail beds causing thickened -toe nails, lacerations of the skin and possible infection. -Resident #6 should have been sent out to a Podiatrist for toe nail care services. Refer to the two letters from the podiatry services provider. Refer to the interview with the Resident Care Coordinator (RCC) on 09/21/20 at 11:29 am. Refer to the second interview with the RCC on 09/23/20 at 11:50 am and 1:00 pm. Refer to the telephone interview with the previous RCC on 09/22/20 at 1:52 pm and 5:08 pm. Refer to the interview with the Administrator on 09/21/20 at 2:09 pm and 09/23/20 at 12:57 pm. Refer to the telephone interview with the Administrator on 09/24/20 at 1:48 pm. Refer to the telephone interview with the Director of Specialty Services for the podiatry provider on 09/21/20 at 12:26 pm and 2:19 pm. Refer to the additional telephone interviews with the Director of Specialty Services for the podiatry provider on 09/23/20 at 12:18 pm and 09/24/20 at 11:39 am.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068024	A. BUILDING: _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT GREEN OF CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

(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 273	Continued From page 13 Review of two letters from the podiatry services provider revealed: -On 03/12/20, facilities were notified routine podiatry services were suspended but would be available to provide medically necessary urgent conditions such as foot infections. -On 06/02/20, facilities were notified podiatry services would be reimplemented and a representative would be reaching out to the facility to schedule services for dates and times. Interview with the RCC on 09/23/20 at 11:50 am and 1:00 pm revealed: -He started in the RCC position 2-3 weeks ago and was responsible for managing facility paperwork. -The PCAs would check residen's' feet when assisting with baths; he could not assess a resident. -If the MA had a nail care concern, he would document the concern and find someone to provide nail care. -Jagged toe nails could cause scratches and cuts on the skin and increase the chances of an infection. -The podiatry provider stopped coming to provide resident services over 3 months ago, January 2020. -He did not know when the podiatry provider would be back to see residents. Telephone interview with the previous RCC on 09/22/20 at 1:52 pm and 5:08 pm revealed: -The podiatry services provider stopped seeing residents because of COVID-19. -She had not received any calls from podiatry services to schedule on-site podiatry care. -She did not receive any communication from the podiatry provider by mail or email related to podiatry services being available.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CRESCENT GREEN OF CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

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D 273	Continued From page 14 -When podiatry services stopped, the PCAs would have done nail care for any resident who was not a diabetic. -Fingernail care was part of the PCAs training. -The staff were responsible for notifying the MA or RCC if residents' toenails needed to be cut. -The MA should have cut the toenails or assigned the toenails to be cut by a PCA that was a certified nursing assistant (CNA). -Diabetic residents' nails could be filed down, even if they could not be cut. -She was not aware of any residents who needed nail care, but she had been out of the facility since 08/03/20 due to personal reasons. -March 2020 was the last time that the Podiatrist came to the facility -The agency was looking for a Podiatrist because the current Podiatrist had resigned, and no one from the agency notified her another Podiatrist was available to provide podiatry services for the residents. Interview with the Administrator on 09/21/20 at 2:09 pm and 09/23/20 at 12:57 pm revealed: -All outside care was stopped that was not medically necessary. -She would have considered podiatry medically necessary, but it was not her call, the providers stopped providing on-site care. -The previous RCC was responsible for all communication with the podiatry provider. -She was not aware podiatry care was available to provide on-site podiatry care. -The previous RCC had not told her podiatry care was available on site. Telephone interview with the Administrator on 09/24/20 at 1:48 pm revealed: -She did know residents' toenails needed to be cut because the podiatrist was not coming to the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT GREEN OF CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

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D 273	Continued From page 15 facility. -The last time the Podiatrist came to the facility was in January 2020. -The Podiatrist stopped coming because of COVID-19. -The previous RCC was responsible for scheduling podiatry appointments for the residents. -The staff were responsible for notifying the Administrator if residents toenails needed to be cut. Telephone interview with the Director of Specialty Services for the podiatry provider on 09/21/20 at 12:26 pm and 2:19 pm revealed: -On 03/12/20, a letter was sent to the facility stopping all face-to-face care due to covid-19; the letter explained care was available for acute needs. -On 06/02/20, a second letter was sent to the facility announcing all specialty services were available for on-site care. -The last time podiatry was provided care at the facility was 01/27/20. -Podiatry was scheduled to go back to the facility on 03/30/20 but was canceled due to COVID-19. -In addition to the letter sent to the facility in June 2020, multiple calls were made to the facility to schedule podiatry care. -Calls were made to the previous RCC who reported no on-site care was allowed due to COVID-19. -She did not keep dates and times of the calls to the previous RCC, but there were multiple attempts to schedule podiatry services after the letter was sent to the facility on 06/02/20. -The primary care provider reached out to the previous RCC several times, and had a podiatrist available to see residents, but the facility did not contact the Director of Specialty Services to make	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CRESCENT GREEN OF CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

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D 273	Continued From page 16 appointments for residents. Additional telephone interview with the Director of Specialty Services for the podiatry provider on 09/23/20 at 12:18 pm and 09/24/20 at 11:39 am revealed: -Both letters were sent by email to the previous RCC. -The primary care provider reached out to the previous RCC several times, and had a Podiatrist available to see residents, but no one from the facility contacted the Director of Specialty Services to make appointments for the residents. -Dictated information from the Podiatrist included Staff should not use clippers or scissors to trim resident's nails or try to thin the nails, a nail file should be used to shorten the nails. -Feet should be washed, thoroughly dried and checked daily. The facility failed to ensure referral and follow up for 3 residents needing podiatry services, including Resident #2, who had a diagnosis of diabetes and needed podiatry services for long fingernails and toenails; Resident #6, who missed an appointment with podiatry services, and had thick, jagged toenails and Resident #7 who had long, broken and jagged toenails. The facility's failure to provide referral and follow-up to the residents was detrimental to their health, safety, and welfare, which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/23/20 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2020.	D 273		

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D912	Continued From page 17	D912		
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. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure physician notification for 3 of 7 sampled residents (#2. #6, and #7) related to podiatry and nailcare with one of the residents diagnosed with diabetes (#2). Based on observations, record reviews and interviews, the facility failed to ensure physician notification for 3 of 7 sampled residents (#2. #6, and #7) related to podiatry and nailcare with one of the residents diagnosed with diabetes (#2). The findings are: Based on observations, record reviews and interviews, the facility failed to ensure physician notification for 3 of 7 sampled residents (#2., #6 and #7) related to podiatry and nailcare with one of the residents with a diagnosis of diabetes (#2) . [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		

Edwards, Wanda A

From: yolandalmorgan@aol.com
Sent: Friday, October 30, 2020 3:51 PM
To: Edwards, Wanda A
Subject: [External] Fwd: Plan of Correction
Attachments: PLANOFCORRECTIONGCOCINC.pdf

Hi Wanda,

Please find the SOD attached.

Kindly,

Yolanda Morgan

Sent from my iPhone

Begin forwarded message:

> **From:** sherri everett <sherrieverett1@hotmail.com>
> **Date:** October 30, 2020 at 3:41:34 PM EDT
> **To:** BOSSLADY <yolandalmorgan@aol.com>
> **Subject: Plan of Correction**