STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey on July 13-15, 2021.	{D 000}		
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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to respond immediately to a medical emergency for 1 of 1 resident sampled (#1) in the Special Care Unit (SCU) who had an unwitnessed fall that resulted in a closed head injury and an abrasion on the forehead. The findings are: Review of the facility's Falls Policy revealed: -This policy aimed to provide guidance to residents and staff on fall prevention and education, steps to take when a fall occurred and actions for proper reporting. -When a fall occurred an incident report should be completed. -Procedures for what to do after a fall occurred	D 271		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

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D 271	Continued From page 1	D 271		

would be on a case by case basis.

Review of Resident #1's FL-2 dated 06/29/21 revealed:
-Diagnosis included Alzheimer's disease, dementia, hypertension, hyperlipidemia, vitamin D deficiency, and pernicious anemia.
-Resident #1 was constantly disoriented and non-ambulatory.

Review of Resident #1's care plan dated 06/22/21 revealed:
-She was incapable of communicating wants and needs.
-She was not oriented to person, place, and time.

Review of Resident #1's Accident/Incident Report dated 07/02/21 revealed:
-She was found on the floor beside her bed on 07/02/21 at 6:20 am.
-She was assessed by the medication aide (MA) to have a cut on the forehead.
-The MA contacted Resident #1's family member at 6:25 am regarding the fall.
-Resident #1's family member instructed the MA to "hold on" and do not send Resident #1 to the emergency room (ER) until the family member arrived.
-The MA provided first aid care.
-The MA called 911 to transport Resident #1 to the ER for further evaluation (no time documented).

Review of Resident #1's care notes dated 07/02/21 revealed:
-She was discovered by the MA in the SCU on the floor beside her bed on 07/02/21 at 6:20 am.
-She sustained a cut on the forehead from the fall.
-The MA contacted Resident #1's family member

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

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D 271	Continued From page 2	D 271		

to inform her of the fall and injury.
-Resident #1's family member instructed the MA to "hold on" and take no further action until she arrived at the facility.

Review of Resident #1's ER discharge summary dated 07/02/21 revealed:
-She was evaluated and treated in the ER on 07/02/21 (no time specified) and dischargd back to the facility on 07/02/21.
-She was diagnosed with a closed head injury and abrasion on the forehead.

Observation of Resident #1 on 07/13/21 at 9:30 am revealed there was a scabbed one inch raised area above the left eye of Resident #1.

Interview with a MA in the SCU on 07/13/21 at 3:15 pm revealed:
-He discovered Resident #1 on the floor beside her bed on 07/02/21 at 6:20 am.
-He assessed Resident #1 for injuries and took vital signs.
-He observed a bump on Resident #1's forehead that was bleeding and provided first aid care.
-The MA contacted Resident #1's family member to inform her of the incident at 6:25 am.
-The family member told staff "hold on," because she was on her way to the facility.
-The Emergency Medical Service (EMS) was called and Resident #1 was transported to the ER after Resident #1's family member arrived at the facility at 8:00 am.
-He was trained that the facility's policy was to immediately send a resident to the ER when a resident fell and hit their head.
-Resident #1's family member was very "particular" regarding Resident #1's care and did not want the facility to make decisions until the facility contacted the Resident #1's family.

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	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

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D 271	Continued From page 3 Interview with the personal care aide/MA (PCA/MA) in the SCU on 07/13/21 at 1:11 pm revealed she was trained that the facility's policy was for a resident to be sent immediately to the ER when a fall occurred which resulted in residents hitting their head. Interview with a second PCA/MA on 07/15/21 at 12:37 pm revealed: -Staff were to notify the Resident Care Coordinator (RCC) or Administrator when a fall occurred. -He was trained that a resident was to be sent out immediately to the ER if the fall resulted in a resident hitting their head. Telephone interview with Resident #1's family member on 07/14/21 at 2:45 pm revealed: -The MA contacted her on 07/02/21 at 6:25 am to inform her Resident #1 fell out of the bed and sustained a cut on her forehead. -She told the MA "to hold on" because she was on her way to the facility. -Resident #1's family member arrived at the facility around 8:00 am and observed a lump on Resident #1's forehead over the left eye that was bleeding and a band-aid had been placed over the lump. -The MA had not effectively communicated to her the severity of Resident #1's injury. -Resident #1's family member expected the facility to call 911 and immediately transport Resident #1 to the ER when the injury first occurred to assess internal injuries, fractures and the extent of the head injury. Interview with the Resident Care Coordinator/Special Care Unit Coordinator (RCC/SCUC) on 07/14/21 at 1:11 pm revealed:	D 271		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

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D 271	Continued From page 4	D 271		

-She was not familiar with the specifics of Resident #1's fall on 07/02/21.
-She was trained that the facility's policy was for a resident to be immediately sent to the ER when a fall occurred which resulted in the resident hitting their head.

Interview with the Administrator on 07/15/21 at 1:36 pm and 5:00 pm revealed:
-The facility's policy was to call 911 and immediately transport a resident to the ER when a fall resulted in the resident hitting their head.
-She instructed the MA to call EMS regarding Resident #1 on 07/02/21.
-She did not know what time the MA called EMS or what time EMS arrived at the facility on 07/02/21.
-She expected the MA to call 911 immediately before calling Resident #1's family member related to the fall.
-It was important to send Resident #1 to the ER for evaluation because there may have been a "brain bleed."
-The MA did not follow the facility's policy.
-Resident #1's family member verbally communicated to the Administrator in the past (time not specified) that the facility was not to do anything regarding Resident #1's care unless the facility called Resident #1's family member first.

Based on observations, interviews, and record reviews it was determined that Resident #1 was not interviewable.

Attempted telephone interview with the primary care provider (PCP) on 07/15/21 at 2:30 pm was unsuccessful.

Attempted telephone interview with the local EMS on 07/15/21 at 11:21 am was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

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D 271	Continued From page 5 The facility failed to respond immediately to a medical emergency for Resident #1 who suffered a head injury after an unwitnessed fall which resulted in a delay in receiving needed medical treatment for Resident #1 until a family member arrived at the facility over one hour and a half after the fall. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 07/15/21. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 29, 2021.	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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure physician notification of 3 of 5 sampled residents regarding signicicant changes of a wound of the buttocks (#3), regarding a resident (#4) that was ordered to follow-up with a cardiologist after a hospital stay for congestive heart failure, and a resident (#1) who had blood pressure readings that were outside their ordered parameters.	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

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{D 273}	Continued From page 6 The findings are: 1. Review of Resident #3's current FL-2 dated 03/10/21 revealed: -Diagnoses included hypertension, cerebrovascular accident, and coronary artery disease. -He was non-ambulatory and used a wheelchair. -He was continent of bowel and bladder. Review of Resident #3's Care Plan dated 06/30/21 revealed: -He was ambulatory with the assistance of a wheelchair. -He had a limited range of motion and limited strength in his upper extremities. -He required extensive assistance with toileting, bathing, dressing, grooming, and transferring. -He required limited assistance with ambulation. Review of Resident #3's Primary Care Physician (PCP) orders dated 07/12/21 revealed an order for doxycycline monohydrate (a broad-spectrum antibiotic) 100mg take one tablet by mouth every 12 hours for 7 days. Interview with personal care aide (PCA) on 07/13/21 at 10:37am revealed Resident #3 had a boil on his right buttocks. Interview with Resident #3 on 07/13/21 at 10:43am revealed: -He had a boil on his buttocks for the last 2 to 3 weeks. -He was supposed to see his doctor last week but she did not visit him. -A PCA took a picture of the boil last week because he told her that he had a boil.	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 273}	Continued From page 7 Review of Resident #3's care note dated 07/01/21 revealed: -He had a boil on his buttocks. -The boil had opened and had a bad odor. -The care note entry was not signed. Review of Resident #3's care note dated 07/06/21 revealed: -He complained of a boil to his right buttock. -His physical therapist recommended a wheelchair cushion for relief. -His physical therapist signed the care note. Review of Resident #3's physician order dated 07/06/21 revealed an order to cleanse right buttock open area with soap and water, apply triple antibiotic ointment daily and as needed until healed. Interview with a PCA on 07/14/21 at 11:11am revealed: -Resident #3 complained about leg pain on 07/05/21. -She looked at the wound that was located on Resident #3's right buttock. -She took a picture of the wound on Resident #3's right buttock and sent it to the Resident Care Coordinator (RCC) on 07/05/21. -The RCC contacted Resident #3's PCP on 07/05/21. -She was told by the RCC that Resident #3's wound was a "boil" and the PCP ordered water and soap treatments. -On 07/10/21 or 07/11/21 she saw Resident #3's wound was draining and had a bad odor and was a little red around the wound. -She notified the medication aide (MA) that was working about Resident #3's wound. -She did not know what the MA did after she notified him of Resident #3's change in his	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 8	{D 273}		

wound.
-Resident #3 used to stay in his wheelchair from 6:30am to 6:30pm, but recently he started to lay down in bed after lunch and stayed in bed for the rest of the day.

Interview with the MA on 07/15/21 at 11:26am revealed:
-He was the MA that worked on 07/10/21 when the PCA reported the change in Resident #3's wound.
-The PCA reported to him that the wound had a bad odor.
-He checked the wound and saw that the wound was draining.
-He cleaned the wound with soap and water and applied the triple antibiotic ointment to the wound.
-He did not see any redness around the wound.
-He documented in a care note that Resident #3's wound was draining and had a bad odor.
-He was expected to notify the RCC or the Administrator about Resident #3's change in wound immediately.
-When a resident had an open wound, the MA were expected to notify the RCC or the Administrator immediately.
-He did not notify the RCC or the Administrator because he did not think it was a major change in Resident #3's wound and he did not want to bother the RCC or the Administrator.
-He worked as the MA on 07/11/21 and looked at Resident #3's wound and noticed there was no draining, odor, or redness.
-Resident #3 did not complain of pain.
-He cleaned Resident #3's wound with soap and water and applied the triple antibiotic ointment.

Observation of Resident #3's buttocks on 07/14/21 at 10:00am revealed:
-There was an open wound the size of a quarter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 273}	Continued From page 9	{D 273}		

on his right buttocks.
-The depth of the wound was obscured by sloughing skin.
-The area that surrounded the wound was about 2 inches in each direction around the wound was very dark red.

Second interview with Resident #3 on 07/14/21 at 2:35pm revealed:
-The MAs had cleaned and put ointment on the wound on his buttocks.
-He did not remember if they cleaned and put ointment on his wound every day.
-He used to like sitting in his wheelchair from the time he woke up at 6:30 until before he went to bed at night around 6:00pm,
-He no longer stayed in his wheelchair all day and he laid down after lunch.
-He started laying down daily after lunch on Monday because his buttocks were hurting and laying down did not hurt as much as sitting in his wheelchair.

Review of Resident #3's PCP orders dated 07/14/21 revealed:
-There was an order for home health nursing for wound care due to the open area to the right buttock.
-There was an order for intramuscular Rocephin (an antibiotic used to treat a wide variety of bacterial infections).
-There was an order to encourage Resident #3 to keep pressure off of his buttocks daily until his right buttock wound is healed.
-There was an order for Acetaminophen (a pain reliever) 500mg tablet take one tablet two times a day for 14 days.

Interview with Resident #3's PCP on 07/14/21 at 10:57am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 10 -She was notified of Resident #3's wound on 07/05/21. -The RCC sent her a picture of Resident #3's wound on 07/05/21. -She wrote orders to cleanse the right buttock open area with soap and water, apply triple antibiotic ointment daily, and as needed until healed. -She was notified on 07/12/21 by the RCC that Resident #3's wound was draining and painful. -She ordered antibiotics for Resident #3. -She looked at Resident #3's wound on 07/14/21. -She was unable to determine what stage the wound was after she looked at it on 07/14/21. -She was concerned that the skin that surrounded the wound was red. -The red skin that surrounded the wound could indicate infection and inflammation. -She ordered home health nursing for wound care for Resident #3. -She ordered an intramuscular antibiotic to treat Resident #3. -If the RCC or any facility staff noticed a change in Resident #3's wound she expected to have notified her immediately. Interview with the RCC on 07/14/21 at 10:11am revealed: -She was not aware Resident #3 had a care note dated 07/01/21 documenting he had a boil to his right buttock that was draining and had an odor. -She was notified by a PCA on 07/05/21 that she noticed a wound on Resident #3's buttocks when the PCA showered him. -The PCA took a picture of the wound and showed her the picture. -She sent the picture to Resident #3's PCP on 07/05/21. -The PCP wrote treatment orders to clean the wound daily with soap and water and apply triple	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 11	{D 273}		

antibiotic ointment daily and as needed until healed.
-She last looked at Resident #3's wound on 07/08/21 during his shower.
-She noticed the wound was draining fluid and the skin that surrounded the wound was red.
-She thought Resident #3 had a boil and it was draining, so she did not notify his PCP about the change in the wound.
-Resident #3 complained that his wound was painful and draining on 07/12/21 so she notified Resident #3's PCP.
-Resident #3's PCP wrote an order for doxycycline monohydrate (a broad-spectrum antibiotic) 100mg take one tablet every 12 hours for 7 days.

Interview with the Administrator on 07/14/21 at 5:14pm revealed:
-PCAs were expected to complete skin assessment on Resident #3 on his shower days.
-The PCAs were expected to look for any change in Resident #3's skin, skin tears, bruising, anything abnormal to the skin.
-If the PCA saw any change in the skin they were expected to notify the MA immediately.
-The MA was expected to notify the RCC or the Administrator immediately.
-The RCC or the Administrator would notify Resident #3's PCP and the Chief Operating Officer (COO).
-The MA who worked on 07/10/21 and 07/11/21 should have immediately reported to her or the RCC the change in Resident #3's skin.
-She was concerned that Resident #3's wound could have become infected because the MA did not notify her or the RCC of the change of his wound.

2. Review of Resident #4's current FL-2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 12 06/15/21 revealed diagnoses included blindness, chronic obstructive pulmonary disease (COPD), hypertension, congestive heart failure (CHF), hyperlipidemia, weakness, sleep apnea, difficulty walking, atrial fibrillation, diastolic dysfunction, pulmonary hypertension and diabetes mellitus. Review of a hospital discharge summary dated 06/09/21 for Resident #4 revealed: -The resident was admitted to the hospital on 06/07/21. -Diagnoses included acute kidney injury, hyperkalemia, anemia, chronic atrial fibrillation, diastolic congestive heart failure, pulmonary hypertension and hypertension. -Resident #4 was last seen by her cardiologist in November 2020 and needed a follow up visit in 2-3 days of discharge from the hospital (06/12/21). -There was an order for a follow up appointment with the cardiologist in 2-3 days. Interview with Resident #4 on 07/14/21 at 2:58pm revealed she did not know if the provider who saw her at the facility was her primary care provider (PCP) or a cardiologist. Second interview with Resident #4 on 07/15/21 at 1:05pm revealed: -She had increased fluid and weight on her body. -The weight made her legs and her heart hurt. Observations of Resident #4 on 07/15/21 at 1:05pm revealed there was swelling to both her lower extremities from her knees to her feet and swelling to both hands. Telephone interview with the receptionist at Resident #4's cardiologist office on 07/15/21 at 8:14am revealed:	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 13 -Resident #4 was last seen in November 2020. -The resident did not have any appointments scheduled since November 2020. -There were no future appointments scheduled for Resident #4. Interview with a medication aide (MA) on 07/15/21 at 12:39pm revealed all referral and follow up appointment information from hospital discharge paperwork was given to the Resident Care Coordinator (RCC). Interview with the transportation staff on 07/15/21 at 11:22am revealed: -She was responsible for scheduling referral appointments for residents and taking the resident to and from the appointment. -Most of the time she was told which appointments needed to be scheduled by the RCC. -The MAs and the RCC also put referral orders in a box on the wall in front office for her. -She checked the box every day she worked. -She did not receive the order for the follow up appointment with a cardiologist for Resident #4 until 07/13/21. -She contacted Resident #4's cardiologist to schedule the appointment on 07/14/21. Telephone interview with Resident #1's PCP revealed: -Resident #4 needed to follow up with a cardiologist following discharge from the hospital on 06/09/21 for congestive heart failure (CHF). -He had sent the resident to the hospital (06/07/21) because she was experiencing an acute flare up of CHF. -If the hospital provider wanted Resident #4 to follow up with a cardiologist the appointment should have been scheduled immediately.	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

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{D 273}	Continued From page 14 -Resident #4 had significant medical history of CHF and pulmonary hypertension and without follow up with a cardiologist the resident could have unidentified worsened CHF. Interview with the RCC on 07/15/21 at 3:46pm revealed: -She was primarily responsible for hospital discharge orders including follow up and referral appointments. -She gave referral and follow up appointment orders to the transportation staff. -She would follow up with the transportation staff on when the appointment was scheduled or if there was difficulty in scheduling the appointment. -She received Resident #4's hospital discharge paperwork on 06/10/21 or 06/11/21. -She put the paperwork for the cardiologist follow up appointment for Resident #4 in the transportation staff's box that same day. -She assumed the appointment had been made because the paperwork was gone from the box and she did not hear of any problems scheduling the appointment from the transportation staff. -The cardiologist follow up appointment for Resident #4 should have been scheduled within one week. -She did not know when she found out the appointment was not scheduled. Interview with the Administrator on 07/15/21 at 5:25pm revealed: -She expected staff to make referral and follow up appointments the same day the order was received or the next business day if received during the evening, at night or on weekends. -The transportation staff received the discharge orders if they picked the resident up from the hospital. -Otherwise the MA or RCC gave the referral	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 273}	Continued From page 15	{D 273}		

and/or follow up appointment order to the transportation staff.
-She was made aware on 07/13/21 the follow up cardiologist appointment for Resident #4 was not scheduled.

3. Review of Resident #2's current FL-2 dated 11/06/20 revealed:
-Diagnoses included dementia, Alzheimer's disease, hypothyroidism, hypoglycemia, hearing loss, legally blind, hypertension and reflux.
-She was constantly disoriented.
-She was admitted to the Special Care Unit (SCU).
-There was documentation the resident was receiving Hospice services.
-There was an order to obtain the resident's blood pressure (BP) monthly.

Review of Resident #2's subsequent orders dated 05/28/21 revealed an order for BPs monthly; BP normal between 100-190/60-80, if outside notify the primary care provider (PCP).

Review of Resident #2's July 2021 electronic medication administration record (eMAR) revealed:
-There was an entry to check the BP once a month, BP normal between 100-190/60-80 if outside notify the PCP with a scheduled time at 7:00am - 2:59pm.
-There was documentation the resident's BP was checked daily from 07/01/21 - 07/12/21.
-There was documentation the resident's BP was 101/53 on 07/03/21.
-There was documentation the resident's BP was 145/94 on 07/06/21.
-There was documentation the resident's BP was 110/54 on 07/10/21.
-There was documentation the resident's BP was

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{D 273}	Continued From page 16	{D 273}		

97/59 on 07/11/21.
-There was no documentation in the note section of the eMAR the resident's PCP was notified.

Review of Resident #2's progress notes revealed there was no documentation the resident's PCP was notified of any BP readings documented on 07/03/21, 07/06/21, 07/10/21 and 07/11/21.

Interview with a medication aide (MA) on 04/15/21 at 12:37pm revealed:
-The MAs were responsible to obtain the residents' BPs.
-The MAs could view the residents' ordered BP parameters when documenting the BP reading in the computer system.
-The MA was responsible to notify the PCP as ordered and document that contact with the PCP was made.
-He would also notify the Resident Care Coordinator/Special Care Unit Coordinator (RCC/SCUC).

Interview with the RCC/SCUC on 04/15/21 at 1:08pm revealed:
-She started working temporarily as the SCUC this past week.
-Her initials were documented as obtaining Resident #2's BP reading of 101/53 on 07/03/21.
-Her initials were documented as obtaining Resident #2's BP reading of 110/54 on 07/10/21.
-Her initials were documented as obtaining Resident #2's BP reading of 97/59 on 07/11/21.
-She did not obtain Resident #2's BPs, a MA from the facility's contract staff did.
-She was not notified by the MA of any BPs out of the ordered parameters for Resident #2.
-The MA would have been responsible to document in Resident #2's progress notes if the PCP was notified.

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{D 273}	Continued From page 17 -The facility was transitioning to electronic charting. -She would check to see if there was any notification in Resident #2's electronic progress notes and provide any information if found for review. -She expected staff to follow all residents' orders as written. Interview with the Administrator on 07/15/21 at 5:23pm revealed: -The previous SCUC resigned last week. -The previous SCUC performed resident record audits weekly by reviewing 4-5 resident records per week to monitor and ensure resident orders were followed. -The previous SCUC had not notified her of any concerns of Resident #2's PCP not being notified of BP readings being recorded outside of the ordered parameters. -She had spoken with Resident #2's Hospice nurse yesterday, (07/14/21) regarding the resident's BP parameters. -She expected staff to follow all residents' orders as written. Attempted telephone interview with Resident #2's Hospice nurse was unsuccessful on 07/15/21. Based on observations, interviews, and record reviews, Resident #2 was not interviewable. Telephone interview with Resident #2's PCP on 04/15/21 at 11:52am revealed: -He had not received any notifications of Resident #2 having any BPs obtained outside of the ordered parameters -He would have concerns of possible dehydration when Resident #2's BPs was low and would expect staff to have notified him in order to treat	{D 273}		

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{D 273}	Continued From page 18 the resident. -If staff had notified him when Resident #2' BPs were low he would have been prompted to possibly order lab work or possible fluid therapy for the resident. A request was made for documentation regarding notification to Resident #2's PCP for BP readings documented outside of the ordered parameters in July 2021 but not provided prior to exit on 07/15/21. _____ The facility failed to ensure physician notification for 3 of 5 sampled residents including a resident (#3) who had a wound to his right buttock that became red, caused the resident pain when he sat in his wheelchair, and had been draining for at least four days before his primary care provider was notified; failed to ensure a resident (#4) was followed up by a cardiologist within 2-3 days as ordered after she was discharged from the hospital for congestive heart failure; and failed to report blood readings for a resident (#2) that were outside their ordered parameters to her primary care provider on at least four different occurences. This failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 07/14/21. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 29, 2021.	{D 273}		

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{D 338}	Continued From page 19	{D 338}		
{D 338}	10A NCAC 13F .0909 Resident Rights	{D 338}		

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

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

Based on these findings, the Previously Unabated Type B Violation was abated. Non-compliance continues.

Based on observations, interviews, and record reviews, the facility failed to respond to a reasonable request for 1 of 5 residents sampled an ordered as needed pain medication order (Resident #6).

The findings are:

Review of Resident #6's current FL-2 dated 03/16/21 revealed:
-Diagnoses included cognitive disorder, hypothyroidism, sleep apnea, bipolar disorder, diabetes type 2, gastroesophageal reflux disease and seizure disorder.
-She was intermittently disoriented.
-She was ambulatory.
-She was admitted to the Special Care Unit (SCU).

Review of Resident #6 's current assessment and care plan dated 06/22/21 revealed:
-She was sometimes disoriented and forgetful and needed reminders.

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{D 338}	Continued From page 20 -The resident's cognitive abilities included oriented to person, time and place. -She was able to take and follow directions, able to follow instructions and able to communicate her needs and wants. Review of a medication order for Resident #6 dated 04/23/21 revealed and order for Tylenol 500mg, two tablets every 6 hours as needed for headache and/or minor discomfort, and contact the primary care provider (PCP) if headache or pain persists longer than 24 hours. (Tylenol is a medication used to treat mild to moderate pain). Observations in the SCU dining room on 07/14/21 from 8:10am - 8:28pm revealed: -Resident #6 was seated at a dining room table with other residents. -At 8:13am, Resident #6 was given her 8:00am medication from the medication aide (MA). -Immediately after Resident #6 swallowed her 8:00am scheduled medications, the resident told the MA (who was still standing beside Resident #6) that her left arm was hurting and she needed a Tylenol for the pain. -The MA told the resident she would be right back with the Tylenol. -The MA returned to the medication cart located in the dining room, looked at the computer screen, opened and closed the lower drawer of the medication cart, walked into the medication room, returned to the medication cart, then began to prepare medications for another resident. -Resident #6 had been served breakfast and ate the remainder of her food and remained seated at the dining room table. -At 8:28am, Resident #6 stood up from the dining room table and walked out of the dining room. -The MA continued to pass medications to other residents and did not administer Tylenol to	{D 338}		

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	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

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{D 338}	Continued From page 21 Resident #6. Interview with Resident #6 on 07/14/21 at 8:38am revealed: -Her upper left arm was hurting in the muscle. -Her upper left arm had been hurting for a "good while" (no additional information of a time period provided). -She had not told the MA her arm was hurting yet. Interview with the MA who had administered Resident #6's 8:00am medications on 07/14/21 at 9:32am revealed: -She had not given Resident #6 any medication yet for the resident's upper arm pain. -At 8:13am, when Resident #6 asked for Tylenol for her upper arm pain, she looked in the medication cart and in the medication room and the resident did not have any Tylenol to administer. -Resident #6's Tylenol was out of stock but should be delivered to the facility from the pharmacy today, (07/14/21). -She would ask the MA/supervisor if there was any Tylenol at the facility and available for the resident to use. -She was not sure if the facility kept "house stock" (over the counter medications commonly used with an order from the residents' PCP) medications that could have been administered to residents with an order. Interview with the MA/supervisor on 07/14/21 at 10:02am revealed: -The MA who administered Resident #6's 8:00am medications today, (07/14/21) had not asked her if there was any stocked Tylenol available to administer to the resident. -The facility kept standing order medications such as Tylenol on the medication cart to administer to	{D 338}		

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	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

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{D 338}	Continued From page 22 residents when indicated and when the resident had an order for the medication. -There was Tylenol 500mg available in the medication cart on the SCU. -When a resident requested an as needed pain medication, the MA would have been responsible to have verified there was an order for the pain medication and responsible to have administered the medication immediately to the resident before proceeding to pass routine scheduled medications to other residents. -It was important for staff to respond to a resident's request as soon as possible. -The MA/supervisor was concerned Resident #6 could have been experiencing ongoing pain if she had not received any medication for her upper arm, -She would not want Resident #6 or any other resident to be in any unnecessary pain if the resident had an order for Tylenol as needed. -When an as needed medication was administered to a resident, the MA would have been responsible to follow up with the resident after 30 minutes to ensure the medication was effective. -She would follow-up with Resident #6 and the MA concerning the resident's reports of pain and if the resident was administered any Tylenol. -Resident #6 should not have waited over an hour for a pain medication. Observation of the standing order medications in the medication cart on the SCU on 04/17/21 at 10:11am revealed: -There was a bottle of Tylenol 500mg stored in the lower left drawer of the medication cart. -The cap of the Tylenol bottle was labeled "House Stock" and a date of 06/03/21 was written on the upper side of the medication bottle.	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 338}	Continued From page 23 Interview with Resident #6 on 04/17/21 at 10:38am revealed: -She had just returned from an activity with another resident and staff. -The MA had given her Tylenol for her upper arm pain. -The Tylenol had helped ease the pain in her upper arm. Review of Resident #6's July 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Tylenol 500mg, two tablets every 6 hours as needed for headache, and or minor discomfort. If pain persists longer than 24hr, contact the PCP. -Tylenol 500mg was documented as administered on 07/14/21 at 10:26am with a reason given as "pain in arm" and the results of the medication was documented as effective. Interview with a second MA on 07/14/21 at 3:40pm revealed: -The MAs were responsible to administer as needed pain medications to residents no later and or within 30 minutes after the resident requested the medication. -It was important for staff not to delay administering an as ordered pain medication to avoid the resident from experiencing ongoing pain. -Staff were responsible to ensure the residents' needs and care were addressed promptly. Interview with a third MA on 04/15/21 at 12:37pm revealed it was important to address a residents' request for pain medication as soon as possible, "it was the right thing to do" and a residents' right. A second interview with the MA who administered	{D 338}		

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{D 338}	Continued From page 24 Resident #6's 8:00am medications on 07/14/21 at 3:14pm on 07/14/21 revealed: -She had worked at the facility for 2 weeks. -Today, 07/14/21 was the first day she worked independently on the medication cart. -She was not sure if the facility kept a "house stock" of medications. -She had verified on Resident #6's eMAR that the resident had an order for as needed Tylenol. -She continued administering other resident's their routine medications at 8:00am and was going to follow up with the MA/supervisor when she completed the 8:00am medication pass. -She should have followed-up with the MA/Supervisor concerning the availability of Tylenol for Resident #6 immediately when she could not find the Tylenol 500mg to prevent the resident from experiencing ongoing pain. Interview with the Administrator on 07/15/21 at 5:23pm revealed: -She expected residents' request for pain relief to be addressed by staff as soon as possible. -Resident #6 should not have waited 2 hours to receive the ordered as needed Tylenol. -Resident #6's request for pain medication should have been addressed prior to the MA proceeding with the next resident scheduled for 8:00am medications on 07/14/21. Telephone interview with Resident #6's PCP on 04/15/21 at 11:52am revealed: -Resident #6 was ordered Tylenol 500mg as needed for discomfort. -He expected staff to administer as needed medication within 30 minutes to one hour after a resident reported pain symptoms. -It was important to ensure resident's pain symptoms were addressed as soon as possible to avoid discomfort for the resident.	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care and personal care and supervision. The findings are: 1. Based on observations, interviews, and record reviews the facility failed to respond immediately to a medical emergency for 1 of 1 resident sampled (#1) in the Special Care Unit (SCU) who had an unwitnessed fall that resulted in a closed head injury and an abrasion on the forehead. [Refer to Tag 271 10A NCAC 13F .0901(c) Personal Care & Supervision (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure physician notification of 3 of 5 sampled residents regarding signicicant changes of a wound of the buttocks (#3), regarding a resident (#4) that was ordered to follow-up with a cardiologist after a hospital stay for congestive heart failure, and a resident (#1) who had blood pressure readings that were outside their ordered parameters. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

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