

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL063022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/12/2021
NAME OF PROVIDER OR SUPPLIER FOX HOLLOW SENIOR LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 190 FOX HOLLOW PINEHURST, NC 28374		
(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 and the Moore County Department of Social Services conducted an annual and follow-up survey on 11/09/21 through 11/10/21 with an exit conference via telephone on 11/12/21.	D 000		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the residents' physicians certified their care by signing and dating care plans within 15 days of assessment for 4 of 5 sampled residents (#2, #3, #4, and #5). The findings are: 1. Review of Resident #4's current FL-2 dated 09/17/21 revealed: -Diagnoses included urostomy with a catheter bag, sleep apnea, and impaired mobility. -Ambulatory with no indicators marked for assistive devices. Review of Resident #4's Resident Register	D 263	The community will complete audit of resident files by 12/27/2021 to verify compliance of rule area. ED or designee will review weekly which care plans are due, complete care plans and submit to the doctor for review and signature. Community will keep a copy of the care plan that is pending review from the doctor until it is received back. If the care plan is not returned within 7 days of it being sent out, community will follow up via telephone with the physician. Completion Date: 12/27/2021.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6099

S86L11

If continuation sheet 1 of 9

Reviewed and Acknowledged 12/29/21 JG

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D 263	Continued From page 1 revealed an admission date of 08/20/21. Review of Resident #4's undated Care Plan revealed: -The assessment was partially filled out. -Ambulation was marked ambulatory with aide or devices. -Bladder was marked normal with catheter type left blank and self-care left blank. -The activities of daily living section were blank. -The Director of Resident Care name was typed on the name line, but signature was left blank. -There was no primary care providers (PCP) signature. Interview with Resident #4 on 11/09/21 at 9:42am revealed: -He had resided at the facility approximately 2 months. -He had a wheelchair but preferred to ambulate with his walker. -He had a urostomy with a leg bag catheter and performed all care for the catheter. -He was supposed to change the catheter bag every 3 days but "I cheat on that" and changed the catheter every 3 weeks. -He had sleep apnea and wore a continuous positive airway pressure (CPAP) machine for 20 years. Interview with a medication aide (MA) on 11/10/21 at 9:00am revealed: -She knew what care to provide to residents by following the resident's Care Plan. -The Director of Resident Care was responsible for completing the resident Care Plans and placed a copy in a notebook at the nurse's station for staff's guidance to know what personal assistance and care to provide to the residents.	D 263			

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D 263	Continued From page 2 Interview with a second MA on 11/10/21 at 9:15am revealed: - The Director of Resident Care provided a copy of the resident Care Plans called "Individualized Care Plan" and was used by staff to know what assistance to provide to each resident. -The 3rd shift personal care aides (PCA's) also talked to residents to see what their care "needs" were and wrote them down on a "communication sheet" that was shared between each shift. -Resident #4 performed catheter care independently. -She did not know Resident #4 used a CPAP machine. -Resident #4 did not have a CPAP machine addressed on his Care Plan. Interview with the Director of Resident Care on 11/09/21 at 3:00pm revealed: -She was responsible for assessing residents, completed the Care Plans, and ensuring the PCP reviewed and signed/dated the Care Plan. -She faxed Resident #4's Care Plan to the PCP and had not received the Care Plan back signed and dated. -She would sometimes send the Care Plans by transport staff to the PCP's office to be completed by the PCP. -She had not followed up with Resident #4's PCP to see why the Care Plan had not been reviewed, signed and dated. Interview with the Administrator on 11/10/21 at 10:00am revealed: -The Director of Resident Care was responsible for making sure Care Plans were completed upon admission of residents. -The facility staff referred to the activities of daily living log book and used the assessment tool to provide the needs of care to residents.	D 263			

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D 263	Continued From page 3 -She did not know why Resident #4's Care Plan was not completed upon admission with the PCP's signature and date. -The facility did not have a "good tracking system" to make sure Care Plans were completed. -A separate form was completed if there was a change in a resident's care needs to indicate that resident would need to be reassessed and a new Care Plan completed. -She or the Resident Care Director did not follow up to make sure Resident #4's Care Plan was completed or signed by the PCP. 2. Review of Resident #5's current FL-2 dated 09/15/21 revealed: -Diagnoses included osteoarthritis, atrial fibrillation, chronic congestive heart failure, edema, dysphagia, pacemaker, and asthma. -Ambulatory with walker. -Continent of bowel and bladder. Review of Resident #5's Resident Register revealed an admission date of 08/31/21. Review of Resident #5's undated Care Plan revealed: -Ambulation was marked ambulatory with walker and limited mobility of lower extremities. -Respiration was marked as shortness of breath. -Orientation/memory was marked as sometimes disoriented and forgetful-needed reminders. -The activities of daily living section were blank. -The Director of Resident Care name was typed on the name line, but signature was left blank. -There was no primary care providers (PCP) signature. Interview with a medication aide (MA) on 11/10/21 at 9:00am revealed: -She knew what care to provide to residents by	D 263			

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D 263	Continued From page 4 following the resident's Care Plan. -The Director of Resident Care was responsible for completing the resident Care Plans and placed a copy in a notebook at the nurse's station for staff's guidance to know what personal assistance and care to provide to the residents. Interview with a second MA on 11/10/21 at 9:15am revealed: - The Director of Resident Care provided a copy of the resident Care Plans called "Individualized Care Plan" and was used by staff to know what assistance to provide to each resident. -The 3rd shift personal care aides (PCA's) also talked to residents to see what their care "needs" were and wrote them down on a "communication sheet" that was shared between each shift. Interview with the Director of Resident Care on 11/09/21 at 3:00pm revealed: -She was responsible for assessing residents, completed the Care Plans, and ensuring the PCP reviewed and signed/dated the Care Plan. -She faxed Resident #5's Care Plan to the PCP and had not received the Care Plan back signed and dated. -She would sometimes send the Care Plans by transport staff to the PCP's office to be completed by the PCP. -She had not followed up with Resident #5's PCP to see why the Care Plan had not been reviewed, signed and dated. Interview with the Administrator on 11/10/21 at 10:00am revealed: -The Director of Resident Care was responsible for making sure Care Plans were completed upon admission of residents. -The facility staff referred to the activities of daily living log book and used the assessment tool to	D 263			

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D 263	Continued From page 5 provide the needs of care to residents. -She did not know why Resident #5's Care Plan was not completed upon admission with the PCP's signature and date. -The facility did not have a "good tracking system" to make sure Care Plans were completed. -A separate form was completed if there was a change in a resident's care needs to indicate that resident would need to be reassessed and a new Care Plan completed. -Herself or the Resident Care Director did not follow up to make sure Resident #5's Care Plan was completed or signed by the PCP. 3. Review of Resident #3's current FL-2 dated 01/25/21 revealed: -Diagnoses included history of falls, history of fractures, and Meniere's disease. -Semi-ambulatory and incontinent of bowel and bladder. Observations of Resident #3 on 11/09/21 at 9:15am revealed: -Resident #3 appeared to have three bruises on her face. -Bruises were located under Resident #3's left eye, another under her nose, and the third under her bottom lip. Interview with Resident #3 on 11/09/21 at 9:15am revealed: -Resident #3 indicated that she had a fall. -Resident #3 was not able to state where and/or when the fall occurred. Record Reviews on 11/09/21 revealed: -Resident #3 was admitted to the facility on 02/01/21. -There were no care plans present in Resident #3's file.	D 263			

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D 263	Continued From page 6 -The care plan that was provided was dated 08/08/21. -This care plan did not have any information regarding Resident #3's Activities of Daily Living (ADLs). -This care plan had no signatures from the administrator nor the doctor. Interview with the Director of Resident Care on 11/09/21 at 4:40pm revealed: -There is no initial care plan for Resident #3. -She did not know why the care plan for Resident #3 was not completed upon admission. -She found several care plans not completed upon her hire in April 2021. -She made efforts to ensure that these care plans were completed but had not finished. -She did fax several of the care plans to resident's primary care providers (PCP) but had not had them returned. -She stated that the facility's fax machine did not give confirmation pages so she was not able to show proof that the faxes were received by the PCP. -She stated that some of these care plans were from as far back as August 2021. -No follow up was completed with the PCP. 4. Review of Resident #2's current FL2 dated 04/03/21 revealed: -Diagnoses included chronic kidney disease stage 4, abdominal pain, acute cardiopulmonary disease and thrombocytopenia.	D 263			

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D 263	Continued From page 7 -Resident #2 was oriented, semi-ambulatory and incontinent of bowel and bladder. -Resident 2 required limited personal care assistance for bathing, dressing and grooming. Review of Resident #2's personal care services assessment dated 03/04/20 revealed: -The resident required limited assistance with bathing, dressing, and grooming. -The resident required extensive assistance toileting and transfers. -The Care Plan was signed by the provider on 03/10/20. Resident #2 should have had an updated annual Care Plan on 03/04/21. Interviewed the Director of Resident Care on 11/09/21 at 4:40pm revealed: -She found several care plans not completed upon her hire in April 2021. -She made efforts to ensure that these care plans were completed but had not finished. -She did fax several of the care plans to resident's primary care provider (PCP) but had not had them returned. -She stated that the facility's fax machine did not give confirmation pages so she was not able to show proof that the faxes were received by the PCP. -She stated that some of these care plans were from as far back as August 2021. -No follow up was completed with the PCP. Interview with the Administrator on 11/09/21 at 2:30pm revealed: -The Resident Care Director was responsible for completing the care plans. -The care plans were behind because of being short staffed.	D 263			

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D 263	Continued From page 8 -There is a activities of daily living book that the personal care aides use to see what care residents need.	D 263			