STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096047	A. BUILDING: _____ B. WING _____	R-C 03/01/2021

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SOMERSET COURT OF GOLDSBORO	603 LOCKHAVEN COURT GOLDSBORO, NC 27530

(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 and a complaint investigation survey with an on site visit on 02/24/21 and 02/25/21 and a desk review survey on 02/26/21 and 03/01/21 with a telephone exit on 03/01/21.	{D 000}		
{D 077}	10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or above at all times in facilities with 13 beds or more; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: FOLLOW UP TO A TYPE A2 VIOLATION Based on the findings the previous Type A2 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health sanitation score of 85 or above at all times. The findings are: Review of the facility's North Carolina Division of Environmental Health inspection report dated 12/04/20 revealed the facility's score was 77 with 23 total demerits.	{D 077}		

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{D 077}	Continued From page 1 Refer to findings in Tag 0079 regarding 10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings. The facility failed to maintain conditions to retain a North Carolina Division of Environmental Health sanitation score of 85 or above resulting in 23 demerits cited with a total score of 77. This score was in place for over 87 days and the facility had not requested a re-inspection as of March 1, 2021. The facility's failure placed the residents at substantial risk of neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 04/08/21 for this violation.	{D 077}		
{D 079}	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A2 VIOLATION Based on the findings the previous Type A2 Violation was not abated. Based on observations, record reviews, and interviews, the facility failed to ensure the	{D 079}		

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{D 079}	Continued From page 2 environment was clean related to mold, urine odors, and feces on the walls in multiple residents' bathrooms, and free of hazards related to smoke detectors, kitchen cleanliness, furniture in hallways, and live and dead roach activity in 5 residents' rooms, and live and dead bed bugs in 7 residents' rooms. The findings are: Observation of resident room #203's bathroom on 02/24/21 at 10:15am revealed: -There was a dried white washcloth with black spots on the shower floor. -There was mold in various places on the shower floor. -There was mold along the bottom of the shower curtain. -There was a greenish blue colored shower mat with mold on top of and under the edges of the shower mat. -There was a shower chair sitting on top of the shower mat. -There were dead roaches along the floor of the bathroom located by the shower. Observation of the wall outside of resident room #201 on 02/24/21 at 10:22am revealed 1 live bed bug crawling up the wall. Observation of the shared bathroom of resident rooms #205 and #207 on 02/24/21 at 10:33am revealed there was a live bedbug crawling on the floor of the bathroom. Observation of resident room #207 on 02/24/21 at 10:36am revealed there were two casings of bedbugs and bedbug excrement in 2 drawers of the chest of drawers.	{D 079}		

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{D 079}	Continued From page 3 Interview with a resident in room #207 on 02/24/21 at 10:33am revealed: -He saw bedbugs from time to time (unable to specify time or date). -He had moved his clothing out of the furniture since they were getting new furniture. -He had seen the exterminator in about 2 weeks ago. -If he saw any bugs crawling around, he would kill them. -He denied being bitten by any bugs. Observation of resident rooms #215 and #216 shared bathroom on 02/24/21 at 10:38am revealed: -There were dried brown to black splatter stains along the tank of the toilet, the wall behind the toilet, and the wall to the left of the toilet. -There was a black dirt around the base of the toilet. -There was a brown splattered substance in the base of the shower with the edges lighter than the center. -There was mold around the shower drain. Observation of resident room #226 on 02/24/21 at 10:47am revealed: -The chests of drawers were empty of any clothing and the resident was preparing for new furniture. -There were 3 bedbug casings on the top of the resident's chests of drawers. -There were numerous bedbug casings and excrement (which were too numerous to count) in 4 of 4 drawers of the chest of drawers. -There was a black smeared area on the resident's wall near the closet. (Interview with resident of room #226 stated it was a bug he smashed).	{D 079}		

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{D 079}	Continued From page 4 Observation of resident room #220's bathroom on 02/24/21 at 4:15pm revealed: -There were brown to black colored splatter stains along the wall to the left of and behind the toilet that extended to the hand rail. -There were brown splatter stains on the toilet tank. -There was dried feces on the inside edges of the toilet bowl. -There was mold and dead roaches in the shower floor. -There was mold along the outside base of the shower. -There was a dead roach on the inside bathroom door jam. -There were socks balled up on the shower seat. A second observation of resident room #220's bathroom on 02/25/21 at 10:09 am revealed: -There was brown and black colored splatter stains along the wall to the left of and behind the toilet that extended to the hand rail. -There were feces along the back and side of the toilet seat. -There were dried feces on the inside edges of the toilet bowl. Observation of the facility's kitchen on 02/25/21 at 9:15am-9:20am revealed: -There was food debris on floor under the stove, within the pantry, and under the food preparation table. -The floors were freshly mopped but were greasy with a lot of crumbs. Observation of resident room #214 on 02/25/21 at 11:18am revealed: -The smoke detector in the ceiling was partially hanging, which exposed the hole in the ceiling where the smoke detector was located which may	{D 079}		

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{D 079}	Continued From page 5	{D 079}		

allow bugs an entrance in to the facility.
-There were two casings of bedbugs noted in 2 of the chests of drawers.

Observation of resident room #226 on 02/25/21 at 11:22am revealed:
-There was a carcass of a cockroach on the resident's floor.
-There was a cockroach on the back of the resident's door, which did not move when touched.

Interview with a resident in room #226 resident on 02/24/21 at 10:47am revealed:
-He saw bugs at times but could not remember the last time.
-He had moved his clothing out of the furniture since they were getting new furniture.
-He saw the bugs crawling around the edges of the windows and heating/air conditioner unit but could not remember the exact day.
-He had smashed a bug on the wall over near his closet.
-He denied being bitten by any bugs.

Observations of the facility hallway on 02/25/21 at 11:07am-11:09am revealed:
-There was one mattress, one box spring mattress, and one bed frame sitting outside of room #213 on a cart.
-On one side of the border of the mattress there was black discoloration from bug excrement measuring approximately 4 feet.
-On other side of the border of the mattress there was black discoloration from bug excrement measuring approximately 2 feet.
-On the box spring mattress on both sides there was black and brown discoloration measuring approximately 2-4 feet.

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{D 079}	Continued From page 6 Observations of resident room #213 on 02/25/21 at 11:09am-11:11am revealed: -There were 3 dead bed bugs on the floor. -There was a very strong odor of urine within the resident's bathroom. Observation of resident room #119 on 02/25/21 at 2:41pm revealed there was one dead roach on the resident's floor. Interview with the Administrator on 02/24/21 at 3:52pm revealed: -The lead housekeeper worked 7:00am - 3:00pm. -The lead housekeeper was responsible for walking the halls for any urgent housekeeping needs such as visibly soiled bedrooms and bathrooms when first starting her shift and making a to do list for on coming housekeeping staff. -The 2nd housekeeper would arrive at 8:00am and be given the to do list made by the lead housekeeper. -It was expected the housekeepers were to sweep residents' bedrooms and bathrooms daily; mop residents' bedrooms and bathrooms daily; and clean the shower, toilet and sinks daily. -There were 3 housekeepers on duty today, 02/24/21. -The lead housekeeper was responsible for the 200 hall today, 02/24/21. -The 2nd housekeeper was responsible for 100 hall today, 02/21/21. -The 3rd housekeeper was responsible to assist with moving resident furniture in and out of the facility today, 02/24/21. -The shared bathroom for resident room #203 was "unacceptable". -The black splotches on the shower curtain in resident room #203 was "mold". -The shared bathroom for resident room #203	{D 079}		

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{D 079}	Continued From page 7	{D 079}		

needed to be cleaned.
-All resident rooms and bathrooms on the 200 hall should have been cleaned by this time today, 02/24/21.

Interview with the lead housekeeper on 02/24/21 at 4:00pm revealed:
-The 3rd housekeeper was responsible for cleaning 200 hall today, 02/24/21.
-She and the 2nd housekeeper were responsible for cleaning 100 hall today, 02/24/21.
-She would clean the bedroom and bathrooms for the female residents on the 200 hall and the 3rd housekeeper would clean the bedroom and bathrooms for the male residents on the 200 hall.
-Today, 02/24/21, all 3 housekeepers were working together.
-This morning, she told the 3rd housekeeper specifically to clean resident bathrooms #215, #216, and #220 because they were the most soiled.
-She thought the 3rd housekeeper had cleaned bathrooms #215, #216, and #220 because she told him they needed to be cleaned first.
-She should have checked behind the 3rd housekeeper to make sure the bathrooms were cleaned but did not because she saw him cleaning on the 200 hall today, 02/24/21.

Interview with a resident on 02/25/21 at 11:00am revealed:
-She lived in Room 116.
-She had seen roaches "everywhere" in her room.
-She had seen roaches below her sofa and around her bed.
-She had seen 1-2 roaches this week, 02/22/21, while sitting in her within her room.

Interview with a resident on 02/25/21 at 11:12am revealed:

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{D 079}	Continued From page 8 -He lived in Room 213. -The one mattress, one box spring mattress, and one bed frame sitting outside of the room was his previous furniture. -The furniture in his room would be replaced today, 02/25/21. -He last observed bed bugs in his room about one month ago. -The same week about month ago, he saw the bed bugs in his room, the facility's contracted pest control provider came to spray his room. -He had not observed any bed bug bites on his body. -His sheets for his bed were changed every three weeks. -His room was cleaned every third day. -His room was cleaned by a housekeeper today, 02/25/21. -His trash was removed, and his bathroom was cleaned. -Prior to today, 02/25/21, his room was last cleaned on Tuesday, 02/23/21. Review of the facility's North Carolina Division of Environmental Health inspection report dated 12/04/20 revealed the facility's score was 77 with 23 total demerits. Telephone interview with the County Health Inspector on 02/25/21 at 10:44am revealed: -Her last visit to the facility was on 02/17/21. -On 02/17/21, she was onsite, did not complete a re-inspection, and met with the new Administrator. -On 02/17/21, the new Administrator told her the facility would be ready in the next couple of weeks for their re-inspection. -On 02/25/21, she spoke with the facility's Regional Maintenance Director by phone and he said the facility would contact her to schedule	{D 079}		

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their re-inspection within the next few weeks.
-He had mentioned he believed the current pest activity was caused by food in the residents' rooms.
-Today, 02/25/21, she would be coming onsite to provide the new Administrator a document titled, Notice of Written Request Required for Reinspection of Institution.
-The Notice of Written Request Required for Reinspection of Institution would outline that a reinspection could be conducted upon request to raise the score and sanitation grade.
-It was "troubling" to her that there was persistent pest activity within the facility after receiving treatments from the facility's contracted pest control provider.
-She was wondering if the facility had followed all the facility's contracted pest control company's recommendations.
-She had concerns if there was still grease buildup within the kitchen as she had observed previously on 12/04/20.
-Heavy grease/food residue buildup in the kitchen could attract pests and then the pests could spread throughout the facility.
-She had recommended to the facility to treat all rooms versus chasing the pests from room-to-room.
-The facility had not been able to have consistent follow-up treatments from their contracted pest control provider since having a COVID-19 outbreak within the facility in 12/2020.
-Since 12/04/20, there had been no requests for her recommendations with pest control received from the facility.
-There were suggestions/recommendations made in the report dated 12/04/20, for example, filling the existing cracks in walls to prevent harborage of pests and replacing any broken electrical outlets.

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{D 079}	Continued From page 10 -Bed bugs did not spread disease but were more of "nuisance" to the residents. -Residents may not realize they are being bitten by bed bugs but had a right not to be bitten. -Live roach activity came with the possibility of the illnesses, Escherichia coli (E. coli) and salmonella. -Roaches could easily transfer both, Escherichia coli and salmonella, to residents anytime they walked over a surface such as a resident's skin or food. -She had concerns about the residents contracting a food borne illness from the roaches. -Pathogens could come from the bathroom to a living space where residents were eating their meals. -The resident outcomes were diarrhea, vomiting, any gastrointestinal issues could be associated with the transfer of salmonella and E. coli. Review of the pest control provider's service slips/invoices for the facility revealed: -On 12/16/20, the pest control provider inspected, treated, and observed German roach activity in resident rooms #202, #205, and #216. -On 12/16/20, the pest control provider inspected, treated, and observed light to heavy bed bug activity in residents' rooms #208, #212, #213, and #215. -On 12/16/20, the pest control provider inspected, treated, and observed no activity at that time in residents' rooms #201, #207, #211, #212, #217, and #219. -On 12/17/20, the pest control provider inspected and treated multiple rooms for bed bugs and German roach activity. -On 12/22/20, the pest control provider inspected and treated all listed rooms on the 200's hall for bed bugs and German roach activity. The rooms were inspected for conducive conditions. There	{D 079}		

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was large amounts of food and debris found in all areas of rooms.
-On 02/04/21, the pest control provider inspected, treated, and, observed German roach activity in residents' rooms #118, #129, #130, and #128.
-On 02/04/21, the pest control provider observed "heavy activity" in resident room, #124, found throughout room and on mattress, box spring, headboard, bed frames, and chair. The pest control provider treated seams, tuffs, and all crack and crevices throughout room. Vacuum was used to remove "activity."
-On 02/04/21, the pest control provider inspected, treated, and observed no live bed bug activity at this time in residents' rooms #127, #129, #131, #132, and #126.
-On 02/05/21, the pest control provider observed no live bed bugs at that time but observed bed bug casings, bed bug fecal matter, and roach fecal were found in residents' rooms #101, #103, #107, #109, #111, and #112. The spot and crack/crevices were treated, and a vacuum was used to remove casings found.
-On 02/05/21, the pest control provider inspected, treated, and, observed German roach activity in residents' rooms #105, #129, #113, #116, #114, #112, #110, #108, #106, and #104.
-On 02/05/21, the pest control provider inspected, treated, and, observed German roach and carpet beetle activity in residents' rooms #115 and #102.
-On 02/10/21, the pest control provider inspected, treated, and, observed "activity" in residents' rooms #212, #205, #214, #228, #208, and #213.
-On 02/10/21, the pest control provider inspected, treated, and, observed German roach activity in residents' rooms #223, #227, and #216.
-On 02/10/21, "poor sanitation" was documented in residents' rooms #218 and #216.
-On 02/11/21, the pest control provider inspected, treated, and, observed live bed bug activity in

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{D 079}	Continued From page 12 residents' rooms #208, #211, #213, #212, #214, #205. Interview with the Divisional Vice President of Operations (DVPO) on 02/24/21 at 10:30am revealed: -She did not reach out to the Local Health Department (LHD) about the bedbugs and roaches in the facility. -During the outbreak, there were not enough empty rooms to be able to move the residents out of the rooms with bedbugs. -Interventions implemented during the COVID-19 outbreak when the pest control provider was not actively treating the facility included bagging the residents clothing and linens and washing and drying them on high heat for at least 45 minutes. -Some of the furniture that was infested with bedbugs was disposed of when the facility's contracted pest control company came to the facility in December 2020. - It was decided after 12/04/20 each resident would get a new headboard, mattress, box spring, nightstand, and chest and all the carpet had been replaced with new flooring. The new furniture was being put together and put in rooms on 02/24/21 and 02/25/21. Telephone interview with the Administrative Assistant for the facility's contracted pest control provider on 02/24/21 at 10:10am revealed they would not go into a facility positive for COVID-19. Telephone interview with the Branch Manager for the facility's contracted pest control company on 02/24/21 at 4:08pm revealed: -The pest control provider went into the facility 12/10/20 and treated the 200 hall for bedbugs and roaches. -There had to be 10-14 days in between	{D 079}		

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treatment of the same rooms.
-When the pest control provider went back to the facility 12/21/20 for re-treatment they were not allowed into the facility due to an active COVID-19 outbreak.
-The facility's pest control provider called the facility 12/30/20, but the facility still had a COVID-19 outbreak.
-At the end of January 2021, the facility called the pest control provider to come into the building.
-On 02/04/21 the facility's contracted pest control provider treated resident room numbers 117-132 in the facility.
-On 02/05/21 the facility's contracted pest control provider treated resident room numbers 101-116 in the facility.
-On 02/10/21 the facility's contracted pest control provider treated resident rooms numbers 201-228 in the facility.
-The pest control provider was scheduled to return to the facility on 02/26/21 for a follow up and the rooms would be reassessed and then the focus would be on the rooms that had bed bug and roach activity.

Interview with the facility's Regional Maintenance Director on 02/25/21 at 12:38pm revealed:
-His last visit to the facility was 02/23/21 and prior to that he was at the facility on 02/16/21 or 02/17/21.
-He had to look at and follow up on the generators.
-When he came to the facility, he would do a walk through to look at "life safety issues".
-He was onsite when the facility's contracted pest control provider came in December 2020.
-He could not recall if there were any recommendations from the pest control company in December 2020.

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{D 079}	Continued From page 14 Telephone interview with the facility's Divisional Maintenance Manager on 02/26/21 at 12:00pm revealed: -He was onsite at the facility on Monday, 12/07/20 with nine maintenance technicians and a professional cleaning crew. -The week of 12/07/20, the maintenance technicians began the process of throwing out furniture and began the re-flooring of residents' rooms. -The week of 12/07/20, the facility's contracted pest control provider completed one full day and one-half day onsite the week of 12/07/20 to exterminate the active pest activity. -The facility's contracted pest control company was due to return to the facility within 14 days from 12/10/20 for another extermination treatment. -An email was received from a local health department about the facility's exposure to COVID-19 with no additional details provided. -All maintenance and pest control activity were stopped at the facility. -With the COVID-19 outbreak for staff and residents, it was the facility's policy to not allow non-essentials within the facility. -It was also the facility's pest control provider's policy to not enter a facility with COVID-19 positive cases. All correspondence and documentation between the facility and facility's contracted pest control provider was requested on 02/26/21 and 03/01/21, but was not received prior to the survey exit. _____ The facility failed to ensure the residents had a clean living environment without the presence of mold, urine odors, and feces on the walls in multiple residents' rooms and an environment	{D 079}		

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{D 079}	Continued From page 15 free of hazards related to smoke detectors, kitchen cleanliness, furniture in hallways, live and dead roach activity in 5 residents' rooms, and live and dead bed bugs in 7 residents' rooms which resulted in residents' observations of active pest activity. The facility's most current North Carolina Division of Environmental Health inspection report dated 12/04/20 revealed the facility's score was 77 with 23 total demerits. This score had been in place for 87 days without the facility requesting a re-inspection. The failure of the facility to ensure an environment which was clean and free of hazards and a continuing sanitation score of 77 placed the residents at substantial risk of serious neglect and constitutes an unabated Type A2 Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 03/16/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 1, 2021.	{D 079}		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 269		

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reviews the facility failed to ensure 2 of 5 residents sampled (#2, #5) received personal care assistance with foot care.

The findings are:

Review of Resident #2's current FL-2 dated 02/08/21 revealed:
-There was a diagnosis of acute respiratory failure.
-The resident was ambulatory and on oxygen (O2) 2 liters per minute (LPM) continuously by nasal canula.

Review of Resident #2's previous FL-2 dated 02/20/20 revealed diagnoses included diabetes mellitus type 2, diabetic peripheral neuropathy, chronic obstructive pulmonary disease, hypertension, osteoarthritis, and lumbar post laminectomy syndrome.

Review of Resident #2's current care plan dated 03/25/20 revealed:
-The resident was ambulatory with a cane, had limited strength of the upper extremities and shortness of breath.
-The resident's skin was documented as normal.
-The resident required limited staff assistance with toileting, ambulation, bathing, dressing, and grooming.
-The resident required supervision/set up for transfers.
-The care plan was not signed by the assessor or the Primary Care Provider (PCP).

Review of Resident #2's activity of daily living (ADL) log dated February 2021 revealed:
-The resident last received a bath on 02/23/21.
-Foot care was documented as performed by staff from 02/08/21 - 02/24/21 and 02/01/21 -

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D 269	Continued From page 17 02/02/21. -There was no foot care documented from 02/03/21 - 02/07/21. Observation of Resident #2's feet on 02/24/21 at 5:13pm revealed: -On the right and left feet were white, cracked, dry, flaking skin around the toenails, the cuticles, on the top of the toes, between the toes, and along the outsides of both feet. -The bottom of the right and left feet was dry, cracked, thick, flaking skin from the heels to the toes. -There were reddish brown colored specks scattered across the bottom of the right and left heels and up the bottom sides of both feet. -Between the 1st - 5th toes on the right foot was dark, thick, yellow skin build up and black, moist debris. -Between the 1st - 5th toes on the left foot was dark, thick, yellow skin build up and black, moist debris. Interview with Resident #2 on 02/24/21 at 5:17pm revealed: -He was independent with bathing and foot care. -On shower days, the resident would apply soap to his washcloth, drop the washcloth on his feet, then use one foot to wash the other foot because he could not bend down or raise his legs enough to wash his feet. -The resident could not wash between his toes on the right or left foot. -Staff did not assist him with bathing or performing foot care. -He had never asked staff to assist him with bathing or performing foot care. -Staff had never asked if he needed assistance with bathing or performing foot care.	D 269		

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D 269	Continued From page 18 Interview with a personal care aide (PCA) on 02/24/21 at 4:30pm revealed: -Resident #2 was independent with bathing and dressing. -Resident #2's shower days were Tuesdays, Thursdays, and Saturdays on 2nd shift. -She had never had to help Resident #2 with foot care. Interview with the Licensed Health Professional Support (LHPS) nurse on 02/25/21 at 2:30pm revealed: -Resident #2 had chronic lung disease and had difficulty breathing. -Resident #2 ambulated with a rollator and required staff assistance with bathing because he had low endurance to activity. -Resident #2 was short of breath on exertion. -She did not know what "limited" assistance with bathing, dressing, and grooming meant on Resident #2's care plan. Interview with a second PCA on 02/25/21 at 2:40pm who documented on various dates of Resident #2's activities of daily living (ADL) log for February 2021 revealed: -"Done" on the ADL log indicated she had washed Resident #2's feet. -She had last washed Resident #2's feet on 02/23/21. -Resident #2's feet were cracked, dry, and his nails were jagged, long, and thick. -She never told any staff about Resident #2's feet because the resident did not wear socks and other staff could see the resident's feet when he was walking. Interview with the Administrator on 02/25/21 at 3:34pm revealed: -She did not know what type of staff assistance	D 269		

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Resident #2 needed.
-She expected the PCA to have performed foot care per the resident's care plan.
-She expected the PCA to have noticed residents' feet and between their toes to be certain they were clean when performing personal care.

Telephone interview with Resident #2's PCP on 02/26/21 at 2:37pm revealed:
-Resident #2 could not reach his feet to provide foot care.
-Resident #2 could not see the bottom of his feet.
-She expected staff to have assisted Resident #2 with foot care because he could not wash his own feet.
-Resident #2 was a diabetic which placed him at increased risk for skin breakdown, infection, and amputation.
-She had not seen or examined Resident #2's feet.
Refer to telephone interview with the Resident Care Coordinator (RCC) on 02/26/21 at 3:41pm.

2. Review of Resident #5's current FL-2 dated 12/23/20 revealed:
-Diagnoses included congestive heart failure, hypertension, and coronary artery disease.
-The resident was independently ambulatory and continent of urine and bowel.
-The orientation status was not documented.

Review of Resident #5's current care plan dated 02/12/20 revealed:
-The resident required limited assistance with bathing, dressing, and grooming.
-The resident required supervision/set up for transfers.
-The resident was oriented and memory adequate.

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D 269	Continued From page 20 Observation of Resident #5's feet on 02/25/21 at 11:09am revealed: -Both feet were swollen, ashy, and dry. -The left 1st - 4th toenails were thick, jagged, and extended past the tip of the toes. -The left 1st toenail was dark gray in color and was elevated above the nailbed. -The skin on top of the left 1st - 4th toenails was white, dry, and flaking. -The left 1st - 4th cuticles were white, dry, flaking, and thick. -The bottom left 5th toe was black from the tip of the toe under the nail for approximately 2mm in diameter. -The right 1st - 4th toenails were thick and extended past the tip of the toes. -The skin on the bottom of the right and left feet was dry, thick, yellow, and cracked. -The left and right heels appeared as elephant skin, dry, thick, yellow, and cracked. Interview with Resident #5 on 02/25/21 at 11:09am revealed: -He was independent with bathing. -He needed staff assistance to put on and remove socks. -He needed staff assistance to wash his feet. -He needed staff assistance for nail care to his feet. -Staff did not wash or help him wash his feet. -Staff did not ask if he needed help washing his feet. -He had not asked staff to help him wash his feet or perform nail care. -He would run water over his feet when showering. -He had dry skin to his feet that would not go away. -The last time his toenails were cut was by podiatry. He could not remember when.	D 269		

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-A personal care aide (PCA) had cut his toenails in the past but could not remember when.
-He could not remember the last time staff looked at his feet.
-He did not want staff to help wash his feet.

Review of Resident #5's activity of daily living (ADL) log for February 2021 revealed:
-Nail care was documented done on 02/06/21, 02/13/21, 02/21/21 daily.
-Foot care was documented as done from 02/01/21 - 02/24/21.

Interview with a PCA on 02/25/21 at 2:40pm who documented on various dates of Resident #5's ADL log for February 2021 revealed:
-"Done" on the ADL log indicated she had washed Resident #5's feet and/or performed nail care.
-Resident #5 was independent with all ADL's.
-She last washed Resident #5's feet on 02/23/21.
-She had never assisted Resident #5 with nail care.
-She documented "done" on the nail care ADL for Resident #5 because the resident could perform nail care independently.
-She knew Resident #5 was independent with nail care because he told her.
-Resident #5 had never asked her to assist with foot or nail care.
-She had never asked Resident #5 if he needed help with foot or nail care.
-She last saw Resident #5's feet today when he was laying down.
-The skin on Resident #5's feet was flaking and had cracked skin.
-She did not tell anyone today the condition of Resident #5's feet because he didn't wear shoes and other staff see his feet when he walks.
-She had never looked between Resident #5's toes.

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D 269	Continued From page 22 Interview with the Administrator on 02/25/21 at 3:34pm revealed: -She did not know what type of staff assistance Resident #5 needed. -She expected the PCA to have performed foot care per the resident's care plan. -She expected the PCA to have noticed residents' feet and between their toes to be certain they were clean when performing personal care. Refer to telephone interview with the Resident Care Coordinator (RCC) on 02/26/21 at 3:41pm Telephone interview with the Resident Care Coordinator (RCC) on 02/26/21 at 3:41pm revealed: -Foot care on the ADL logs meant "wash feet". -When staff documented "done" on the ADL log it meant staff physically did the task or assisted the resident. -If staff documented "done" on the ADL log she expected staff to have performed foot care to the resident.	D 269		
{D 271}	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.	{D 271}		

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This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE A1 VIOLATION

Based on these findings, the previous Type A1 Violation was not abated.

Based on observations, interviews, and record reviews the facility failed to ensure an immediate response and intervention by staff during an incident in which 1 of 1 sampled resident (#2) was in respiratory distress.

The findings are:

Review of Resident #2's current FL-2 dated 02/08/21 revealed:
-There was a diagnosis of acute respiratory failure.
-The resident was ambulatory and on Oxygen (O2) 2 liters per minute (lpm) continuously per nasal canula.
-There was an order for Duo-Neb (a combination of 2 bronchodilators that relax muscles in the airways and increase air flow to the lungs) 3 milliliters (ml) inhalant every 4 hours as needed (prn). There was no documentation indicating symptoms for administering prn.
-There was an order for Albuterol (a bronchodilator used to prevent and treat difficulty breathing) 2 puffs inhaled every 4 hours prn wheezing.
-There was an order for Pulmicort (an inhaled steroid used to control and prevent wheezing and shortness of breath by reducing swelling and irritation of the airways) 0.5mg inhaled twice daily.
-There was an order for Atrovent (an inhaled medication used to control and prevent wheezing

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and shortness of breath) 500 micrograms (mcg) inhaled 4 times daily.
-There was an order for Spiriva (a bronchodilator used to prevent bronchospasms) 18mcg inhaled daily.

Review of Resident #2's previous FL-2 dated 02/20/20 revealed diagnoses included type 2, diabetes, diabetic peripheral neuropathy, chronic obstructive pulmonary disease, hypertension, osteoarthritis, and lumbar post laminectomy syndrome.

Review of Resident #2's current care plan with an observation date of 03/25/20 revealed:
-The resident was short of breath and required a nebulizer.
-There was no documentation that indicated the resident was on Oxygen.
-The care plan was not signed by the assessor or the Primary Care Provider (PCP).

Review of Resident #2's current Licensed Health Professional Support (LHPS) evaluation dated 02/12/21 revealed:
-The resident was unable to ambulate long distances due to shortness of breath and was O2 dependent at 3 lpm via nasal canula.
-There was no documentation that indicated the frequency of O2 administration.
-Staff monitored the resident's O2 for safe administration.
-Staff competency was validated for nebulizers and oxygen.
-There was documentation to continue with the resident's existing care plan.

Observation of and interview with Resident #2 on 02/25/21 at 12:30pm revealed:
-Resident #2 was breathing rapidly, taking deep

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breaths.
-He said he was short of breath and he was upset that his family member had passed away.
-His oxygen (O2) concentrator was on delivering O2 via nasal cannula (NC) at 2.5 liters per minute.
-He needed help.
-The medication aide (MA) was notified immediately by the surveyor.
-The MA checked Resident #2's oxygen saturation level.

Interview with the MA on 02/25/21 at 12:30pm revealed Resident #2's O2 saturation was 74%; he called 911.

Interview with Resident #2 on 02/25/21 at 12:38pm revealed:
-He was having shortness of breath.
-He walked to the nurse's station to get another O2 cylinder because his was empty.

Observation of the nurse's station on 02/25/21 from 12:38pm - 12:47pm revealed:
-Resident #2 was sitting on his rollator at the nurse's station with the O2 tubing draped across his shoulders and around his neck.
-The other end of the O2 tubing was attached to Resident #2's portable O2 cylinder on the rollator.
-The resident's portable O2 cylinder was empty with the regulator needle in the red area indicating need for replacement.
-Resident #2's face was cyanotic (bluish or grayish color of the skin caused when oxygen-depleted blood circulates through the skin).
-Resident #2's speech was short and broken.
-The resident's respirations were short and heavy with use of abdominal muscles.
-The MA was standing at the nurse's station

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facing Resident #2.
-The MA required prompting to ensure Resident #2 was wearing the O2 NC at 12:39pm.
-The MA required prompting to ensure Resident #2's O2 tank contained O2 at 12:39pm.
-The MA required prompting to retrieve O2 for Resident #2 at 12:40pm.
-The MA asked Resident #2 how long his O2 cylinder had been empty.
-Resident #2 told the MA his O2 cylinder had been empty for 15 minutes.
-The MA retrieved a portable O2 cylinder for Resident #2 from the supply closet.
-Resident #2 had removed the regulator from the empty O2 cylinder.
-The MA was unable to apply the regulator to the O2 cylinder retrieved from the supply closet.
-Resident #2 took the regulator from the MA and attempted to apply the regulator to the O2 cylinder retrieved from the supply closet.
-The MA took the regulator from Resident #2 and attempted again to apply the regulator to the O2 cylinder.
-The MA could not apply the regulator to the O2 cylinder.
-Emergency Medical Services (EMS) arrived at 12:43pm.
-Resident #2's O2 levels were 73% upon EMS assessment.
-EMS prompted the MA to step aside so EMS could supply Resident #2 with O2.
-EMS provided Resident #2 with O2 at 10 LPM via non-rebreather (a face mask that allows for delivery of high flow O2) at 12:45pm.
-EMS escorted Resident #2 from the facility via stretcher at 12:47pm.

Review of Resident #2's local emergency department (ED) provider note dated 02/25/21 revealed:

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{D 271}	Continued From page 27 -The resident had a past medical history of COVID-19, COPD, and tobacco abuse. -The resident arrived in the ED for decreased O2 saturations as low as 71%. -The resident was on chronic O2 via nasal canula at the facility. -The resident had shortness of breath which was normal for the resident, coughing, and wheezing. -The resident was administered Solu-Medrol (a steroid used to treat respiratory conditions) injection, Albuterol (an inhaled bronchial dilator used to treat difficulty breathing), and a Duo-Neb (a combination of 2 inhalant bronchodilators which work together to open airway of the lungs) in the ED and prescribed an oral steroid. -Discharge diagnoses were Dyspnea and COPD exacerbation. Interview with the MA on 02/25/21 at 12:50pm revealed: -He was told by a member of the survey team Resident #2 was having shortness of breath. -He checked Resident #2's O2 saturation in the resident's room and the result was 74% with O2 in place. -He left Resident #2 in the room while he walked to the nurse's station to call EMS to transport the resident to the hospital. -He stayed at the nurse's station to prepare Resident #2's papers for transport to the hospital. -He saw Resident #2 walking towards the nurse's station with the rollator. -He did not notice if Resident was wearing the nasal canula or using O2. -He thought Resident #2 could wait for O2 until EMS arrived because EMS was expected any minute. -He did not realize Resident #2 was not wearing the O2 nasal canula until prompted by surveyor. -He did not realize Resident #2's portable O2	{D 271}		

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cylinder was empty until prompted by surveyor.
-He had been working as a MA at the facility for about 1.5 months.
-He had not received skills check-off or LHPS task training since working at the facility.
-He transferred from a sister facility about 1.5 months ago.
-He received skills check offs and LHPS task training at the sister facility.

Interview with the Resident Care Coordinator (RCC) on 02/25/21 at 1:15pm revealed:
-When Resident #2 was observed by the MA walking to the nurse's station, the MA should have had the resident stop walking and to sit down on the rollator, applied the nasal canula to the resident, and checked the O2 cylinder to ensure it contained O2.
-She expected the MA to have administered O2 to the resident without prompting.
-The facility did not have a specific policy related to O2 administration or how staff were supposed to respond if a resident was in respiratory distress or had low O2 saturations.

Interview with the Administrator on 02/25/21 at 1:40pm revealed:
-She expected the MA to have noticed Resident #2 was not wearing the nasal canula without prompting.
-She expected the MA to have placed the nasal canula on Resident #2 without prompting.
-She expected the MA to have ensured O2 was being administered to Resident #2 via nasal canula by checking the O2 cylinder to ensure it was not empty without prompting.
-It was unacceptable for Resident #2 to be without O2 for 7 minutes.
-MAs were supposed to have skills check offs and LHPS task training before passing

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medications on the medication cart.
-The MA knew how to administer oxygen because of previous training.
-The MA was from a sister facility and should have been checked off on O2 administration and responding to emergencies at the sister facility.
-She did not know if the MA was checked of on O2 administration and responding to emergencies since working at the facility.

Interview with the LHPS nurse on 02/25/21 at 2:30pm revealed:
-Resident #2 had chronic lung disease and had difficulty breathing.
-Resident #2 ambulated with a rollator and required staff assistance with bathing because he had low endurance to activity.
-Resident #2 was short of breath on exertion.
-The MA had not received skills check off prior to passing medications at the facility.
-It was dangerous to Resident #2 that the MA was not checked off on skills and medication administration prior to passing medications because the resident could have died from lack of oxygen.

Telephone interview with Resident #2's PCP on 02/26/21 at 2:37pm revealed:
-The resident contracted COVID-19 in December 2020 and required O2 continuously.
-The MA should not have required prompting to check the residents O2 cannula, administer O2, or change out the O2 cylinder because it was empty.
-It was expected the MA to have stopped Resident #2 from walking in the hall.
-It was expected the MA to have had Resident #2 sit on the rollator or obtain a wheelchair to wheel the resident back to his room and place the resident on the room O2 concentrator until EMS

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{D 271}	Continued From page 30 arrived. -If the resident was not taken back to his room, it was expected staff to have brought the resident's O2 concentrator to him and administered O2. -It was expected the MA to have remained in Resident #2's room when the resident reported shortness of breath and the O2 saturations were 74%. -The MA should have never left the resident until EMS arrived because the resident was short of breath and had low O2 saturation levels and O2 saturations would have continued to drop with exertion causing an increase in shortness of breath. -Signs and symptoms of respiratory distress were cyanosis and short, broken speech. -The resident could have passed out and fell or eventually gone into (respiratory arrest). -She declined to provide additional information on the potential outcome to Resident #2 as related to respiratory arrest. -The MA should have yelled out for help when discovering Resident #2 was in respiratory distress. -She expected MAs to know how to change regulators on O2 cylinders to ensure resident care. Telephone interview with the facility's Divisional Vice President of Operations (DVPO) on 03/01/21 at 1:45pm revealed: -In an emergency, staff should remain with the resident until EMS arrived to ensure resident safety. -It was expected for the MA to have stayed with Resident #2 until EMS arrived. -She expected the MA to have administered O2 to Resident #2 without prompting by surveyor. The facility failed to respond immediately when	{D 271}		

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{D 271}	Continued From page 31 Resident #2 who was diagnosed with COPD, had a history of COVID-19, and dependent upon Oxygen 2 liters per minute continuously via nasal cannula, was short of breath with an oxygen saturation of 73% was left alone in his room by the medication aide instead of calling staff for help, the resident was cyanotic (a bluish gray colored face from lack of oxygen) and in respiratory distress on 02/25/21. The resident went 7 minutes without Oxygen. The medication aide required 3 prompts to provide Resident #2 with Oxygen. Upon EMS arrival the resident's oxygen saturation was 73% and required Oxygen 10 liters per minute via non-rebreather. Upon arrival to the hospital the resident's oxygen saturation was 71%. The facility's failure resulted in serious harm and neglect which constitutes an Unabated Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/25/21 for this violation.	{D 271}		
{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 B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur. THIS IS A TYPE A2 VIOLATION	{D 273}		

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{D 273}	Continued From page 32 Based on observations, interviews, and record reviews, the facility failed to ensure health care needs were met for 4 of 5 sampled residents (#1, #2, #3, #5) related to the scheduling of medical appointments with the primary care provider (PCP) and pulmonology (#2) and podiatry (#1, #2, #5); notification to the PCP for residents exhibiting shortness of breath (#3, #5); and coordination of care for an appointment for an overnight pulse oximetry test (#1) and checking to ensure oxygen canisters contained oxygen for administration. The findings are: 1. Review of Resident #2's current FL-2 dated 02/08/21 revealed: -There was a diagnosis of acute respiratory failure. -The resident was ambulatory and on oxygen (O2) 2 liters per minute (lpm) continuously by nasal canula. -There was an order for Duo-Neb (a combination of 2 bronchodilators that relax muscles in the airways and increase air flow to the lungs) 3 milliliters (ml) inhalant every 4 hours as needed (prn). There was no documentation indicating symptoms for administering prn. -There was an order for Albuterol (a bronchodilator used to prevent and treat difficulty breathing) 2 puffs inhaled every 4 hours prn wheezing. -There was an order for Pulmicort (an inhaled steroid used to control and prevent wheezing and shortness of breath by reducing swelling and irritation of the airways) 0.5mg inhaled twice daily. -There was an order for Atrovent (an inhaled medication used to control and prevent wheezing	{D 273}		

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and shortness of breath) 500 micrograms (mcg) inhaled 4 times daily.
-There was an order for Spiriva (a bronchodilator used to prevent bronchospasms) 18mcg inhaled daily.

Review of Resident #2's previous FL-2 dated 02/20/20 revealed diagnoses included diabetes myelitis type 2, diabetic peripheral neuropathy, chronic obstructive pulmonary disease, hypertension, osteoarthritis, and lumbar post laminectomy syndrome.

Review of Resident #2's current care plan dated 03/25/20 revealed:
-The resident was ambulatory with a cane, had limited strength of the upper extremities and shortness of breath, and required a nebulizer.
-There was no documentation that indicated the resident was on oxygen.
-The resident required limited staff assistance with toileting, ambulation, bathing, dressing, and grooming.
-The care plan was not signed by the assessor or the Primary Care Provider (PCP).

Review of Resident #2's current Licensed Health Professional Support (LHPS) evaluation dated 02/12/21 revealed:
-The resident was unable to ambulate long distances due to shortness of breath and was O2 dependent at 3 lpm via nasal canula.
-Staff monitored the resident's O2 for safe administration.
-There was documentation to continue with the residents existing care plan.

a. Observation of Resident #2 on 02/25/21 from 12:38pm - 12:47pm revealed:
-Resident #2 was sitting on his rollator at the

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nurse's station with the O2 tubing draped across his shoulders and around his neck.
-The other end of the O2 tubing was attached to Resident #2's portable O2 cylinder on the rollator.
-The resident's portable O2 cylinder was empty with the regulator needle in the red area indicating need for replacement.
-Resident #2's face was cyanotic (bluish or grayish color of the skin caused when oxygen-depleted blood circulates through the skin).
-Resident #2's speech was short and broken.
-The resident's respirations were short and heavy with use of abdominal muscles.
-The residents O2 levels were 73%.

Interview with Resident #2 on 02/25/21 at 12:38pm revealed:
-His O2 cylinder had been empty for 15 minutes.
-He walked to the nurse's station to get another O2 cylinder.

Interview with a medication aide (MA) on 02/25/21 at 12:50pm revealed:
-O2 cylinders were to be checked every third shift to ensure they contained O2.
-He had never checked Resident #2's O2 cylinder.

Interview with the Resident Care Coordinator (RCC) on 02/25/21 at 1:15pm revealed:
-The MA on each shift was responsible for checking resident O2 cylinders to ensure they contained oxygen.
-There was nothing documented on the electronic medication administration record (eMAR) to prompt the MAs to check resident O2 cylinders.
-The MAs would not know to check residents' O2 cylinders because it was not documented on the eMAR.

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{D 273}	Continued From page 35 -There was no process in place to ensure residents' O2 cylinders did not run empty. -Resident #2's current FL-2 dated 02/08/21 contained an order for O2 2 lpm by nasal canula continuously. -Resident #2's current LHPS assessment dated 02/12/21 documented the resident was ordered O2 3 lpm by nasal canula. Interview with the Administrator on 02/25/21 at 1:40pm revealed there was no system in place to ensure the MAs checked residents' O2 cylinders to ensure they did not run out of O2. A second interview with the MA on 02/25/21 at 2:10pm revealed: -He knew Resident #2 was ordered O2 because he had seen the O2 concentrator in the resident's room. -He did not know how much O2 Resident #2 was ordered. -Resident #2 did not have an order for O2 documented in the eMAR. Interview with the LHPS nurse on 02/25/21 at 2:30pm revealed: -Resident #2 had chronic lung disease and had difficulty breathing. -Resident #2 ambulated with a rollator and required staff assistance with bathing because he had low endurance to activity. -Resident #2 was short of breath on exertion. Telephone interview with the RCC on 03/01/21 at 11:00am revealed: -Staff did not know how to monitor/check residents' O2 every shift because it was not on the eMAR. -She was responsible for ensuring staff checked O2 cylinders every shift to ensure they did not run	{D 273}		

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{D 273}	Continued From page 36 out of O2. -She was responsible for ensuring staff monitored/checked residents who were on O2. -She did not know how staff knew to monitor/check O2 cylinders every shift before 02/26/21 when discovered by the survey team because there was no process in place to ensure the O2 cylinders were monitored/check. -She did not know until 02/26/21 when discovered by the survey team that staff did not know who was responsible for ensuring residents did not run out of O2 every shift. -Staff should have been trained by the RCC to monitor/check O2 cylinders and residents every shift to be certain they did not run out of O2. -It was the responsibility of the Administrator to ensure the RCC trained staff to monitor residents on O2 and their O2 cylinders every shift. Telephone interview with the facility's Divisional Vice President of Operations (DVPO) on 03/01/21 at 1:45pm revealed: -O2 cylinders were to be checked each shift to ensure they were working properly and contained O2. -O2 cylinders should be changed out when the regulator needle was in the refill area because if not the resident may not have O2. -O2 cylinders were to be used when O2 dependent residents were out of their rooms or out of the facility. -O2 cylinder checks should be included on the eMAR so the MAs would know to check the O2 cylinders. Telephone interview with Resident #2's PCP on 02/25/21 at 2:37pm revealed it was expected for staff to check O2 cylinders every shift to prevent the cylinders from running out of O2.	{D 273}		

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{D 273}	Continued From page 37 b. Observation of Resident #2's feet on 02/24/21 at 5:13pm revealed: -The left 1st toenail was thick, dark yellow, jagged, elevated, and had a hole approximately 2mm in diameter with a jagged parameter in the middle right of the nailbed. The hole was brown to a darker yellow color. -The left 2nd - 4th nails were thick, white to cream in color, flaking, and extended approximately 2 millimeters (mm) past the tip of the toes. -The left 5th toenail was thick and dark yellow to light orange in color and was cut at an angle across the nail bed. -The left 5th toe crossed up and over on top of the left 4th toe. -The right 1st toenail was thick, jagged, and dark yellow to orange in color and white around the perimeter of the nailbed and nail. There was a black area to the left cuticle. -The right 2nd and 3rd toenails were thick, dark yellow, jagged, had white flakes, curved and extended past the tip of the toes. -The right 4th toenail was thick, yellow, and jagged. The right 5th toenail was thick, dark yellow to gray in color, jagged, had white flakes, curved and extended past the tip of the toe. -There was dry, cracked, black colored skin between the 1st - 2nd, 3rd - 4th, and 4th - 5th toes. Interview with a personal care aide (PCA) on 02/25/21 at 2:40pm who documented on various dates of Resident #2's activities of daily living (ADL) log for February 2021 revealed: -"Done" on the ADL log indicated she had performed the task herself. -Resident #2's feet were cracked, dry, and nails were jagged, long, and thick.	{D 273}		

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{D 273}	Continued From page 38 -She last saw Resident #2's feet today when she went in the resident's room. -She never told any staff about Resident #2's feet because the resident did not wear socks and other staff could see the resident's feet when he was walking. -She should have told the medication aide (MA) about Resident #2's feet. Telephone interview with Resident #2's Primary Care Provider (PCP) on 02/25/21 at 2:48pm revealed: -Resident #2 was a diabetic which placed him at risk for diabetic ulcers, infection, and limb amputations from poorly cared nail and foot care. -She expected Resident #2 to have been examined by a podiatrist because he was a diabetic. -Residents diagnosed with diabetes did not need a referral to see the facility's contracted podiatrist. -It was expected all residents with a diagnosis of diabetes to have been added to the list to be examined by the facility podiatrist. -She did not know Resident #2's toenails were thick, jagged, and yellow. -She did not know Resident #2 had a hole in the left 1st toe. -She expected to have been told by staff that Resident #2 had a hole in his left 1st toe and his toenails were thick, jagged, and yellow when first discovered. Interview with a medication aide (MA) on 02/25/21 at 2:55pm revealed: -Staff had not told him Resident #2 had thick, jagged, yellow toenails or a hole in the left great toe. -He expected to have been told of the condition of Resident #2's feet so he could have told the Resident Care Coordinator (RCC).	{D 273}		

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{D 273}	Continued From page 39 Telephone interview with the office Manager for the facility's contracted podiatrist on 02/25/21 at 3:00pm revealed: -It was expected all residents with a diagnosis of diabetes be added to the list of residents to be examined by the facility podiatrist. -A referral order was not needed for residents who were diagnosed with diabetes to be examined by the facility podiatrist. -It was the responsibility of the RCC to add residents with a diagnosis of diabetes to the to be examined by the facility podiatrist. -Resident #2 had never been examined by the facility's podiatrist. -The podiatrist was last in the facility November 2020. -The facility's podiatrist visit for January 2021 was canceled because the facility had a COVID-19 outbreak. Telephone interview with the Physician Assistant (PA) for the facility's contracted podiatrist on 02/25/21 at 3:15pm revealed: -Resident #2 had not been seen by podiatry. -Residents who had a diagnosis of diabetes were at increased risk of ingrown toenails which could cause a break in the skin; sores under the nailbed from the nails curving and growing into the toe; bacteria from dark moist places from wearing shoes or laying in the bed; and infection from catching toenails on bedding or socks, or pushing the nail against the inside of shoes. -Thick toenails could cause a decrease in space when wearing shoes, causing the nail to be pushed down which could cause pain even when wearing socks. -Nails could be caught on bedding which could cause the nail to be pulled from the nailbed. -If the nail was attached to the nail bed when	{D 273}		

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{D 273}	Continued From page 40 pulled off could cause pain and cellulitis of the nailbed (a serious bacterial infection that enters through a break in skin which causes swelling, pain, and redness requiring antibiotics that can be fatal). -Residents who had a diagnosis of diabetes were at increased risk of delayed wound healing and infection. -Infection could progress up the leg which could lead to amputations of the toe, foot, and leg. -It was expected residents who had a diagnosis of diabetes to be examined by podiatry to prevent complications. Interview with the Administrator on 02/25/21 at 3:34pm revealed: -She did not know how often podiatry made facility visits, when the last podiatry visit was, or when the next podiatry visit was scheduled. -A referral to see the podiatrist was not needed for residents who had a diagnosis of diabetes. -She expected all residents who had a diagnosis of diabetes to be placed on the list to be examined by the facility podiatrist. -There was no system in place for ensuring residents who had diabetes be examined by the facility's podiatrist. -She did not know why Resident #2 had not seen the facility's podiatrist. -She expected all PCAs and MAs to pay attention to the residents' feet and between their toes. -She expected the PCA to have told the MA about the condition of Resident #2's feet. -The MA should have told the RCC about Resident #2's feet so the resident could have been examined by the resident's PCP or the facility's podiatrist. Interview with the facility's Divisional Vice President of Operations (DVPO) on 02/25/21 at	{D 273}		

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{D 273}	Continued From page 41 3:35pm revealed: -Podiatry made facility visits every 3 months. -Residents with a diagnosis of diabetes did not need a referral or an order to see podiatry. -Residents with a diagnosis of diabetes should "automatically" be placed on the list to be examined by the facility's podiatrist. A second telephone interview with Resident #2's PCP on 02/26/21 at 2:37pm revealed: -Resident #2 could not reach the bottom of his feet to provider foot care. -She would have made certain Resident #2 was on the list to be examined by podiatry if the facility had told her the condition of Resident #2's toenails. -She would have referred Resident #2 to an outside podiatrist if the resident was unable to have been examined by the facility podiatrist. -She would have examined Resident #2's feet herself if the resident was unable to follow with an outside podiatrist. -Resident #2 was a diabetic which placed him at increased risk for skin breakdown, infection, and amputation. Telephone interview with the RCC on 02/26/21 at 3:41pm revealed staff were expected to report long toenails, thick yellow skin and toenails, and cracked skin to the MAs, the MAs were to report to the RCC, and the RCC would schedule the resident to see the facility podiatrist. c. Review of Resident #2's local hospital discharge summary dated 02/08/21 revealed: -Admission dates were from 02/02/21 - 02/08/21. -The resident was diagnosed with COVID-19 on 12/24/20 and admitted to the hospital previously on 01/04/21 for hypercapnia (a buildup of carbon dioxide in the blood stream caused by inadequate	{D 273}		

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respirations) respiratory failure.
-On 02/02/21 the resident was admitted from the emergency department (ED) for severe hypercapnia.
-Discharge diagnoses included acute respiratory failure, acute exacerbation of COPD, acute bronchopneumonia, pneumonia due to COVID-19, chronic hypercapnia respiratory failure.
-Discharge instructions were to follow with the Primary Care Provider (PCP) within 2 - 3 days of hospital discharge.
-There was an electronic signature.

Telephone interview with Resident #2's PCP on 02/26/21 at 2:37pm revealed:
-She did not know Resident #2 was to follow up within 2-3 days after his 02/08/21 hospital discharge.
-She expected the facility to have called her office to schedule a 2-3-day hospital follow up appointment with her for Resident #2.
-Resident #2 smoked which placed him at increased risk for COPD exacerbation which could require hospitalization.

Telephone interview with the Resident Care Coordinator (RCC) on 02/26/21 at 3:41pm revealed:
-She was "unsure" if the facility made Resident #2 a hospital follow up appointment with his PCP per the 02/08/21 hospital discharge summary.
-She was on leave until 02/09/21.
-She was not notified by the acting RCC (in her absence) of any outstanding referrals and/or orders when she returned on 02/09/21.
-There was no process in place to ensure resident follow up appointments were not missed.
-She did not see Resident #2's 02/08/21 hospital discharge summary until 02/25/21; she did not

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know Resident #2 needed a PCP hospital follow up appointment until 02/25/21.

Telephone interview with the Administrator on 03/01/21 at 10:39am revealed:
-She did not know Resident #2 was referred to the PCP for a 2 - 3-day hospital follow up per the 02/08/21 hospital discharge summary.
-She did not know who was responsible for ensuring hospital discharge summaries were reviewed to ensure follow up appointments were not missed because she had just started working at the facility around the 1st of February 2021.

Telephone interview with the previous Interim RCC on 03/01/21 at 11:37am revealed:
-The former Business Office Manager (BOM) was responsible for processing hospital follow ups/appointments.
-The previous Interim RCC did not know Resident #2 was ordered to have a PCP hospital follow up appointment within 2 - 3 days after hospital discharge per the 02/08/21 discharge summary.

d. Review of Resident #2's local hospital discharge summary dated 02/08/21 revealed:
-Discharge diagnoses were acute respiratory failure, acute exacerbation of COPD, acute bronchopneumonia, pneumonia due to COVID-19, chronic hypercapnia respiratory failure.
-Discharge instructions were to follow with the resident's pulmonologist within 2 - 3 weeks of hospital discharge.
-There was an electronic signature.

Telephone interview with Resident #2's Primary Care Provider (PCP) on 02/26/21 at 2:37pm revealed:
-She did not know Resident #2 was to have a

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{D 273}	Continued From page 44 pulmonology follow up appointment per the 02/08/21 hospital discharge summary. -She did not know if Resident #2's hospital pulmonology follow up appointment was made by the facility. -The facility was expected to schedule to pulmonology appointment per the hospital discharge summary. Telephone interview with the Resident Care Coordinator (RCC) on 02/26/21 at 3:41pm revealed: -Resident #2 did not have an appointment scheduled with the pulmonologist. -There was no process in place to ensure resident referrals/orders on hospital discharge summaries were not missed. -She did not see Resident #2's 02/08/21 hospital discharge summary until 02/25/21. -She did not know Resident #2 needed a hospital pulmonary follow up appointment until 02/25/21. -She would call on 03/01/21 to make Resident #2 an appointment with a pulmonologist. -The RCC was responsible for processing all orders. -The referral process was shared between the RCC and the transporter. -There was no process in place to ensure the transporter scheduled needed appointments. Telephone interview with the Administrator on 03/01/21 at 10:39am revealed: -She did not know Resident #2 was referred to a pulmonologist for a follow up per the 02/08/21 hospital discharge summary. -She did not know who was responsible for ensuring hospital discharge summaries were reviewed to ensure referrals were not missed because she began working at the facility around the 1st of February 2021.	{D 273}		

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{D 273}	Continued From page 45 Telephone interview with the previous Interim RCC on 03/01/21 at 11:37am revealed: -The former Business Office Manager (BOM) was responsible for processing resident follow up appointments. -He did not remember a hospital order for Resident #2 to have a follow up with the pulmonologist. -He would have made the referral for Resident #2 to see the pulmonologist if he had of known about the referral order. Attempted inteview with the former BOM on 02/25/21 at 10:15am was unsuccessful. 2. Review of Resident #5's current FL-2 dated 12/23/20 revealed: -Diagnoses included congestive heart failure, COVID-19, hypertension, and coronary artery disease. -The resident was independently ambulatory and continent of urine and bowel. Review of Resident #5's current care plan dated 02/12/20 revealed: -The resident was independent with toileting and ambulation. -The resident required limited assistance with bathing, dressing, and grooming. -The resident required supervision/set up for transfers. a. Observation of Resident #5 on 02/24/21 at 10:40am revealed: -Resident #5 was walking at a quick pace down the hall to his room and would stop and hold onto the hand rails. -The resident's speech was short and broken. -The resident would purse his lips as he	{D 273}		

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breathed.
-He said he was short of breath and he got short of breath "frequently" and has told staff.
-He did not remember which staff he had told or how often he got short of breath.
-Resident continued walking to his room.
-He sat down on his bed and after 2 to 3 minutes his shortness of breath slowed upon resting.
-He did not have diabetes.

A second observation of Resident #5 on 02/24/21 at 4:30pm revealed:
-The resident was sitting in a chair located across from the nurse's station.
-The resident's respirations were even and nonlabored.

Interview with Resident #5 on 02/24/21 at 4:30pm revealed:
-He was not short of breath and was not having breathing difficulty.
-He would become short of breath when he was tired.

Review of Resident #5's progress notes, faxed provider notifications, and PCP visit notes revealed there was no documentation the resident's PCP was notified the resident had experienced shortness of breath on 02/24/21 or other dates.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 02/26/21 at 2:37pm revealed:
-She had never been told Resident #5 experienced shortness of breath.
-Resident #5 did not have a history of shortness of breath.
-She last saw Resident #5 on 02/17/21 and he was not short of breath at that visit.

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{D 273}	Continued From page 47 -She observed Resident #5 walking in the hallway on 02/17/21 and he did not display shortness of breath. -She expected to have been notified Resident #5 was short of breath on 02/24/21. -If notified, she would have evaluated Resident #5 the same week for cardiac issues. -Resident #5 had a history of congestive heart failure without shortness of breath. -Not notifying her the resident had shortness of breath placed the resident at risk for developing cardiac issues which could lead to pulmonary edema or a heart attack. Telephone interview with a medication aide (MA) on 02/26/21 at 4:00pm revealed: -She saw Resident #5 having shortness of breath while walking in the hall on 02/24/21. -Resident #5 told he her could not catch his breath. -She had Resident #5 sit down near the nurse's station and gave him a soda to drink to help with his breathing. -Resident #5 did not have shortness of breath after sitting down and drinking a soda. -Resident #5 had not had shortness of breath other than on 02/24/21. -She did not remember the last time Resident #5 told her he was short of breath. -She did not notify anyone Resident #5 was short of breath while walking in the hall on 02/24/21 because the resident was no longer short of breath after resting, -She did not notify Resident #5's PCP the resident was short of breath on 02/24/21 because the resident was no longer short of breath after resting. -She should have notified Resident #5's PCP the resident was short of breath.	{D 273}		

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{D 273}	Continued From page 48 Telephone interview with the Resident Care Coordinator (RCC) on 03/01/21 at 9:45am revealed: -The MA was to notify the RCC when a resident was short of breath then the RCC would tell the PCP. -It was the responsibility of the RCC to notify the PCP of a resident change in condition. -The MA should have called the PCP when she observed Resident #5 having shortness of breath since she did not tell the RCC. Telephone interview with the Administrator on 03/01/21 at 10:39am revealed: -The MA was to notify the RCC when a resident was short of breath, the RCC would notify the resident's PCP immediately because it would be a change in condition for the resident. -She expected Resident #5's PCP to have been notified of the MA's observation and resident's complaint of shortness of breath immediately on 02/24/21. Telephone interview with the facility's Divisional Vice President of Operations (DVPO) on 03/01/21 at 1:58pm revealed she expected the MA to have notified Resident #5's PCP "immediately" when the resident was observed having and reported shortness of breath. Attempted telephone interview with Resident #5's guardian on 03/01/21 at 9:40am was unsuccessful. b. Review of Resident #5's podiatry visit note dated 11/12/20 revealed: -Diagnoses included infection (not specified), onychogryphosis (a nail disease that causes one side of the nail to grow faster than the other which are thick and curvy), onychocryptosis (a condition	{D 273}		

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where the corner or side of toenail grows into the flesh), and onychomycosis (a nail fungus causing thick, brittle, jagged, crumbly nails).
-Four calluses were shaved, 10 toenails debrided.
-It was documented professional treatment of the toenails and keratotic lesions (rough scaly patches on the skin) was required to relieve pain due to pressure.
-The resident was to be treated in 60 days for foot care due to symptomatic conditions, or sooner if complications developed.

Review of Resident #5's activity of daily living (ADL) log dated February 2021 revealed:
-Nail care was documented performed on 02/06/21, 02/13/21, 02/21/21 daily.
-Foot care was documented performed from 02/01/21 - 02/24/21.

Observation of Resident #5 on 02/24/21 at 9:45am upon entering the facility revealed:
-Resident was sitting in a chair up at the front hallway wearing flip-flops type sandals.
-His feet were observed to be dry, ashy, and flaky.
-The left foot was in worse condition that the right foot.
-The toenails on the left foot were jagged, thickened, overgrown and discolored.
-The toenails on his right foot were overgrown and jagged in shape.
-The middle, fourth and last toenails on the right foot were jagged, thickened and discolored.

A second observation of Resident #5's feet on 02/25/21 at 11:09am revealed:
-Both feet were swollen, ashy, and dry.
-The left 1st - 4th toenails were thick, jagged, and extended past the tip of the toes appoximately 2 millimeters (mm).

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{D 273}	Continued From page 50 -The left 1st toenail was dark gray in color and was elevated above the nailbed. -The skin on top of the left 1st - 4th toenails was white, dry, and flaking. -The left 1st - 4th cuticles were white, dry, flaking, and thick. -The bottom left 5th toe was black from the tip of the toe under the nail for approximately 3mm. -The right 1st - 4th toenails were thick and extended past the tip of the toes approximately 3mm. -The skin on the bottom of the right foot was dry, thick, yellow, and cracked. -The skin on the bottom of the left foot was dry, thick, yellow and cracked. -The left and right heels appeared as elephant skin, dry, thick, yellow, and cracked. Interview with Resident #5 on 02/25/21 at 11:09am revealed: -He was independent with bathing. -He needed staff assistance to put on and remove socks. -He needed staff assistance to wash his feet. -He needed staff assistance for nail care to his feet. -He had not asked staff to help him wash his feet or perform nail care. -He had dry skin to his feet that would not go away. -The last time his toenails were cut was by podiatry. He could not remember when. -A personal care aide (PCA) had cut his toenails in the past but could not remember when. -He could not remember the last time staff looked at his feet. -His feet did not hurt. -He could not remember the last time he saw podiatry.	{D 273}		

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{D 273}	Continued From page 51 Interview with a personal care aide (PCA) on 02/25/21 at 2:40pm who documented on various dates of Resident #5's activities of daily living (ADL) log for February 2021 revealed: -"Done" on the ADL log indicated she had performed the task herself. -Resident #5 was independent with all ADL's. -She had never assisted Resident #5 with foot or nail care. -Resident #5 had never asked her to assist with foot or nail care. -She had never asked Resident #5 if he needed help with foot or nail care. -She last saw Resident #5's feet today when he was laying down. -Resident #5's feet looked "horrible", had dead skin, crumbling and cracked skin. -She last told a MA about 4 months ago Resident #5's feet looked "horrible". -She did not tell anyone today the condition of Resident #5's feet because he didn't wear shoes and other staff see his feet when he walks. Telephone interview with the office Manager for the facility's contracted podiatrist on 02/25/21 at 3:00pm revealed: -The podiatrist was last in the facility November 2020. -Resident #5 was last seen by podiatry in November 2020. -The facility podiatrist visit for January 2021 was canceled because the facility had a COVID-19 outbreak. -The facility did not notify the podiatrist the condition of Resident #5's feet. -It was expected the facility to have notified the podiatrist of Resident #5's long thick toenails, and dry, cracked skin. -If notified, the podiatrist could have made an emergency visit within 1 week if in the vicinity of	{D 273}		

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{D 273}	Continued From page 52 the facility if it was out of the 2-week window of last having COVID-19 positive cases in the facility. -The facility's podiatrist was usually in the area monthly. Telephone interview with the Physician Assistant (PA) for the facility's contracted podiatrist on 02/25/21 at 3:15pm revealed: -He did not have Resident #5's podiatry notes to refer to. -Thick toenails could cause a decrease in space when wearing shoes causing the nail to be pushed down which could cause pain even when wearing socks. -Nails could be caught on bedding which could cause the nail to be pulled from the nailbed. -If the nail was attached to the nail bed when pulled off could cause pain and cellulitis of the nailbed (a serious bacterial infection that enters through a break in skin which causes swelling, pain, and redness requiring antibiotics that can be fatal). Interview with the Administrator on 02/25/21 at 3:34pm revealed: -She did not know how often podiatry made facility visits, when the last podiatry visit was, or when the next podiatry visit was scheduled for. -She expected all PCAs and MAs to pay attention to the residents' feet and between their toes. -She expected the PCA to have notified the MA about Resident #5's feet and nails, the MA to have notified the RCC, and the RCC to have notified the podiatrist. Interview with the Divisional Vice President of Operations (DVPO) on 02/25/21 at 3:35pm revealed podiatry made facility visits every 3 months.	{D 273}		

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{D 273}	Continued From page 53 Telephone interview with the Resident Care Coordinator (RCC) on 02/26/21 at 3:41pm revealed staff were to report long toenails, thick yellow skin and toenails, and cracked skin to the MAs, the MAs were to report to the RCC, and the RCC would schedule the resident to see the facility podiatrist. -The PCA should have notified the MA about Resident #5's feet and nails so podiatry could have been notified. Attempted telephone interview with Resident #5's guardian on 03/01/21 at 9:40am was unsuccessful. 3. Review of Resident #1's current FL-2 dated 05/29/20 revealed: -Diagnoses included congestive heart failure, diabetes mellitus, hypertension, depression, cerebral infarction (stroke), heart disease, pulmonary sarcoidosis (inflammatory process of the lungs), and muscle weakness. -The resident was oriented. -The resident was semi-ambulatory with a walker and wheelchair. -There was a physician's order to check blood sugar twice daily. Review of Resident #1's care plan dated 06/02/20 and signed by provider on 06/01/20 revealed: -The resident was ambulatory with a walker and wheelchair. -The resident had limited strength in her right arm and leg. -The resident needed limited assistance with toileting, ambulation, bathing, dressing, grooming, and transferring. a. Review of Resident #1's hospital provider	{D 273}		

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{D 273}	Continued From page 54 discharge summary note dated 01/25/21 revealed: -Her admit date was 01/21/21 and she was discharged on 01/25/21. -Her primary problem on admission was documented as microcalcification of the left breast on mammography. -She received an ultrasound guided breast biopsy for suspicious calcifications and was then admitted to the hospital for hypoxia (absence of enough oxygen in the body tissues to sustain bodily functions). -Her other active problems included sarcoidosis and acute respiratory failure with hypoxia. -Her oxygen was unable to be weaned in the post anesthesia care unit after the breast biopsy. -Her chest x-ray showed some vascular congestion. -Her sarcoidosis had been previously followed but not recently. -Her computerized tomography scan (CT) showed chronic lung disease consistent with sarcoidosis. (A CT scan is a set of x-rays taken at different angles to produce a 3-D image.) -She had a history of right middle lobe lung resection. -A walking oxygen test was done, and she required oxygen on exertion. -Her hospital course was complicated by a left breast hematoma making some imaging of her chest difficult to evaluate. -She was discharged with oxygen and a referral to pulmonology as outpatient. -Instructions included to follow up on lung function with a pulmonologist; her sarcoid lung disease had progressed, and she now appeared to be having chronic respiratory failure. Review of Resident #1's hospital after visit summary dated 01/25/21 revealed she was on	{D 273}		

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{D 273}	Continued From page 55	{D 273}		

continuous oxygen to run via nasal cannula at 2 liters per minutes via a portable oxygen tank and concentrator.

Review of Resident #1's pulmonologist visit note dated 02/08/21 revealed:
-She was referred and seen for a history of sarcoidosis and lobectomy (lung resection) to be worked up for exertional fatigue and respiratory failure due to hypoxia and exertional dyspnea (difficulty breathing).
-She received a pulmonary function and a 6-minute walking test in the clinic that day.
-She was to have an overnight pulse oximetry test scheduled to rule out nocturnal hypoxemia (low oxygen values in the blood).
-She was to continue the use of her oxygen at night.

Review of Resident #1's pulmonology after visit summary dated 02/08/21 revealed:
-She was seen by the pulmonologist for pulmonary sarcoidosis.
-She was to follow up with the pulmonologist on 03/10/21.

Telephone interview with a medical assistant (MA) at Resident #1's pulmonologist's office on 02/26/21 at 3:18pm revealed:
-Resident #1's pulse oximetry test ordered on 02/08/21 had not been scheduled yet.
-She had tried to contact the facility and Resident #1 to schedule the pulse oximetry test and to verify if Resident #1 was experiencing any oxygen desaturating during the night hours.
-There were "several" phone attempts made by phone to contact the facility and Resident #1 without success.
-She was unable to provide the specific time and dates of the phone contact attempts to the facility

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{D 273}	Continued From page 56 to schedule the overnight pulse oximetry test. Telephone interview with the Resident Care Coordinator (RCC) on 02/26/21 at 3:41pm revealed: -She was out of office at the time the referral for the overnight pulse oximetry for Resident #1 was ordered on 02/08/21. -She returned as acting RCC on 02/09/21. -She did not know the process for appointment referrals and orders prior to her return on 02/09/21. -Upon her return, when she received referral orders, the transporter or her would process them within 24 hours. -Upon her return, she was responsible for overseeing the processing and follow through of all orders which included the processing of Resident #1's orders from her pulmonary visit dated 02/08/21. -She or the transporter would schedule any appointments and write it in a book or tell each other. -She did not routinely check behind the transporter to ensure appointments were made. -She was unaware of an overnight pulse oximetry referral from the pulmonologist on 02/08/21 for Resident #1. -There was no process in place to notify her of pending referrals while she was out of office. -The interim RCC who covered her position while she was out of office was responsible for referrals and orders during that time period. -There was no process to verify and ensure all resident appointments were made and carried out. Telephone interview with Resident #1's Primary Care Provider (PCP) on 03/01/21 at 9:46am revealed:	{D 273}		

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{D 273}	Continued From page 57 -She was unaware Resident #1 needed an overnight pulse oximetry test scheduled, as ordered by the pulmonologist on 02/08/21. -She did not know Resident #1 was on oxygen. -There was a lack of communication regarding the resident from the facility. -She could not recall any further details about Resident #1 as she was driving during the interview and did not have access to the resident's records. Telephone interview with the interim RCC on 03/01/21 at 11:37am revealed: -He acted as interim RCC at the facility around the dates of mid-January 2021 to early February 2021. -He recalled when Resident #1 returned to the facility after hospitalization on 01/25/21 with continuous oxygen use. -He did not recall an order or referral for Resident #1 for the overnight pulse oximetry test ordered on 02/08/21. -He had not received any telephone calls to schedule the overnight pulse oximetry test for Resident #1. -He was responsible for processing office or hospital visit notes for new orders and referrals. -Either the transporter or resident would give the notes to the RCC for processing upon arrival back to the facility. Telephone interview with the Administrator on 03/01/21 at 12:59pm revealed: -She had not seen the office note dated 02/08/21 and was unaware of the need for an appointment for an overnight pulse oximetry test that needed to be scheduled for Resident #1. -She expected appointments to be scheduled and completed through the RCC "as soon as possible" so that she was aware of what was in	{D 273}		

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{D 273}	Continued From page 58	{D 273}		

place for residents' care and she could oversee follow through.
-She did not know why Resident #1's pulse oximetry test was not scheduled.

Telephone interview with the facility's Divisional Vice President of Operations (DVPO) on 03/01/21 at 1:35pm revealed:
-She was unaware of the order for an overnight pulse oximetry test dated 02/08/21 for Resident #1.
-She was "not sure" why Resident #1's pulse oximetry test was not scheduled.
-She would have expected the interim RCC filling in on that date to schedule the appointment for the overnight pulse oximetry test.

Second telephone interview with a medical assistant at Resident #1's pulmonologist's office on 03/01/21 at 4:38pm revealed:
-Resident #1's overnight pulse oximetry test was to determine if Resident #1 was experiencing nocturnal hypoxemia which was defined as a decrease in oxygen saturation during sleep.
-Resident #1 had a history of pulmonary sarcoidosis, lobectomy, and hospitalization in January 2021 related to low oxygen levels which was concerning that the overnight pulse oximetry test was not scheduled yet.
-It was very "dangerous" for Resident #1 to not have the ordered test completed yet because Resident #1's oxygen level could decrease while she slept, and she could go into respiratory distress.
-Resident #1's overnight pulse oximetry test ordered 02/08/21 had not been scheduled yet.
-Per an office note dated 02/11/21 in the computer system, another medical assistant at Resident #1's pulmonology office had documented she tried to reach facility personnel

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and Resident #1 several times to schedule the overnight pulse oximetry test.
-Specific dates and times of contact attempts from the medical assistant were not noted on the 02/11/21 office note.
-She spoke with a staff member at the facility on Friday, 02/26/21, related to the scheduling of Resident #1's overnight pulse oximetry test.
-She could not recall the staff member at the facility with whom she spoke with on Friday, 02/26/21.
-The staff member at the facility had reassured her they would call the pulmonology office back with Resident #1's durable medical equipment (DME) provider which was required information to proceed with scheduling Resident #1's overnight pulse oximetry test.
-As of 03/01/21, she had not received a return call from the facility with the name of Resident #1's DME provider.
-Prior to the end of the business day at 5:00pm on 03/01/21, she planned to contact the facility again to follow-up and try and obtain Resident #1's DME information.

b. Review of Resident #1's primary care provider (PCP) visit note dated 12/02/20 revealed:
-Resident #1's had diagnoses including type 2 diabetes mellitus.
-Resident #1 was to be referred to in-house podiatry.
-Resident #1 was to follow up with PCP in 2-3 months.

There was no documentation the PCP was notified of the condition of Resident #1's toenails.

Observation of Resident #1's feet on 02/25/21 at 2:17pm revealed:
-Both of her feet were dry with flakey skin.

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{D 273}	Continued From page 60 -The pad of the right first toe was reddened on the bottom and the toenail was yellowed, thickened and long, curling over the tip of the toe. -The third toenail on her right foot was yellowed, thickened, long and jagged. -The first toenail of her left foot was long. Interview with Resident #1 on 02/25/21 at 2:17pm revealed: -She had never seen a podiatrist. -She was not seen the last time the podiatrist came to the facility because they told her she "wasn't signed up". -The last time the podiatrist was at the facility was prior to Halloween 2020. -She was going to sign up to be seen the next time the podiatrist came, but they had not returned. -Her feet were "well kept" prior to admission and she used to get pedicures. -She had never received any assistance with foot care from the facility since her admission. -She could bath herself and put lotion on her own feet, so the facility staff had not seen her feet. -The length of her toenails was not painful, but she "just wants them gone". Review of Resident #1's personal care logs from 01/01/21 to 02/24/21 revealed: -Skin care included providing foot care. -It was documented by facility staff that they provided skin care to Resident #1 every day, 3 times per day, except for when Resident #1 was out of the facility. -It was documented by facility staff that Resident #1 was provided nail care once per week on Wednesdays. -There were no exceptions documented of nail care provided.	{D 273}		

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{D 273}	Continued From page 61 There was no documentation in the resident record of Resident #1 visiting podiatry for toenail care. There was no documentation in the resident record of the facility contacting Resident #1's primary care provider to report the condition of her nails. Interview with the Resident Care Coordinator on 02/25/21 at 10:38am revealed: -She did not currently have all the residents' primary care provider (PCP) visit notes in their records yet. -She had only been at the facility for three weeks and was trying to go through piles of previous paperwork. -She was addressing residents' records one by one. -It was the facility's policy to have all residents with diabetes seen by in-house podiatry. -Resident #1 was not on the current podiatry list but would be included as a podiatry referral for the upcoming podiatry visit on 03/11/21. -She was not sure why Resident #1 had not been seen by podiatry during previous onsite visits. Telephone interview with a receptionist at the facility's contracted podiatry office on 02/25/21 at 3:10 pm revealed that Resident #1 was not a patient at their office and was not scheduled to be "evaluated" by their office. Telephone interview with a Physician Assistant (PA) at the facility's contracted podiatry office on 02/25/21 at 3:15pm revealed: -People with diabetes were more prone to get in-grown toenails that could curve around toes and cut into the skin. -Bacteria liked warm dark places like a shoe or	{D 273}		

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{D 273}	Continued From page 62 bed. -Infection could result if long toenails were to catch on bedding or socks. -Shoes could push against long toenails causing pain. -He had seen open sores develop under long toenails he had cut before. -People with diabetes are more prone to infection from bacteria could cause amputation of toes or worse; amputation to the knee or higher could be possible. -People with diabetes have increased blood sugar creating a bigger risk of infection and delayed wound healing. -All resident with diabetes were recommended to receive podiatry services for prophylactic (preventative) care. Interview with the Administrator on 02/25/21 at 3:35pm revealed: -She did not know when or how often the podiatry provider was supposed to come to the facility. -All residents with diabetes should be on the schedule to see in-house podiatry. -It was expected for personal care aides (PCAs) to provide foot care to resident's feet paying attention to issues on the feet and between the toes, and report any issues to the RCC so they could be followed up by and seen by the podiatry provider. -She was unaware Resident #1 had never seen podiatry and was not on the list to see podiatry. Interview with the facility's Divisional Vice President of Operations (DVPO) on 02/25/21 at 3:35pm revealed: -The in-house podiatry provider came quarterly, meaning every 3 months. -Residents with diabetes should "automatically" be placed on the list to be seen by podiatry; no	{D 273}		

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(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 63 order was necessary. Telephone interview with a medication aid (MA) on 02/26/21 at 1:02pm revealed: -She had seen Resident #1's feet once or twice, but the resident usually had her socks on. -None of the PCAs had reported any issues to her regarding Resident #1's feet. Telephone interview with a second PCA on 02/26/21 at 1:40pm revealed: -Resident #1 bathed herself and she would offer the resident help as needed or requested. -She had last seen Resident #1's feet on 02/25/21 and her toenails need to be cut. -She had not reported the overgrowth of Resident #1's toenails to anyone because she assumed the facility's contracted podiatry provider would cut the resident's toenails the next time they came. -She had never been told to report skin or nail issues to the MA or the RCC. Telephone interview with a second MA on 02/26/21 at 4:26pm revealed: -None of the PCAs had reported any abnormal skin assessments for Resident #1 to her. -She expected the PCAs to report abnormal skin or nail assessments to her. -She was not aware of the condition of Resident #1's toenails. Telephone interview with the RCC on 02/26/21 at 3:50pm revealed: -She expected the PCAs to document long toenails and thickened toenails and report this information to the MA or RCC for follow up. -She expected all foot care needs to be reported to her, especially for residents with a diagnosis of diabetes, so she could report that information to	{D 273}		

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{D 273}	Continued From page 64 the PCP or podiatry provider and ensure they received evaluation and care. Telephone interview with Resident #1's PCP on 03/01/21 at 9:46am revealed: -The facility had an in-house podiatry provider and she was unsure when they were last at the facility. -She would have expected the facility to report Resident #1's overgrowth of toenails to her. Telephone interview with the Administrator on 03/01/20 at 12:59pm revealed: -She was unaware of the condition of Resident #1's toenails. -She did not know why Resident #1 was not referred to in-house podiatry. -She was unaware Resident #1 was a diabetic and would have expected the resident to be on the podiatry list. Telephone interview with the DVPO on 03/01/21 at 1:35pm revealed: -She would have expected Resident #1's toenail overgrowth to be reported to the MA or RCC to bring attention to the need of a podiatry referral. -She did not know why Resident #1 was not referred to the podiatrist. -All residents with diabetes must be seen by the podiatrist because staff could not cut diabetic residents' toenails. -If reported, the facility's contracted nurse could have looked at Resident #1's feet and provided guidance on what to do to care for the resident's feet and toenails. 4. Review of Resident #3's current FL2 dated 06/01/20 revealed diagnoses included hypertension and dementia.	{D 273}		

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{D 273}	Continued From page 65 Review of Resident #3's care plan dated 11/09/20 revealed: -Resident #3 used a walker for ambulation. -Resident #3's respirations were normal. Review of Resident #3's progress notes dated 01/25/21 - 02/16/21 revealed there was no documentation of Resident #3 having any shortness of breath. Observation of Resident #3 on 02/25/21 at 9:15am revealed Resident #3 was having labored respirations and audible wheezing after walking to unlock the door. Interview with Resident #3 on 02/25/21 at 9:15am revealed: -She had shortness of breath when she got up and moved around. -She did not know why she had shortness of breath. -She told the staff at the hospital when she went to the emergency department (ED) after she fell (could not recall when)but they did not do anything about the shortness of breath. -She had told someone at the facility but could not remember who or when she told them. Interview with the medication aide (MA) on 02/25/21 at 9:34am revealed: -He had never witnessed any shortness of breath with Resident #3. -No one had made him aware of Resident #3 having shortness of breath. -He would check Resident #3's pulse oximetry. Interview with the same MA on 09/25/21 at 10:27am revealed: -Resident #3 was no longer shortness of breath. -Resident #3's pulse oximetry was 97.	{D 273}		

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{D 273}	Continued From page 66 Observation of Resident #3 on 02/25/21 at 9:40am revealed: -She was sitting on her rollator. -She did not have any labored respirations or audible wheezes. Another interview with Resident #3 on 02/25/21 at 9:40 revealed: -She was feeling better. -She was no longer short of breath. Interview with a personal care aide (PCA) on 2/25/21 at 2:19pm revealed: -She was aware Resident #3 had shortness of breath when she was up moving around. -This was something she has been having for a while. -She had not told anyone about Resident #3's shortness of breath. -She thought the MA's knew about Resident #3's shortness of breath because the resident would walk down the hall. Telephone interview with Resident #3's primary care provider (PCP) on 02/26/21 at 11:57am revealed: -She was not aware Resident #3 had shortness of breath with exertion. -She had no diagnoses of respiratory issues or congestive heart failure (CHF). -Her concerns would be that she would not know if Resident #3 was in CHF or having respiratory issues from having had COVID-19. -She would expect to be notified of shortness of breath because she would need a chest x-ray to see what was going on with her lungs. -Resident #3 having shortness of breath could lead to her being hospitalized or even death.	{D 273}		

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{D 273}	Continued From page 67 Interview with the Resident Care Coordinator (RCC) on 03/01/21 at 9:58am revealed: -When a PCA noticed a resident having shortness of breath she should report it to the MA immediately. -The MA should check the resident and notify the RCC and the PCP. -She had not been notified regarding Resident #3 having shortness of breath. Interview with the Administrator on 03/01/21 at 10:08am revealed: -The PCA should have notified the MA immediately if she was aware Resident #3 was having shortness of breath. -The MA would then check Resident #3 and notify the RCC and the PCP immediately. -The concern would be that there was a change in Resident #3's condition and may need to be sent out to the emergency department (ED). -She had not been made aware Resident #3 was having shortness of breath. -She and the RCC were on call 24 hours a day and were to be contacted with any issues. -Once she or the RCC was made aware of the residents' issue then they could also contact the PCP. -There was an on-call number to call for the PCP on the weekend and at night. Interview with the Divisional Vice President of Operations (DVPO) on 03/01/21 at 1:35pm revealed: -The PCA should have notified the MA or RCC about Resident #3's shortness of breath. -The MA or RCC should have notified the PCP. -The PCP should be notified so she could evaluate Resident #3.	{D 273}		

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{D 273}	Continued From page 68 The facility failed to have established systems in place to ensure the provision of referral and follow up for health care service for 4 of 5 sampled residents (#1, #2, #3, #5). Resident #2 who had diagnoses including chronic obstructive pulmonary disease (COPD), was dependent on continuous oxygen, and was hospitalized from 02/02/21-02/08/21 for diagnoses including acute respiratory failure, acute COPD exacerbation, and pneumonia due to COVID-19 did not follow up with the primary care provider (PCP) as ordered within 2-3 days of hospital discharge and did not follow up with a pulmonologist within 2-3 weeks of hospital discharge which placed the resident at increased risk for recurrent COPD exacerbation and hospitalization. Resident #1 who had diagnoses including pulmonary sarcoidosis and congestive heart failure (CHF), and a medical history of right middle lobe lung resection, and was hospitalized from 01/21/21-01/25/21 for diagnoses including hypoxia did not have coordination of care related to scheduling an overnight pulse oximetry test as ordered by the pulmonologist at a post hospitalization follow up visit completed on 02/08/21, resulting in the pulmonologist being unable to determine if the resident was having a decrease in oxygen saturation in the blood during sleep and placed the resident at risk for respiratory distress. The facility failed to notify Resident #5's PCP of the resident exhibiting episodes of shortness of breath. The resident had a history of CHF. The failure to notify the PCP resulted in the PCP not evaluating the resident for other cardiac diagnoses and placed Resident #5 at risk for pulmonary edema (fluid in the lungs) and heart attack. Resident #1 and Resident #2 both had diagnoses which included diabetes were not evaluated and or treated by podiatry resulting in both residents being at increased risk for	{D 273}		

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{D 273}	Continued From page 69 ingrown toenails, skin breakdown, infection, and progression of infection up the leg which could lead to amputations of toes, a foot, and or a leg due to altered wound healing. The facility's failures resulted in substantial risk of death, neglect and serious physical harm to the residents which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-21 on February 5, 2021 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 31, 2021.	{D 273}		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed ensure oxygen was administered as ordered and failed to implement and maintain systems for documenting oxygen administration and communication of oxygen administration orders to staff for 2 of 2 sampled residents (#1, #2) with orders for oxygen use.	D 358		

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D 358	Continued From page 70 The findings are: 1. Review of Resident #2's current FL-2 dated 02/08/21 revealed: -There was a diagnosis of acute respiratory failure. -The resident was ambulatory and on oxygen (O2) 2 liters per minute (lpm) nasal canula continuously. Review of Resident #2's previous FL-2 dated 02/20/20 revealed diagnoses included diabetes mellitus type 2, diabetic peripheral neuropathy, chronic obstructive pulmonary disease (COPD), hypertension, osteoarthritis, and lumbar post laminectomy syndrome. Review of Resident #2's current care plan dated 03/25/20 revealed: -The resident was ambulatory with a cane, had limited strength of the upper extremities and shortness of breath, and required a nebulizer. -The oxygen section was blank and did not have documentation related to the resident's O2 orders, administration, or how staff monitored or documented the resident's oxygen use. -The care plan was not signed by the assessor or the Primary Care Provider (PCP). Observation of Resident #2 on 02/25/21 at 12:30pm revealed: -The resident was wearing a nasal canula attached to his room O2 concentrator. -His O2 concentrator was on and set at 2.5 lpm. Review of Resident #2's electronic medication administration record (eMAR) dated January 2021 revealed there was no entry or documentation of O2 administration.	D 358		

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D 358	Continued From page 71 Review of Resident #2's eMAR dated February 2021 revealed there was no entry or documentation of O2 administration. Review of Resident #2's current Licensed Health Professional Support (LHPS) evaluation dated 02/12/21 revealed: -The resident transferred without assistance, used a rollator for ambulation assistance, was unable to ambulate long distances due to shortness of breath, and was O2 dependent at 3 lpm via nasal canula. -Staff monitored the resident's O2 for safe administration. -Staff competency was validated for ambulation, rollator, nebulizers, and oxygen. Interview with the LHPS nurse on 02/25/21 at 2:30pm revealed: -Resident #2 had chronic lung disease and had difficulty breathing. -Resident #2 was short of breath on exertion. -She must have made a "mistake" documenting Resident #2's O2 amount (3 lpm) on the residents LHPS assessment. Interview with a medication aide (MA) on 02/25/21 at 2:10pm revealed: -He knew Resident #2 was ordered O2 because he had seen the O2 concentrator in the resident's room. -He did not know how much O2 Resident #2 was ordered. -Resident #2 did not have an entry or order for O2 documented in the eMAR. Interview with the Resident Care Coordinator (RCC) on 02/25/21 at 1:15pm revealed: -Resident #2's current FL-2 dated 02/08/21 contained an order for O2 2 lpm by nasal canula.	D 358		

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-Resident #2's current LHPS assessment dated 02/12/21 documented the resident was ordered O2 3 lpm.
-She was concerned that Resident #2's O2 concentrator was set on 2.5 lpm because it was not the ordered amount per the FL-2 dated 02/08/21.
-The MA was expected to review Resident #2's current FL-2 to ensure the resident was administered the correct amount, route, and frequency of O2.

Telephone interview with Resident #2's PCP on 02/26/21 at 2:37pm revealed:
-The resident contracted COVID-19 in December 2020 and required O2 continuously.
-She expected the facility to follow orders as written.

Refer to the interview with the Resident Care Coordinator (RCC) on 02/25/21 at 1:15pm.

Refer to the interview with the Administrator on 02/25/21 at 1:40pm.

Refer to the Interview with the LHPS nurse on 02/25/21 at 2:30pm.

Refer to the telephone interview with the Administrator on 03/01/21 at 10:39am.

Refer to the telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/01/21 at 10:21am.

Refer to the telephone interview with the RCC on 03/01/21 at 11:00am.

Refer to the telephone interview with the facility's Divisional Vice President of Operations (DVPO)

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D 358	Continued From page 73 on 03/01/21 at 1:45pm. 2. Review of Resident #1's current FL-2 dated 05/29/20 revealed diagnoses included congestive heart failure, diabetes mellitus, hypertension, depression, cerebral infarction (stroke), heart disease, pulmonary sarcoidosis (inflammatory process of the lungs), and muscle weakness. Review of Resident #1's hospital after visit summary dated 01/25/21 revealed she was referred home on continuous oxygen to run via nasal cannula at 2 liters per minutes via a portable oxygen tank and concentrator. Review of Resident #1's pulmonologist visit note dated 02/08/21 revealed: -She was referred and seen for a history of sarcoidosis and lobectomy (lung resection) to be worked up for exertional fatigue and respiratory failure due to hypoxia and exertional dyspnea (difficulty breathing). -She received a pulmonary function and a 6-minute walking test in the clinic that day. -She was to continue the use of her oxygen at night. Review of Resident #1's electronic medication administration record (eMAR) dated January 2021 revealed there was no entry or documentation of O2 administration. Review of Resident #1's eMAR dated February 2021 revealed there was no entry or documentation of O2 administration. Observation of Resident #1on 02/25/21 at 2:17-2:30pm revealed:	D 358		

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D 358	Continued From page 74 -There was an oxygen concentrator in her room with oxygen tubing attached to the oxygen concentrator. -She was ambulating in her room without wearing any oxygen. Interview with Resident #1 on 02/25/21 at 2:17pm revealed she wore her oxygen every night and as needed, for example, if she experienced shortness of breath when walking. Telephone interview with a personal care aide (PCA) on 02/26/21 at 2:17pm revealed: -She observed Resident #1 wearing her oxygen at times in her room. -She could not recall how many liters of oxygen Resident #1 was wearing or when she last saw Resident #1 wearing her oxygen. Telephone interview with a medication aide (MA) on 02/26/21 at 4:29pm revealed: -She thought Resident #1 was always supposed to wear her oxygen. -She knew Resident #1 would wear her oxygen at night. -Resident #1 got the oxygen when she came back from her hospitalization in January 2021. -Resident #1 also had a portable tank when she left the facility for appointments. -If she saw Resident #1 not wearing her oxygen during her medication pass, she would prompt Resident #1 to wear her oxygen. -She had to constantly remind Resident #1 to apply her oxygen. -The week of 02/22/21, she had seen Resident two times without her oxygen in place. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/01/21 at 10:21am revealed the pharmacy did not have	D 358		

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D 358	Continued From page 75 an oxygen order for Resident #1 within in their computer system. Telephone interview with Resident #1's PCP on 03/01/21 at 9:46am revealed she did not know Resident #1 was on oxygen. Refer to the interview with the Resident Care Coordinator (RCC) on 02/25/21 at 1:15pm. Refer to the interview with the Administrator on 02/25/21 at 1:40pm. Refer to the Interview with the LHPS nurse on 02/25/21 at 2:30pm. Refer to the telephone interview with the Administrator on 03/01/21 at 10:39am. Refer to the telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/01/21 at 10:21am. Refer to the telephone interview with the RCC on 03/01/21 at 11:00am. Refer to the telephone interview with the facility's Divisional Vice President of Operations (DVPO) on 03/01/21 at 1:45pm. _____ Interview with the Resident Care Coordinator (RCC) on 02/25/21 at 1:15pm revealed: -The medication aides (MAs) would not know the amount of O2 a resident was ordered because the O2 orders did not populate on the electronic medication administration record (eMAR). -She did not know why the O2 orders did not populate on the eMAR. -There was no system in place for ensuring the MAs knew the residents' ordered O2 amount and	D 358		

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frequency.
-She was responsible for reviewing and faxing residents' FL-2s to the pharmacy so the pharmacy could enter the orders in the eMAR.

Interview with the Administrator on 02/25/21 at 1:40pm revealed
-She did not know if O2 administration populated on the eMAR.
-She did not know how the MAs would know who the residents were who were ordered O2 or the amount and frequency ordered.

Interview with the LHPS nurse on 02/25/21 at 2:30pm revealed the resident's oxygen administration and frequency needed to match the FL-2 and physician orders, care plans, and O2 concentrator settings.

Telephone interview with a pharmacist technician at the facility's contracted pharmacy on 03/01/21 at 10:21am revealed:
-When the pharmacy received a resident's oxygen order by fax from the facility, the order would be "keyed" in by the pharmacy's personnel, and once the oxygen order was entered it would appear on the electronic eMAR.
-It was "standard" for the pharmacy to enter all oxygen orders for the facility.
-If the pharmacy did not receive a resident's order for oxygen it would not appear on the eMAR.

Telephone interview with the Administrator on 03/01/21 at 10:39am revealed:
-The RCC was responsible for reviewing all orders and hospital discharge summaries to include new or changed orders, then comparing the orders to the eMAR and previous orders for changes.
-The RCC was responsible for comparing the

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eMAR to the orders.
-The RCC was responsible for making sure everything was on the eMAR.
-O2 administration should be documented on the eMAR to ensure staff knew who was ordered O2, the amount ordered, and the frequency.
-She did not know what the process was for O2 administration prior to Friday 02/26/21 but this was the process since 02/26/21.
-She did not know how MAs would know how much O2 a resident was on or the frequency of the O2 if it was not on the eMAR.
-She did not know how staff would know a resident's O2 order if it was not documented on the eMAR, unless the staff saw the resident wearing O2.
-She expected the RCC to have trained staff to monitor residents who were on O2.
-She did not know if the RCC had trained staff to monitor residents who were on O2.
-It was her responsibility for ensuring the RCC trained staff.
-She did not know until 02/26/21 that staff did not know the residents' ordered O2 frequency and amount.
-The Administrator and the facility's Divisional Vice President of Operations (DVPO) were responsible for ensuring orders were processed.

Telephone interview with the RCC on 03/01/21 at 11:00am revealed:
-Staff did not know which residents were ordered O2 unless they saw the O2 concentrator/cylinder in the resident's room.
-Staff did not know how to monitor residents' O2 because it was not on the eMAR.
-She did not know until 02/26/21 when discovered by the survey team that staff did not know how to monitor residents who were ordered O2.
-She did not know until 02/26/21 when discovered

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D 358	Continued From page 78 by the survey team that staff did not know how much and the frequency of O2 a resident was ordered. -The RCC was responsible for making sure everything on the eMAR was correct. -She did not know if it was the responsibility of the RCC for ensuring staff monitored residents who were on O2. Telephone interview with the facility's DVPO on 03/01/21 at 1:45pm revealed it was expected for the MAs to refer to the resident's current FL-2 or last order to check for the amount and frequency of O2 to be administered.	D 358		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by	D 612		

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the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of residents during the global pandemic of COVID-19 related to screening of staff.

The findings are:

Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities dated 11/20/20 revealed:
-As part of routine practice, ask healthcare personnel (including consultant personnel and ancillary staff such as environmental and dietary services) to regularly monitor themselves for fever and symptoms consistent with COVID-19.
-Personnel should be screened for the presence of fever and symptoms of COVID-19 before starting each shift.
-Actively take their temperature and document absence of symptoms consistent with COVID-19.

Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of coronavirus in LTC facilities dated October 2020 revealed:
-Residents and staff should be screened daily for signs and symptoms of COVID-19.

Review of the facility's infection control policies and procedures revealed:
-The community will ensure all employees are screened upon entry into the community for signs and symptoms of COVID-19 (e.g., temperature checks and symptom questions) using the electronic Coronavirus Visitor Screening tool during an active pandemic. Any employee exhibiting signs or symptoms should be denied

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entry.
-All staff must answer questionnaire and have temperatures taken upon arrival before beginning shift.
-The questionnaire was completed via an electronic tablet.

Review of the facility's staff schedule and COVID-19 Screening Log dated from 02/21/21 and 02/23/21-02/24/21 revealed:
-There were columns for the submitted date/time, screened name, screen type, and temperature.
-This was all staff which included management, medication aides, personal care aides, dietary, housekeeping, and maintenance.
-On 02/21/21, 1 out of 12 total staff members failed to complete the COVID-19 Screening Log at the beginning of shift.
-On 02/23/21, 3 out of 12 total staff members failed to complete the COVID-19 Screening Log at the beginning of shift.

Interview with the lead housekeeper on 02/24/21 at 3:50pm revealed:
-The staff completed their COVID-19 screening themselves.
-Upon her entry to the facility, she would answer the COVID-19 screening questions and check her temperature.
-Once screening was completed, she electronically signed the screening log at the front entrance of the facility and would hit the submit button.
-The COVID-19 screening questions and her temperature check were important to confirm if any staff member had COVID-19 symptoms or to confirm if any staff member had exposure to COVID-19.
-She did complete her self-screening of the COVID-19 questions and temperature check on

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D 612	Continued From page 81 02/23/21 but maybe she did not hit the submit button. -There had never been a time where she had not completed the COVID-19 screening and temperature check prior to working her scheduled shift. Interview with a housekeeper on 02/24/21 at 4:00pm revealed: -He self-screened for COVID-19 which included screening questions and a temperature check when he arrived at the facility. -It was important to complete the COVID-19 screening questions and a temperature check to verify if a staff member had COVID-19 symptoms or had exposure to COVID-19. -The importance of completing the COVID-19 screening was to protect the residents and his colleagues. -On 02/23/21, he honestly just forgot to complete his COVID-19 screening questions when he arrived to work. -He forgot to complete his COVID-19 screening because he was tasked with moving furniture on 02/23/21. Telephone interview with the facility's Divisional Vice President Operations on 03/01/21 at 1:36pm revealed: -The staff members did not complete a "self-screen" when completing the COVID-19 Screening Log at the beginning of shift. -The off going medication aide/supervisor in charge (MA/S) would screen the on-coming staff upon entrance to the facility which included asking the COVID-19 screening questions and a temperature check. -It was the facility's policy for all staff members to complete the COVID-19 Screening Log daily before they started their scheduled shift.	D 612		

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D 612	Continued From page 82 -She expected for all staff members to complete the COVID-19 Screening Log daily before they clocked in to start their scheduled shift. Attempted telephone interview with the Local Health Department (LHD) on 02/25/21 at 9:56am was unsuccessful.	D 612		
{D914}	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of neglect and provided with the necessary care and services to maintain their health as related to personal care and supervision, health care, and implementation. The findings are: 1.Based on observations, interviews, and record reviews the facility failed to ensure an immediate response and intervention by staff during an incident in which 1 of 1 sampled resident (#2) was in respiratory distress. [Refer to Tag 271, 10A NCAC 13F. .0901(c) Personal Care and Supervision (Unabated Type A1 Violation)]. 2.Based on observations, interviews, and record reviews, the facility failed to ensure health care needs were met for 4 of 5 sampled residents (#1, #2, #3, #5) related to the scheduling of medical appointments with the primary care provider	{D914}		

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{D914}	Continued From page 83 (PCP) and pulmonology (#2) and podiatry (#1, #2, #5); notification to the PCP for residents exhibiting shortness of breath (#3, #5); and coordination of care for an appointment for an overnight pulse oximetry test (#1) and checking to ensure oxygen canisters contained oxygen for administration.. [Refer to Tag 273, 10A NCAC 13F. .0902(b) Health Care (Type A2 Violation)]. 3.Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, total operations, and policies and procedures were implemented to maintain each resident's right and to receive appropriate and adequate care and services and to be free from serious physical harm and neglect as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, personal care and supervision and housekeeping and furnishings. [Refer to Tag D980, G.S. 131D-25 Implementation (Unabated Type A1 Violation)]. 4.Based on observations, interviews, and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health sanitation score of 85 or above at all times. [Refer to Tag D0077, 10A NCAC 13F .0306(a)(4) Housekeeping and Furnishings (Unabated Type A2 Violation)]. 5.Based on observations, record reviews, and interviews, the facility failed to ensure the environment was clean related to mold, urine odors, and feces on the walls in multiple residents' bathrooms, and free of hazards related to smoke detectors, kitchen cleanliness, furniture in hallways, and live and dead roach activity in 5 residents' rooms, and live and dead bed bugs in 7 residents' rooms. [Refer to Tag D0079, 10A	{D914}		

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{D914}	Continued From page 84 NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Unabated Type A2 Violation)].	{D914}		
{D980}	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE A1 VIOLATION Based on these finding, the previous Type A1 Violation was not abated. Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, total operations, and policies and procedures were implemented to maintain each resident's right and to receive appropriate and adequate care and services and to be free from serious physical harm and neglect as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, personal care and supervision and housekeeping and furnishings. The findings are: Telephone interview with the facility's Division Vice President of Operations (DVPO) on 03/01/21 at 1:35pm revealed: -The facility had a gap in leadership beginning 12/08/20 with the termination of the last	{D980}		

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Administrator until the hire of the new Administrator on 02/01/21.
-They also had multiple staff members who were out with the COVID-19 virus during this time period to include the previous RCC who went out on 12/27/20 and then resigned on 01/08/21.
-A lot was on hold after 12/04/21 due to the COVID-19 pandemic and virus in the facility; even the contracted facility nurse was out.
-The interim RCC came to assist the facility in January 2021.
-The new RCC was hired 01/18/21 but went out with the COVID-19 virus shortly thereafter.
-The new RCC was still in training and the interim RCC was there to fill in and assist.
-She oversaw the facility operations from 12/08/20 to 02/01/21 and no one called her for guidance during this time period.
-The new Administrator was hired on 02/01/21.
-The Administrator hours would be 8:00am -5:00pm or she may have to come in early and work late.
-There were no "real world hours" for an Administrator plus she would be on call 24 hours a day; 7 days a week.
-The Administrator would be expected to make rounds in the facility upon arrival, midday and then before leaving the building in the evening.
-When the Administrator was making rounds in the facility, she would be looking for any safety concerns, cleanliness and also she would be interacting with the residents.
-When the Administrator would be out the Resident Care Coordinator (RCC) would be in charge.
-Weeknights and weekends when the Administrator or RCC would not be present in the facility there would be a medication aide /supervisor (MA/S) in charge.
-If the Administrator was not available to the

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facility there would always be someone in management the RCC could contact such as the Divisional Director of Clinical Services (DDCS) or the DVPO if there was a need.
-The Administrator was responsible for handling any concerns from the residents or family members.
-There was a hot line number that was available for the residents or family members to call regarding any concerns. When the hot line number was called it went to the DVPO then the DVPO would contact the family and the facility.
-The hot line number could be found posted in the facility and in the resident handbook.
-MAs were trained to leave referrals in the box for the RCC to follow up on.
-The Business Office Manager was responsible to cover when the Administrator and the RCC were out.
-The previous Business Office Manager resigned on 01/24/21 and "he should have communicated better".
-The staff should be screened for COVID-19 by another person. Staff then answered the screening questions, then signed into the facility for their shift if cleared.
-If staff had a temperature, they should not enter the facility. This pertained to all staff: dietary, housekeeping, clinical staff, etc.
-She expected all staff to screen every shift.
-There was not reason anyone should not screen.
-Everyone screened to ensure they did not have symptoms of COVID-19 and bring it into the facility.
-She was working with the Administrator and the housekeeping staff to "get things together" with cleaning.
-She expected everything to be cleaned daily, or more than once daily as needed.
-The facility also needed to get on a deep

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cleaning schedule; which had not happened yet due to getting new furniture.
-She expected linens to be changed with every resident shower and as needed with accidents.
-Residents should have 3 showers per week or more if requested.
-The lead housekeeper and the Administrator were responsible to make sure all areas of the facility were cleaned per expectations.
-The Administrator should round on the facility at least three times per day looking for safety concerns, checking in with residents, and observing resident rooms.
-The Supervisor was in charge on the weekends, but the Administrator and RCC were always on call.
-The RCC was in charge of the clinical aspect of operations and the Business Office Manager was in charge when the Administrator needed to be out of office on leave.
-The facility could always contact the DVPO for guidance as well.
-The Administrator handled resident or family concerns; or they could call a hotline that was posed inside the facility and in the resident handbook.
-The hotline number was routed to her, the DVPO, and she would call the family members and facility as needed.
-The Administrator had all the policies and procedures and knew all general statutes from being a licensed administrator so the facility should have been following all the rules.
-The Administrator had her first meeting with staff today, 03/01/21, but they had other meetings previously with staff over the phone and in person to review concerns such as notifications to the primary care provider, incident reports, communication logs, and 24 hours reports.
-Progress notes should have reflected all

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{D980}	Continued From page 88 follow-up attempts for residents. -They had a lot of phone issues recently and just got the phones working well again today, 03/01/21. Noncompliance was identified at violation level in the following rule areas: 1. Based on observations, record reviews, and interviews, the facility failed to ensure the environment was clean related to mold, urine odors, and feces on the walls in multiple residents' bathrooms, and free of hazards related to smoke detectors, kitchen cleanliness, furniture in hallways, and live and dead roach activity in 5 residents' rooms, and live and dead bed bugs in 7 residents' rooms. [Refer to Tag 079,10A NCAC 13F..0306(a)(5) Housekeeping and Furnishings (Type B Violation)]. 2.Based on observations, interviews, and record reviews the facility failed to ensure an immediate response and intervention by staff during an incident in which 1 of 1 sampled resident (#2) was in respiratory distress. [Refer to Tag 271, 10A NCAC 13F. .0901(c) Personal Care and Supervision (Unabated Type A1 Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to ensure the primary care provider (PCP) was notified of changes in condition and acute health care needs for 4 of 5 sampled residents, (#1, #2, #3, #5) related to follow up medical care with a pulmonologist for shortness of breath (#5), hypoxemia (low oxygen levels in the blood) (#1), and podiatrist for evaluation and treatment for (#1, #2, and #5). [Refer to Tag 273, 10A NCAC 13F. .0902(b) Health Care (Type A2 Violation)]. _____	{D980}		

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{D980}	Continued From page 89 The Administrator, who was responsible for the overall operations of the facility, failed to ensure systems were implemented and maintained to ensure coordination and referral and follow up for health care services resulting 4 of 5 sampled residents not receiving health care services necessary to maintain their health such as podiatry, primary care provider, and pulmonology appointments; failed to ensure the facility was clean and free of hazards resulting in live bed bug activity in multiple residents rooms and roaches observed in 5 residents' rooms placing the residents as increased risk for Escherichia coli and salmonella infection; and a resident (#2) in respiratory distress with oxygen saturation levels of 73-74% sitting for seven minutes with no oxygen and required ambulance transport to the emergency department for evaluation treatment. The Administrator's failure resulted in serious neglect which constitutes an Unabated Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/01/21 for this violation.	{D980}		