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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey and complaint investigation on 03/29/22 through 04/01/22. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on 03/22/22.	D 000		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on observations, interviews and records reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and C) were competency validated for Licensed Health Professional Support (LHPS) tasks related to clean dressing changes, feeding techniques, medication administration through injection, transfers of non-ambulatory residents and ambulation using assistive devices that require physical assistance. The findings are: 1. Review of Staff A's, medication aide (MA),	D 161		

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D 161	Continued From page 1 personnel record revealed: -Staff A was hired on 12/29/21. -There was no documentation Staff A completed a LHPS validation in the personnel records. Interview with Staff A on 04/01/22 at 4:11 pm revealed: -She was hired by a local staffing agency in December of 2021 and started at the facility in January 2022. -The Registered Nurse (RN) at the staffing agency completed an LHPS check off as part of her training upon hire. -Her responsibilities at the facility were to administer medications and assist the personal care aides (PCAs) with the personal care tasks of the residents. -She administered insulin through subcutaneous injection, applied TED hose, assisted with feeding residents, clean dressing changes if needed, assisted with transfers of residents using a sit to stand or hoyer lift, and assisted residents in wheelchairs who were not able to ambulate independently. -The facility nurse did not require a return demonstration of the LHPS tasks she would be required to perform. -She did not know who was responsible for training at the facility since she did not receive any training while working there. Refer to interview with the Health and Wellness Director (HWD) on 03/30/22 at 12:40pm. Refer to interview with the Health and Wellness Coordinator (HWC) on 04/01/22 at 11:45am. Refer to interview with the RN at the staffing agency on 04/01/22 at 2:00pm.	D 161		

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D 161	Continued From page 2 Refer to interview with the Administrator on 04/01/2022 at 3:39pm. 2. Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C was hired on 02/03/22. -There was no documentation Staff C completed a LHPS validation in the personnel records. Interview with Staff C on 04/01/2022 at 10:00am revealed: -She worked as a MA in the facility from a local staffing agency since February 2022. -Her responsibilities at the facility were to administer medications and assist the personal care aides (PCAs) with the personal care tasks of the residents. -She administered insulin through subcutaneous injection, applied TED hose, assisted with feeding residents, clean dressing changes if needed, assisted with transfers of residents using a sit to stand or hoyer lift, and assisted residents in wheelchairs who were not able to ambulate independently. -The facility nurse did not require a return demonstration of the LHPS tasks she would be required to perform. -She did not remember if the staffing agency RN checked her off for any LHPS tasks before she went to the facility. -She did not know who was responsible for training at the facility since she did not receive any training while working there. Observation of Staff C on 03/29/22 at 8:22am revealed she provided feeding assistance to a resident in the dining room during the breakfast meal. Refer to interview with the HWD on 03/30/22 at	D 161		

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D 161	Continued From page 3 12:40pm. Refer to interview with the HWC on 04/01/22 at 11:45am. Refer to interview with the staffing agency RN on 04/01/22 at 2:00pm. Refer to interview with the Administrator on 04/01/2022 at 3:39pm. _____ Interview with HWD on 03/30/22 at 12:40pm revealed: -She was responsible for ensuring facility staff had the required documentation before providing care to the residents. -She did not know she should alert the facility's RN educator to perform a facility specific check off for LHPS competency validation for agency staff before they provided care to the residents. -She relied on the training and check offs the staffing agency provided. Interview with the HWC on 04/01/22 at 11:45am revealed: -The HWD scheduled the facility's Registered Nurse (RN) to come in and complete the residents' quarterly LHPS reviews. -She did not know the skin assessments and open wounds documentation was not completed on Residents #1 and #3. Interview with the staffing agency RN on 04/01/22 at 2:00pm revealed: -She completed the 15 hour training for the medication aides before they were sent to the facility. -She also provided infection control training to the staff as part of the new employee training. -She completed a LHPS competency validation	D 161		

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D 161	Continued From page 4 for the staff as part of their training. -She had not been asked to provide the documentation of training to the facility. Interview with the Administrator on 04/01/2022 at 3:39pm revealed: -She was not aware of the LHPS competency validation requirements for staff performing care for residents. -The facility's Registered Nurse (RN) Educator was responsible to check off all agency staff on facility specific training requirements. -It was the responsibility of the HWD to inform the nurse educator of new employees requiring facility specific training requirements. -She did not know if the LHPS competency validation for staff specific to the tasks they would perform at this facility was one of the educator's tasks.	D 161		
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: TYPE A1 VIOLATION Based on interviews, observations and record reviews, the facility failed to ensure staff provided personal care assistance to 2 of 3 sampled	D 269		

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residents (Residents #3 and #1) including one resident with diabetic pressure ulcer wounds on the heels of both feet and orders to place protective booties, off load pressure to the wounds and not to drag his feet along the floor during ambulation were followed as ordered by the Home Health Nurse (HHN) and wound care physician and not attending to multiple skin tears and nail care on both feet (#3), and a resident with recurrent pressure ulcers on the heel of both feet, orders to place protective booties, who obtained 3 additional wounds on the sacrum and buttocks, and orders to off load pressure to the wounds (#1).

The findings are:

1. Review of Resident #3's current FL2 dated 03/04/22 revealed:
-Diagnoses included vascular dementia, Type II diabetes, left sided hemiplegia and glaucoma.
-He was documented as constantly disoriented and non-ambulatory with the use of a wheelchair.
-The current level of care was documented as the Special Care Unit (SCU).

Review of Resident #3's primary care provider's (PCP) progress note dated 02/18/22 revealed there was an order for skilled nursing to evaluate and treat the resident's open wound on the left heel twice a week.

Review of Resident #3's Home Health Nursing (HHN) documentation dated 02/23/22 revealed an order for a left foot heel protector to be applied by the staff daily when out of bed, and a pillow under his feet when sitting in the wheelchair to reduce pressure on the heel wounds.

Review of Resident #3's HHN documentation

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D 269	Continued From page 6 dated 03/03/22 revealed an order for foam foot booties to protect the wound when his foot dragged on the ground. Review of Resident #3's current Care Plan dated 01/31/22 revealed: -Resident #3 required staff assistance for all dressing and grooming needs, and for weekly showers. -He required staff to assist with bathroom tasks related to his inability to stand. -He ambulated in a wheelchair with the assistance of staff to the dining area and community activities, and transferred with the aid of a lift and 2 person assistance. Review of the facilty's clinical guidelines regarding skin breakdown dated September 2018 revealed: -Community associates should report skin concerns to the Health and Wellness Director (HWD). -A new Skin Observation Form should be completed upon a change of condition. -Skin observation may be completed more frequently based on the individual resident's needs and the nurse's clinical judgement. -Management in the community of skin breakdown includes high density foam overlays for mattresses, gel cushion for the wheelchair and float the resident's heels off the bed. -Encourage position change. -Manage incontinence as needed, applying a barrier ointment to buttocks for heavy incontinence. -Increased protein, zinc and vitamin C intake. -Document on the Open Area flowsheet weekly with a separate sheet for each open area, reviewed weekly by the Executive Director and the HWD. -Update the Personal Service	D 269		

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D 269	Continued From page 7 Assessment/Personal Service Plan. -Provide in-service to associates on preventing skin breakdown. Review of Resident #3's most recent Skin Observation Form dated 02/17/22 revealed: -The form was completed by the Health and Wellness Coordinator (HWC). -Skin was documented as "excessive dryness and flakiness", with an open area on the left heel. -Friction and shearing were documented as "not a problem" -A Braden Scale was used to predict the risk of developing pressure sores in a resident. -Resident #3's Braden Scale was 14, indicating a moderate risk for developing pressure sores.. -A Braden Scale score of 16 or less required prevention strategies. -No prevention strategies were listed. -An Open Area Flowsheet was to be completed due to the wound noted on the left heel. Attempted review of Resident #3's Open Area Flowsheets for wounds to the right and left heel were not produced prior to exit. Review of the Shift Assignment Plans from 03/21/22 through 04/01/22 revealed: -The Shift Assignment Plans were located in a binder in the common living room and identified tasks for first, second and third shift medication aides (MAs) and personal care aides (PCAs). -The Plans also listed the tasks for each resident, and the staff were to refer to the binder in caring for the personal care needs of each resident. -The tasks listed for Resident #3 on first and second shift included; offering to toilet after meals and at bedtime, ensure adequate meal intake due to diagnosis of diabetes, he may cough or choke while eating, he was wheelchair dependent and	D 269		

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required 2 person assist with all transfers using a lift.
-There was no entry regarding pressure ulcers on his right and left foot, foam booties to be applied to both feet when out of bed, to elevate his legs when in the wheelchair, provide a pillow under his feet when in a dependent position and his feet should not drag along the floor when pushed in the wheelchair.

a. Observation on 03/29/22 at 9:25am, at 11:40am and at 12:10pm revealed:
-Resident #3 was sitting in a highback wheelchair in the common living area after breakfast.
-His legs were dependent and his feet were resting on the floor.
-He had yellow non skid socks on both feet and no observable dressings.
-Resident #3 was propelled in his wheelchair by staff to his room before lunch.
-Staff propelled him in the wheelchair down the hall with his feet dragging on the floor.
-Resident #3 was in the dining room for lunch at the back table in his wheelchair.
-He had yellow non skid socks on both feet and his feet were resting on the floor.
-There were no foot pedals applied to the wheelchair.

Observation of Resident #3 on 03/29/22 at 3:30pm revealed:
-The resident was propelled in his wheelchair by staff to his room.
-The resident had yellow non skid socks on both feet and his feet dragged along the floor as he was propelled in his wheelchair by staff down the hall.
-In his bedroom, on a chair at the foot of the bed, were 2 purple foam booties.
-The resident transferred from the wheelchair to

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the bed with the assistance of a sit to stand lift and 2 staff.
-Removing the socks, there were dressings on both feet from the heel to above the ankle.
-The dressings were wrapped with gauze and Coban, a self adherent wrap, to secure them to the area.
-The dressings were unable to be removed by staff since there were no supplies to redress the areas.
-When the resident's brief was removed, there was a large bowel movement, some of which was caked onto his skin.
-The buttocks and surrounding area was reddened and 3 additional open areas, the size of a dime, were observed.
-There was no evidence of a barrier cream applied to the area.

Review of Resident #3's HHN documentation dated 02/18/22 through 03/11/22 revealed:
-The HHN Clinical Manager dated the resident's start of care for the left heel wound as 02/18/22.
-The assessment of the left heel wound was that it was an unstageable pressure ulcer (the wound was covered extensively with dead tissue).
-HH treated the left heel pressure ulcer until 03/11/22, when another agency took over the case.
-The left heel pressure ulcer was unstageable on 03/11/22.

Telephone interview with the previous HHN on 03/30/22 at 11:20am revealed:
-The HH agency received orders from Resident #3's PCP to evaluate a wound on his left heel.
-The start of care was on 02/18/22, to be seen two days a week.
-The pressure ulcer on the left heel was unstageable due to eschar (dead skin that

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needed to be removed to heal).
-On 02/23/22 the wound had no sign of infection.
-A left heel protector was ordered and was to be applied by the staff, and a pillow under his feet, to off load the pressure when sitting in the wheelchair.
-After 3 weeks the wound was still unstageable and it was recommended to the Health and Wellness Coordinator (HWC) that a visit to the wound clinic was required.
-She did not have any documentation Resident #3 was seen at the wound clinic at that time.
-On two occasions when she visited the facility to provide care, Resident #3 was sitting in his wheelchair with no protective booties on his feet or pillow under his feet to reduce the pressure on the wounds.

Review of Resident #3's electronic progress note dated 03/04/22 and 03/09/22 revealed:
-On 03/04/22, the first shift agency medication aide (MA) documented the HHN visited Resident #3 on 03/03/22, dressed the left heel wound, and ordered foam foot booties to protect the wound when his foot dragged on the ground (during wheelchair ambulation).
-On 03/09/22, it was documented Resident #3's left heel wound was bleeding and appeared infected, with blackened tissue present.
-The heel was not wrapped with a dressing and it was reported to the Health and Wellness Coordinator (HWC).
-The HWC reported to the MA that HH was taking care of the wound.
-The skin on the right back heel was breaking down also and required attention.
-This was also reported to the HWC.

Review of Resident #3's second HHN progress notes dated 03/17/22 and 03/21/22 revealed:

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D 269	Continued From page 11 -At the start of care on 03/17/22 the left heel wound measurements were 14.0cm Length x 8.0cm Width and 0cm Depth. -The left heel wound was an unstageable pressure ulcer and required wound clinic assessment to debride (remove the dead tissue). -The right heel was a stage 2 pressure ulcer, (a shallow and reddened wound with no dead tissue or deeper tissue exposed), with redness and a foul odor, mostly eschar, and required debridement for effective treatment and healing. -The right heel wound measurements were 2.0cm length x 2.7cm width x 0.1cm depth, with redness and some drainage. -An entry titled "Care Staff" directed staff to ensure Resident #3's feet were elevated when sitting and to keep the foam booties on both feet while out of bed. -On 03/21/22, the left heel wound measurements were 13.5cm L x 9.0cm W and 0.2cm D, with redness, serosanguinous drainage (clear fluid mixed with blood) and some pain. -The right heel wound measurements were 2.5cm L x 2.5cm W and 0.1cm D with some serosanguinous drainage. -In bold letters and underlined to the staff there were strict instructions to not drag the resident's heels when transporting. Review of Resident #3's wound clinic summary note dated 03/17/22 revealed: -The resident was seen for a Stage 2 diabetic pressure ulcer on the right and left heel. -The right heel was debrided (dead tissue and infected tissue removed) during the visit with the fat layer of the wound exposed. -Fibrin (a protein used in the clotting of blood), fluid from the wound bed and and dead skin were removed during debridement, with moderate serosanguinous (red blood cells mixed with clear	D 269		

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plasma) drainage.
-The measurements of the total wound was 1cm L, 1cm W and 0.1cm D.
-The fat layer beneath the skin was exposed with a vaseline gauze dressing applied.
-The left heel was also debrided during the visit with the fat layer of the wound exposed, and further debridement necessary.
-The measurement of the left heel was 6.5cm L, 7.5W and 0.1 D.
-The orders for both wounds were to cleanse and pat dry, cover with a 4x4 dressing and secure with kerlix and tape, change daily and wear foam booties daily.

Telephone interview with an agency MA on 03/31/22 at 9:20am revealed:
-Resident #3 had wounds on his right and left heel that started about a month ago.
-The left heel wound started as a dime size opening.
-She documented in the electronic progress notes and reported the wound to the HWC (03/04/22).
-Her next shift assignment was the following week and Resident #3's left heel wound was uncovered, draining, filled with pus (yellow thick drainage) and had a foul odor.
-The resident was "hollering" during transfers on the sit to stand lift.
-She reported to the HWC her concerns regarding Resident #3's wounds and the HWC responded that the HHN was taking care of the wound now. The staff were not to provide any care to the wound.
-The MA took it upon herself to cover the wound and requested pain medication for the resident.
-His feet were dragging on the ground when propelled in the wheelchair.
-The HWC stated wheelchair foot rests were a

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restraint and needed a physician's order, so they were not applied.
-Home Health started treating the wound about 3 weeks ago when it was quarter size.
-The foam booties which were ordered and left in his room were never on Resident #3's feet when she would start her shift. She had to apply them.

Telephone interview with Resident #3's second HHN on 03/30/22 at 9:51am revealed:
-On 03/17/22, the HHN assessed Resident #3's left heel and right heel wound.
-The left heel was unstageable, the right heel was a stage 2 pressure ulcer.
-She recommended to the HWC the resident be seen at the wound clinic for debridement of the wounds.
-She implemented the wound orders from the clinic, documented in the progress note and informed the MA on the floor and the HWC that the resident's heels were not to touch the floor and foam booties were to be on his feet at all times to protect his heels.
-She recommended to the HWC that Resident #3 should be seen at the wound clinic a second time, and reinforced the necessity of wearing the foam booties and keeping his feet off the floor.
-She had observed at times when she visited the facility, the resident's booties were not on and his feet were on the floor
-It had not been reported to her that Resident #3 had three additional open areas on his buttocks and genital area.
-She assessed the resident each visit for additional skin breakdown and those areas were not open on 03/28/22 when she last saw the resident.

Telephone interview with Resident #3's primary care provider (PCP) on 03/31/22 at 10:00am

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revealed:
-She had ordered HHN to evaluate and treat Resident #3's wounds on 02/17/22.
-She had been informed by the HWC that the facility would change HH agencies since Resident #3's wounds were not healing.
-She had not been informed of any additional open areas on the residents buttocks or genital areas.
-She expected the HHN and herself to be informed by the facility staff of any new open areas on Resident #3.
-The facility had not requested an order for a gel mattress or wheelchair pad for Resident #3.

Interview with Resident #3's wound clinic nurse on 03/30/22 at 10:30am revealed:
-She had consulted with the physician providing treatment for Resident #3's wounds.
-The assessment plan was as follows; control the edema in the wound area by elevating the resident's legs whenever possible out of bed, apply santyl daily (a debriding agent used to break up and remove dead skin in a wound), padding the heels at all times with foam booties and reducing the pressure on his wounds with a pillow under his feet if his feet were not elevated.
-If he was in the wheelchair with legs dependent and/or not applying foot booties to both feet for protection, this would impede healing process of the wounds.

Interview with a first shift agency personal care aide (PCA) on 03/29/22 at 4:10pm revealed:
-Resident #3 was total care and used a lift to transfer from the bed to the wheelchair.
-He had wounds on both of his feet that the HHN was treating.
-He noticed a few weeks ago during personal care that the open area on the left heel was

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draining and reported it to the HWC.
-He did not know the resident had to wear protective foam booties when out of bed or a pillow under his feet to off load the pressure on his feet.
-He had not been trained by the facility before working with the residents.
-He had worked in other facilities and knew how to care for residents.
-There were assignment sheets available in the common area and if he had any questions he would go to the MA.

Interview with a second agency PCA on 04/01/22 at 10:05am revealed:
-This was her first day at the facility.
-She was given report by the previous shift for what residents needed personal care and assistance with ambulation.
-She had not received any information from management on the personal care needs of the residents.
-She would go to the MA if she needed additional information or assistance.

Interview with the agency MA on 03/30/22 at 8:45am revealed:
-She was not aware it was her responsibility to place booties on Resident #3 and a pillow under his feet to off load pressure when he was in the wheelchair.
-She did not see the order for foot booties and elevation of legs when dependent, on the electronic medication administration record (eMARs).

Review of Resident #3's March 2022 eMARs revealed:
-There was no entry for foam booties to be applied daily when the resident was in the

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D 269	Continued From page 16 wheelchair. -There was no entry to elevate legs or reduce pressure on the wounds with a pillow under the resident's feet, when they were not elevated. Interview with the HWC on 03/30/22 at 3:55pm and 04/01/22 at 11:45am revealed: -She was responsible for receiving orders from physicians and entering orders on the eMARs, review of the eMAR for accuracy of orders, personal care issues and referral and follow up with the physicians for the residents in the Special Care Unit (SCU). -She was first aware of Resident #3's left heel wound last month when a PCA reported it to her. -She requested an order from Resident #3's PCP on 02/17/22 for HHN to evaluate and treat the wound. -HHN started care for the wound on 02/18/22, and the wound was unstageable due to Eschar in the wound bed. -After several weeks it was still unstageable, so she requested a new agency to take over the case. -The second HHN started care on 03/17/22 and recommended a wound clinic consult. -It was the responsibility of the Health and Wellness Director (HWD) to complete a skin assessment when there was a change in condition and complete the open wounds documentation weekly. -The HWD also scheduled the facility's Registered Nurse (RN) to come in and complete the resident's quarterly Licensed Health Professional Support (LHPS) reviews. -She did not know the skin assessment, open wounds documentation and updated LHPS was not completed on Resident #3. -There was a staff assignment binder on each floor in the common area which had staff	D 269		

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D 269	Continued From page 17 assignment sheets for each week. -The staff assignment sheets listed the residents on each floor and described their personal care needs for grooming, dressing, toileting, transfers, ambulation and feeding assistance. -Staff were supposed to review the assignment sheets to become familiar with the care of each resident. -Agency staff were directed to the staff assignment binder for information on their resident and to go to the MA or nurse for additional information if needed. -She did not know who generated the information on the assignment sheets and why Resident #3's wounds, booties to be applied, pillow to offload pressure and elevation of legs when sitting in the wheelchair was not included in the weekly assignment sheets for the staff. -She also thought these interventions were included on the eMARs and were the responsibility of the MAs to ensure the tasks were completed. -She had been told by the HWD that wheelchair foot rests were a restraint and that was the reason she had kept them off all wheelchair bound residents. -She had not observed Resident #3 without booties and a pillow to reduce the pressure on his feet while she was in the building. -She had informed staff of Resident #3's orders from HHN during stand up meetings per shift. -The HHN was responsible for the treatment and orders for the wound care. -The facility was not able to provide any wound care to residents. Interview with the HWD on 03/30/22 at 12:40pm revealed: -She was responsible for overseeing the SCU and the Assisted Living Unit.	D 269		

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D 269	Continued From page 18 -Since they were 2 different buildings, she spent half her week in each building. -There was a HWC in each of the buildings and she relied on them to handle the day to day operations of their respective buildings. -She was not aware of the skin assessment on 02/17/22 completed by the HWC. -Resident #3's pressure ulcers were being treated at that time by the HHN and should have been recorded with aggressive interventions listed. -For wound healing, especially with a diabetic, she would have requested an increase of protein in the diet and a zinc supplement. -It would have been the responsibility of the HWC to follow up with the physician for interventions regarding wound healing -There was a facility policy that skin assessments with open wounds should have a follow up flow sheet completed weekly by the HWC that included an assessment of the wound until healed. -There were no open wound flow sheets completed by her or the HWC on Resident #3. -The nursing staff was concerned Resident #3's wound was not healing and another wound on the right heel had been observed. -They initiated a change in HH agencies and continued skilled nursing services for the pressure ulcers. -The staff was aware of the orders to off load the pressure on the heels with a pillow, but there was all agency staff on first shift and it was a struggle to get them to follow the HHN orders. -It was the MAs task to apply the foam booties and ensure Resident #3's feet were propped on a pillow when he was in the wheelchair. -The orders were in the eMAR, so it fell on the MA to complete the task. Review of Resident #3's record revealed there	D 269		

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D 269	Continued From page 19 was no additional documentation in the progress notes, no entries on the electronic medication records (eMARs), or personal care records regarding the resident's skin status, wounds or any care provided to the resident's diabetic pressure ulcers by the facility staff. Interview with the Administrator on 04/01/22 at 3:39pm revealed: -She knew Resident #3 had pressure ulcers and was being treated by HHN. -She did not know staff were not following the orders of the HHN and the wound clinic physician. b. Observation of Resident #3 on 03/29/22 at 3:30pm revealed: -The resident had been wheeled to his room in his wheelchair by staff to provide incontinent care. -Staff removed the resident's socks and exposed his bare feet. -On the left foot there were 3 toes with several dime size skin tears scabbed over, on each toe. -The toenails on both feet were thick and discolored with dried skin peeling on several areas near the cuticles. -On the second toe of the left foot there was a yellow, tough material caked on the cuticle bed reaching over to the skin. -On the third, fourth and fifth toes of both feet there was a smaller amount of the same yellow tough material around the nail beds. -The toenails on the second, fourth and fifth toe of the left foot were long and needed to be trimmed. Review of Resident #3's HHN documentation dated 02/18/22 revealed: -The right and left toenails were yellow. -The right foot second toe was bruised and the nail needed to be trimmed.	D 269		

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D 269	Continued From page 20 Review of the second HHN progress notes dated 03/17/22 and 03/21/22 revealed no documentation of the condition of the toes and toenails. Interview with the primary care provider (PCP) on 03/31/22 at 10:00am revealed: -She was not aware of Resident #3's skin abrasions, toenail discoloration and peeling skin on the toes of the right and left foot, and the toenails needing to be trimmed. -She relied on the staff to inform her of any skin breakdown and to schedule an appointment on her next visit to assess. Interview with the HWC on 03/30/22 at 3:55pm revealed: -She completed Resident #3's skin assessment on 02/17/22. -She documented his skin was dry and flaky. -She did not observe the yellow toenails or the buildup around the cuticles, since she was focusing on his pressure ulcer. -She expected the personal care aides (PCAs) to inform her of any skin breakdown when they were providing personal care. -If she had been aware of the condition of his toes and toenails she would have requested a podiatry consult since he was a diabetic. Interview with HWD on 03/30/22 at 12:40pm revealed: -It was the responsibility of the HWC to perform skin assessments of the residents in the Special Care Unit (SCU). -She was not aware of Resident #3's skin breakdown on the toes of his his right and left foot and the yellowing toenails with thick crusting on the cuticles of several toes on both feet, and	D 269		

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toenails needing to trimmed.
-The PCAs or MAs should have reported this condition to the HWC or herself and a podiatry appointment should have been made.
-The staff do not provide nail care to the residents.

Interview with the Administrator on 04/01/22 at 3:39pm revealed:
-She relied on the nursing staff to manage the clinical needs of the residents.
-She was not aware of the condition of Resident #3's toe nails and skin tears on his toes.
-The HWD was responsible for the oversight of the SCU and could delegate tasks to the HWC.

Review of Resident #3's record revealed there was no additional documentation in the progress notes, no entries on the electronic medication records (eMARs), or personal care records regarding the resident's skin status on his feet or toenails by the facility staff.

Attempted telephone interview with the HWD on 04/01/22 at 10:20am was unsuccessful.

Attempted telephone interview with Resident #3's responsible family member on 03/30/22 at 11:55am was unsuccessful.

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

Refer to interview with the HWC on 03/30/22 at 3:55pm and 04/01/22 at 11:44am.

Refer to telephone interview on 04/01/22 at 10:50am with a second shift PCA.

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D 269	Continued From page 22 Refer to interview on 04/01/22 at 3:39pm with the Administrator. 2. Review of Resident #1's current FL2 dated 07/16/21 revealed diagnoses included unspecified dementia without behaviors. Review of Resident #1's current Care Plan dated 12/30/21 revealed: -She had stage 2 pressure ulcers to her heels that were being treated by the facility's home health agency. -She was encouraged to elevate her heels while in bed and to wear her foam cushion booties. -She was incontinent of bowel and bladder. -She used a wheelchair for mobility and required staff escort to and from activities. -She had a diagnosis of dementia and required staff assistance to complete all activities of daily living (ADLs). -She was mainly non-verbal and staff had to anticipate her needs. -She currently used home health services, but a Hospice consult was being obtained. -She was a 2 person transfer, but only required limited assistance with transfers. -She was totally dependent for all other ADLs. Review of Resident #1's Hospice communication note dated 01/04/22 revealed she was referred to Hospice Services and the Hospice plan of care was initiated. Review of Resident #1's progress notes revealed: -On 12/04/21, the resident had open areas to bilateral heels. -On 12/06/21, Home Health evaluated the resident for wound care orders for the heel wounds. -On 12/31/21, the family agreed to have a	D 269		

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Hospice consult initiated.
-On 01/05/22, the resident was admitted to Hospice due to an overall decline in status, not eating, and to monitor heel wounds.

Review of Resident #1's Licensed Health Professional Support (LHPS) dated 02/02/22 revealed:
-She had been transferred from home health services to Hospice care on 01/05/22 for continued wound care to bilateral heel pressure ulcers, decline, and weight loss.
-LHPS tasks were transfers and wound care.

Review of Resident #1's current Skin Observation form dated 02/03/22 revealed:
-Her skin was documented as intact, with no open areas.
-She was chairfast and completely immobile.
-She had no apparent problem with friction and shear.
-Her Braden Scale for Predicting Pressure Sore Risk was 16.
-A score of 16 or less required prevention strategies.
-No prevention strategies were listed.
-The skin assessment was completed and reviewed by the medication aide (MA).

Review of Resident #1's record revealed:
-There was a Hospice Interdisciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report dated 01/12/22 which documented bilateral heel wounds with orders for heel protectors and wound care provided weekly.
-There was a Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated 03/08/22 which documented a stage II pressure injury to the left ischial tuberosity (a rounded bone that extends from the bottom of the

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pelvis and supports the weight of the body when one is sitting) and a stage II to the sacrum requiring wound care 2 times per week.
-There was an order dated 03/22/22 for zinc barrier cream to be applied to the sacrum daily as needed for each incontinent episode.
-There was an order dated 03/31/22 for wound care to the left heel - apply protective foam dressing and apply heel protectors to both feet daily to prevent breakdown.
-There was an order dated 03/31/22 for wound care to the left ischial tuberosity - apply Medihoney (a medical-grade honey-based product for the management of wounds and burns) and bordered foam dressing twice a week and as needed (PRN) if dressing falls off or becomes soiled.

Review of the facility's computer-generated Assignment Plan for Resident #1 revealed:
-The resident "has a wound".
-The sheet did not specify what type of wound, location of the wound, or type of wound care needed.

Interview on 03/30/22 at 9:58am with the Health and Wellness Coordinator (HWC) revealed:
-Hospice performed the wound care for the bilateral heels and now the resident had a new wound on her buttocks.
-She thought the new buttock wound was not an open area, and was located on the left side.
-They had received new wound care orders on 03/22/22 to apply barrier cream to the sacrum area daily.

Interview with the Health and Wellness Director (HWD) on 03/30/22 at 12:30pm revealed:
-The current skin assessment for Resident #1 was completed by a MA on 02/03/22.

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D 269	Continued From page 25 -There was a facility policy that skin assessments with open area wounds should have a follow-up flow sheet completed weekly by her, that included an assessment of the wound until healed. -She had never completed a skin assessment or weekly follow-up flow sheet for Resident #1. -There were no other skin assessments completed by the facility since the resident started with Hospice on 01/05/22. -Resident #1 had a heel pressure ulcer that was scabbed over, and another heel pressure ulcer that was open. -The Hospice nurse was performing wound care twice weekly. -If the dressing came loose or was soiled, staff would notify the Hospice nurse. -The resident did not go to a wound clinic for evaluation and treatment. -She was not aware of any pressure relieving interventions for Resident #1 including foam heel protectors while in bed or in the wheelchair. -She had "something" on her buttocks, the onset of the buttocks wound was "a couple weeks ago" and she was not sure what stage it was. -She was certain the buttocks wound was a pressure ulcer, but was not sure if it was open or just redness, and was not sure of the exact location on the resident's buttocks. Observation on 03/30/22 at 1:25pm of Resident #1 revealed: -She was in the living room sitting in her high back wheelchair. -She had thick gray and pink socks and her feet were resting directly on the floor. -She did not have her leg rests on the wheelchair and was not wearing her foam heel protectors. Observation on 03/30/22 at 4:20pm of Resident #1 revealed:	D 269		

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D 269	Continued From page 26 -She was lying in the bed on her right side when the second shift personal care aide (PCA) entered the room -When the PCA removed her incontinent brief, there was a medium size loose bowel movement, which had smeared onto her skin. -There was a bordered foam dressing over the left ischial tuberosity (area right below the left buttock and left upper thigh), the edges of the dressing was soiled, but was intact. -The left hip was reddened and had one additional open wound, the size of a dime, with no dressing in place, with no drainage noted. -The sacral area had an open wound, the size of a dime, there was no dressing in place, and no drainage noted. -The PCA cleaned the areas with a disposable wipe and applied a barrier cream to the sacrum and left hip. Interview with the second shift PCA on 03/30/22 at 4:20pm revealed: -The dressings could not be removed by staff because the Hospice nurse performed the wound care twice weekly. -The PCAs were only allowed to clean the buttocks with disposable wipes and apply barrier cream. -The woundson Resident #1's buttocks, hip and sacrum had started about 4-6 weeks ago. Observation on 03/31/22 at 9:05am of Resident #1 revealed: -She was in the living room sitting in her wheelchair with white ankle socks on both feet, no leg rests and no heel protectors in place. -Both feet were resting directly on the floor. Observation on 03/31/22 at 11:03am of Resident #1's wounds during the Hospice nurse visit	D 269		

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D 269	Continued From page 27 revealed: -There was a stage II pressure ulcer on the left ischial tuberosity that measured 2.0cm x 1.5cm x 0.1cm and had medihoney and bordered foam dressing applied. -There was a stage II pressure ulcer on the sacrum that measured 1cm x 1cm x 0.2cm, hydrocolloid dressing applied. -There was a stage I pressure ulcer on the left hip that measured 1.5cm x 0.25cm, with no depth, barrier cream applied. -There was a scabbed over area on the left heel that measured 5cm x 2cm, with no depth, with bordered foam dressing applied. -There was a scabbed over area on the right heel that measured 1cm x 1cm, with no depth with bordered foam dressing applied. Interview on 03/31/22 at 11:03am and 12:00pm with Resident #1's Hospice nurse revealed: -The order for heel protectors was generated by Hospice and should be worn while in the bed or in the wheelchair with leg rests in place to prevent skin breakdown. -If a dressing became loose or soiled the facility staff should notify her and she or the Hospice CNA would apply a new dressing. Interview with the first shift medication aide (MA) on 03/31/22 at 1:35pm revealed care provided to Resident #1 included transfers with a hoyer lift, incontinent care, feeding assistance, application of heel protector booties, application of barrier cream to the sacrum and buttocks as needed with each incontinent episode, and use of foam wedge and pillows to turn and position her in the bed every 2 hours. Review of Resident #1's Hospice IDG Comprehensive Assessment and Plan of Care	D 269		

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D 269	Continued From page 28 Update Report notes from 01/05/22 to 03/22/22 that were requested from the Hospice nurse revealed: -On 01/05/22, there was documentation of a history of bilateral heel wounds with orders for heel protectors. -On 01/12/22, there was documentation of bilateral heel wounds with orders for heel protectors and wound care provided weekly. -On 01/25/22, there was documentation of bilateral heel wounds with orders for heel protectors and wound care provided weekly. -On 02/08/22, there was documentation of bilateral heel wounds with orders for heel protectors and wound care provided weekly, and a new stage II pressure ulcer on the left ischial tuberosity. -On 02/22/22, there was documentation of bilateral heel wounds and a new stage II pressure injury on the left ischial tuberosity requiring wound care two times per week. -On 03/08/22, there was documentation of a stage II pressure injury to the left ischial tuberosity and a stage II to the sacrum requiring wound care 2 times per week. -On 03/22/22, there was documentation of a stage II pressure injury on the left ischial tuberosity and a stage II to the sacrum requiring wound care 2 times per week. Telephone interview on 04/01/22 at 10:50am with a second shift PCA revealed: -The PCAs would let the HWC know if the dressing came off. -The HWC would notify the Hospice nurse. -She had heel protectors in her room, but she was not sure of the frequency for them to be applied and removed. -She took them off at night and put them on when the resident was up in the wheelchair or in the	D 269		

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D 269	Continued From page 29 bed. -She sometimes used a pillow under the back of her lower legs when she was in a wheelchair -She used wedges in the bed and under her legs to reposition her every 2 hours. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's Hospice provider on 03/30/22 at 4:02pm was unsuccessful. Refer to interview with the HWC on 03/30/22 at 3:55pm and 04/01/22 at 11:44am. Refer to telephone interview with a 2nd shift PCA on 04/01/22 at 10:50am. Refer to interview with the Administrator on 04/01/22 at 3:39pm. _____ Telephone interview with a 2nd shift PCA on 04/01/22 at 10:50am revealed: -The PCAs would make notes on their computer generated assignment sheets each shift and would turn them into the HWC at the end of each shift for review. -The assignment sheets informed the PCAs of residents' needs and care plan information. -PCAs got report at the start of each shift from the first shift PCA in order to know what was going on with each resident. -Second shift staff also had stand-up meetings daily to discuss resident care and any changes to care needed. -If the PCAs found any issues like new wounds or new skin breakdown they would notify the MA	D 269		

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and/or the HWC immediately.
-The facility nurses were responsible for skin assessments on residents for new or open wounds.
-PCAs completed shower or bed bath log for each resident in the past, but had stopped using the logs when the new HWC started to work.

Interview with the HWC on 03/30/22 at 3:55pm and 04/01/22 at 11:44am revealed:
-The HWD was responsible for completing a skin assessment when there was a change in condition and completed the open wounds documentation weekly.
-She did not know who generated the information on the assignment sheets and why information regarding wounds, booties to be applied, pillow to offload pressure and elevation of legs when sitting in the wheelchair was not included in the weekly assignment sheets for the staff.
-She also thought these interventions were included on the eMARs and were the responsibility of the MAs to ensure the tasks were completed.
-She had been told by the HWD that wheelchair foot rests were a restraint and that was why she kept them off all wheelchair bound residents.
-The facility was not able to provide any wound care to residents.

Interview with the Administrator on 04/01/22 at 3:39pm revealed:
-All staff were responsible to report new wounds or skin breakdown to the HWC.
-The HWC was responsible to complete skin assessments and request appropriate treatment.
-The HWD was responsible to complete the initial, quarterly, yearly and significant change Care Plans (Personal Service Assessment (PSA) and Personal Service Plan (PSP) for all residents.

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D 269	Continued From page 31 -Current wound information and skin breakdown prevention should be listed on the PSA and PSP. -The daily staff assignment sheets were generated by the information entered on the PSA and PSP. -The assignment sheets were only updated when information in the PSA/PSP was updated. _____ The facility failed to provide personal care assistance for a resident with type 2 diabetes mellitus, who required care for pressure wounds on the right and left heel, one with eschar, and three additional open areas observed, not reported to the Home Health nurse or physician, and toenails on both feet were thick and discolored with a yellow, tough material caked on the cuticle bed reaching over to the skin and dime size skin tears scabbed over on several toes whose nails needed to be trimmed (Resident #3), and for a resident with dementia, who required care for recurrent bilateral heel pressure ulcers and 3 additional pressure ulcers on her sacrum and buttocks within the last 7 weeks (Resident #1). This failure placed the residents at a substantial risk for serious physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 03/31/22 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 1, 2022.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

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D 273	Continued From page 32 (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 A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 5 sampled residents (Residents #3 and #5) related to failure to contact the physician for a resident with a diagnosis of diabetes, and had wounds on his backside, an order for a urine sample to rule out sepsis, and needed a podiatrist appointment for yellowing toenails with buildup around the cuticles and skin peeling on the toes of both feet (Resident #3), and failure to contact the physician for a refill prescription for a pain medication (Resident #5). The findings are: 1. Review of Resident #3's current FL2 dated 03/04/22 revealed: -Diagnoses included vascular dementia, Type II diabetes, left sided hemiplegia and glaucoma. -He was non-ambulatory and dependent on staff with the use of a wheelchair. Review of Resident #3's current Care Plan dated 01/31/22 revealed: -Resident #3 required staff assistance for all dressing and grooming needs, and for weekly showers. -He ambulated in a wheelchair with the assistance of staff to the dining area and community activities, and transferred with the aid of a lift and 2 person assistance. Review of the facilty's clinical guidelines regarding	D 273		

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skin breakdown dated September 2018 revealed:
-Community associates should report skin concerns to the Health and Wellness Director (HWD).
-Complete documentation of the skin breakdown should be in the resident's record.
-Notification was to be given to the responsible family member and the primary care provider (PCP).

Review of the Shift Assignment Plans from 03/21/22 through 04/01/22 revealed:
-The Shift Assignment Plans were located in a binder in the common living room and identified tasks for first, second and third shift medication aides (MAs) and personal care aides (PCAs), and were updated weekly or as needed.
-The Plans also listed the tasks for each resident, and the staff were to refer to the binder in caring for the personal care needs of each resident.
-The tasks listed for Resident #3 on first and second shift included; offering to toilet after meals and at bedtime, assure adequate meal intake due to diagnosis of diabetes, he may cough or choke while eating, he was wheelchair dependent and required 2 person assist with all transfers using a lift.
-There was no entry regarding open areas on Resident #3.

a. Observation of Resident #3 on 03/29/22 at 3:30pm revealed:
-Resident had been wheeled to his room in his wheelchair by staff.
-Removing the resident's footwear, the toes and nails of both feet were exposed.
-On the left foot there were 3 toes with several dime size skin tears scabbed over, on each toe.
-The toenails on both feet were thick and discolored with dried skin peeling on several

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areas near the cuticles.
-On the second toe of the left foot there was a yellow, tough material caked on the cuticle bed reaching over to the skin.
-On the third, fourth and fifth toes of both feet there was a smaller amount of the same yellow tough material around the nail beds.
-The toenails on the second, fourth and fifth toe of the left foot needed to be trimmed.

Review of Resident #3's Home Health Nurse (HHN) documentation dated 02/18/22 revealed:
-The right and left toenails were yellow.
-The right foot second toe was bruised and the nail needed to be trimmed.
-There was no documentation a referral was made to a podiatrist.

Review of the second HHN progress notes dated 03/17/22 and 03/21/22 revealed no documentation of the condition of the toes and toenails.

Interview on 3/29/22 at 4:10pm with a first shift agency PCA revealed:
-She had not been trained by the facility regarding the needs of the residents in the SCU.
-The staff received an assignment sheet at the beginning of the shift and the previous shift would give report.
-If she had any questions she would go to the medication aide (MA) on the floor.
-She did not cut the resident's toenails or fingernails.
-Nail care was not on Resident #3's assignment sheet.
-She had assisted with the Resident 3's personal care but was not aware of any problems with his feet or nails.

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D 273	Continued From page 35 Interview with Resident #3's primary care provider (PCP) on 03/31/22 at 10:00am revealed: -She was not aware of Resident #3's skin abrasions, toenail discoloration and peeling skin on the toes of the right and left foot. -She was not aware of the tough crusted material surrounding the cuticles on several toes on both feet.. -She relied on the staff to inform her of any skin breakdown and to schedule an appointment on her next visit to assess. -Since Resident #3 had diabetes, had she been aware of the condition of his toenails and toes, she would have referred him to a podiatrist for foot care. Interview with the Health and Wellness Coordinator (HWC) on 03/30/22 at 3:55pm revealed: -She had completed Resident #3's skin assessment on 02/17/22. -She documented his skin was dry and flaky. -She did not observe the yellow toenails or the buildup around the cuticles. -She expected the personal care aides (PCAs) to inform her of any skin breakdown when they were providing personal care. -If she had been aware of the condition of his toes and toenails she would have requested a podiatry consult since he had diabetes. Interview with the Health and Wellness Director (HWD) on 03/30/22 at 12:40pm revealed: -It was the responsibility of the Health and Wellness Co-ordinator (HWC) to perform skin assessments on the residents in the Special Care Unit (SCU). -She was not aware of Resident #3's skin breakdown on the toes of his right and left foot and the yellowing toenails with thick crusting on	D 273		

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the cuticles of several toes on both feet.
-The PCAs or medication aides (MAs) should have reported this condition to the HWC or her self and a podiatry appointment should have been made.

Interview with the Administrator on 04/01/22 at 3:39pm revealed:
-She relied on the nursing staff to manage the clinical needs of the residents.
-She was not aware of the condition of Resident #3's toenail and skin tears on his toes.
-The HWD was responsible for the oversight of the SCU and could delegate tasks to the HWC.

Review of the facility's electronic progress notes from 02/18/22 through 03/30/22 revealed there was no documentation that Resident #3 was seen by a podiatrist for the care of his toes and toenails.

Review of Resident #3's record revealed there was no additional documentation in the progress notes, no entries on the electronic medication records (eMARs), or personal care records regarding the resident's skin status on his feet or toenails by the facility staff.

b. Review of Resident #3's hospital discharge summary dated 03/14/22 revealed:
-Resident #3 was sent to the Emergency Department (ED) for a possible infection of his left heel pressure ulcer.
-The diabetic ulcers were found to be without evidence of infection.
-A urinalysis was performed to rule out urinary sepsis.
-Telephone contact with the resident's special care facility for further history was attempted without answer.

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D 273	Continued From page 37 -It was unclear if any further work up needed to be pursued at this time. -The resident was discharged back to the facility with an order to continue the Keflex every 8 hours. Review of Resident #3's hospital discharge follow-up summary dated 03/22/22 revealed: -On 03/14/22, Resident #3's urine sample taken at the hospital was contaminated, and a repeat urine was ordered. -The hospital staff attempted to contact Resident #3's facility by phone on 03/17/22, 03/18/22, 03/21/22 and 03/22/22 to request a urine sample to be obtained and was not able to reach a staff person in the SCU. -On 03/22/22, a certified letter was sent to the facility with the request to follow up on Resident #3's repeat urine sample to rule out a urinary tract infection. Review of Resident #3's record revealed there was no documentation showing a repeat urine sample had been obtained from the resident. Interview with the Health and Wellness Coordinator (HWC) on 03/30/22 at 12:40pm revealed: -She had never received any notification from the hospital team that Resident #3 had to have a repeat urine. -She did not have any difficulty in reaching the facility by phone. Interview with the HWD on 03/30/22 at 12:40pm revealed: -She did not receive notification from the hospital regarding a repeat urine to be obtained from Resident #3 due to contamination of the hospital specimen.	D 273		

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-It was very difficult to contact the facility by telephone.
-The phone was cordless and often was not able to be located on the unit.

Interview with the Administrator on 04/01/22 at 3:39pm revealed:
-She had never received a certified letter from the local hospital regarding Resident #3's ED visit on 03/14/22
-She did not have any reports individuals had a difficult time reaching the facility by phone.

Attempted telephone interview with Resident #3's responsible family member on 03/30/22 at 11:55am was unsuccessful.

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

c. Observation of Resident #3 on 03/31/22 at 1:00pm revealed:
-The staff propelled Resident #3 to his bedroom in his wheelchair.
-The resident was transferred from his wheelchair to the bed with a sit to stand lift.
-In changing his brief there was a small bowel movement and urine in the brief.
-His sacral area was reddened and there were 2 wounds on his left buttock and 1 wound on his scrotum, all three were dime sized.
-There was a fourth wound midcenter of his buttocks, larger than dime size with some depth, which was not present on 03/29/22.
-When the PCA attempted to clean the area over the fourth wound, the resident let out a groan and attempted to bat her hand away.

Interview with the primary care provider (PCP) on

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D 273	Continued From page 39 03/31/22 at 10:00am revealed: -She had ordered HHN to evaluate and treat Resident #3's left heel wounds on 02/17/22. -She had been informed by the HWC that the facility would change HH agencies since Resident #3's left heel wound was not healing and there was a new wound on the right heel. -She had not been informed of any additional open areas on the residents buttocks or genital areas. -The HWC was the liaison between her and the facility. -She expected the HHN to be informed by the facility staff of any new wounds on Resident #3 as well. Interview with the HWC on 04/01/22 at 11:45am revealed: -She would expect the care staff to inform her of any skin breakdown observed during personal care of the residents. -She did not perform any skin assessments on Resident #3 since he was being followed by the HHN. -She expected the HHN to perform skin assessments on Resident #3 and inform her of any new wounds. -She was not informed of any additional skin break down in Resident #3's sacral area. Interview with the Administrator on 04/01/22 at 3:39pm revealed: -She relied on the nursing staff to manage the clinical needs of the residents. -She would expect the care staff to inform the nurses if there was any skin breakdown on the residents. -The HWC was the liaison between the facility and the PCP, and would be the person to inform the physician of any changes in the resident's	D 273		

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health.
-The HWC or HWD was responsible to enter all new orders and care tasks into the eMAR for the medication aides to verify and ensure they were performed by themselves or the PCAs.

Attempted telephone interview with the HWD on 04/01/22 at 10:20am was unsuccessful.

Attempted telephone interview with Resident #3's responsible family member on 03/30/22 at 11:55am was unsuccessful.

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

2. Review of Resident #5's current FL2 dated 03/04/22 revealed:
-Diagnoses included vascular dementia, muscle spasms, and cerebrovascular accident (CVA).
-There was an order for Mobic 15mg (a medication used to treat moderate pain) take one tablet daily.

Review of Resident #5's signed primary care provider's (PCP) order summary report dated 02/25/22 revealed an order for Mobic 15mg take 1 tablet daily for pain.

Observation of the medication pass on 03/29/22 at 8:57am revealed Resident #5 did not have Mobic 15mg available on the medication cart for administration.

Observation of Resident #5's medications available for administration on 03/29/22 at 8:57am revealed there was no Mobic 15mg available for administration on the medication cart.

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D 273	Continued From page 41 Interview on 03/29/22 at 9:00am with the medication aide (MA) revealed: -She had reordered Resident #5's Mobic 15mg yesterday from the facility's contracted pharmacy. -The medications were delivered at night on the day they were ordered or the following day. -If the medication did not come in today, he would miss the dose. -The back-up pharmacy had not been contacted. Review of Resident #5's PCP's progress note dated 11/19/21 revealed: -His chief complaint was leg pain and visit type was noted as acute. -The assessment and plan documented back pain, related to a fall several weeks ago. -Diagnoses included multilevel degenerative disc disease of the lumbar spine and low back pain, unspecified. -The prescription for Mobic 15mg daily was initiated at this visit to help treat his back pain. Review of Resident #5's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Mobic 15mg, take 1 tablet daily for pain, scheduled for 8:00am. -Mobic 15mg was documented as not administered at 8:00am on 03/11/22, 03/12/22, 03/16/22 to 03/19/22, 03/22/22 to 03/26/22, 3/28/22 and 03/29/22. -The reason the medication was not administered was documented as "16 - pharmacy action required" for 03/11/22, 03/12/22, 03/16/22 to 03/19/22, 03/22/22 to 03/26/22, 3/28/22 and 03/29/22. -Mobic 15mg was documented as administered at 8:00am on 03/13/22, 03/14/22, 03/15/22, 03/20/22, 03/21/22, and 03/27/22, despite the	D 273		

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D 273	Continued From page 42 medication was not available on the cart. Interview with the Health and Wellness Coordinator (HWC) on 03/30/22 at 10:21am revealed: -She was not aware that Mobic 15mg was not available for administration for Resident #5 during the medication pass on 03/29/22. -She was not aware until she contacted the pharmacy by telephone on 03/30/22 that Resident #6's Mobic 15mg, for a quantity of 9 tablets was last filled on 02/27/22. -Mobic 15mg for a quantity 9 tablets only was dispensed because the facility was getting ready to start the resident on cycle fill, and they were trying to get all medications filled on the same day of the month. -Cycle fill had started in the facility in February 2022. -The MAs faxed several requests for refills to the pharmacy, and she would look for the documentation. -The pharmacy noted medications had been dispensed for Resident #5, when they had not. -She notified the PCP and pharmacy on 03/30/22 by telephone of the need for a new prescription for Resident #5's Mobic 15mg. Interview on 03/30/22 at 11:15am with the MA revealed: -The Mobic 15mg for Resident #5 had not been received yet. -She called the pharmacy again today (03/30/22) to request a refill. Review of a medication refill request sheet for Resident #5 revealed: -A refill request for Mobic 15mg was faxed to the pharmacy on 03/14/22 at 4:22pm. -There were no other requests for refill or	D 273		

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D 273	Continued From page 43 notification of the PCP. Interview with the Health and Wellness Director (HWD) on 03/30/22 at 12:30pm revealed: -The MAs requested refills by placing a sticker on a piece of paper and faxing it to the pharmacy each day, or refills could be requested online. -If there was a problem with getting the medications she expected them to notify her and the HWC. -If the MAs contacted the pharmacy or PCP regarding a refill it would be documented in the progress notes, and they would be expected to notify the HWC. -She was not aware that Resident #5's Mobic 15mg was not available for administration since 03/11/22. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/31/22 at 8:39am revealed: -Mobic 15mg was dispensed on 01/21/22 for a quantity of 30 tablets, and on 02/27/22 for a quantity of 9 tablets only. -A new prescription for Mobic 15mg was needed and received on 03/30/22 and was dispensed for a quantity of 8 tablets due to cycle fill scheduled to begin on 04/07/22. Telephone interview with Resident #5's PCP on 03/31/22 at 10:20am revealed: -She had just been notified of a refill request made this week by the facility. -She had not been notified that the resident had missed the medication due to the medication not being available for administration. -The resident took Mobic 15mg daily for generalized musculoskeletal pain. -If the resident was without the medication for 19 days, it would be possible for him to have	D 273		

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increased pain.
-It would be hard to tell if he was having more pain because the resident was non-verbal most of the time.

Interview on 04/01/22 at 11:44am with HWC revealed she did not have any documentation of the PCP being notified Resident #5 needed a new prescription for Mobic 15mg until 03/29/22.

Interview with the Administrator on 04/01/22 at 3:39pm revealed:
-The HWC was responsible to handle all orders for care received by the facility's contracted PCPs or other outside medical providers.
-She expected the HWD or HWC to notify the PCPs of any issues with medications.

_____

The facility failed to contact the physician for a resident with a diagnosis of diabetes who had open areas on the residents backside, an order for a urine sample to rule out sepsis, and a podiatrist appointment for yellowing toenails with buildup around the cuticles and skin peeling on the toes of both feet (Resident #3), and failure to contact the physician for a prescription for a pain medication used to treat degenerative disc disease of the lumbar spine, that was not administered for 19 days (Resident #5). This failure placed the residents at a substantial risk for serious physical harm and neglect which constitutes a Type A2 Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/31/22 for this violation.

CORRECTION DATE FOR THE TYPE A2

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D 273	Continued From page 45 VIOLATION SHALL NOT EXCEED MAY 1, 2022.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure physician orders were implemented for 2 of 3 sampled residents (Residents #1 and #3) who had orders for foam protective booties to be applied to each foot when out of bed. The findings are: 1. Review of Resident #3's current FL2 dated 03/04/22 revealed: -Diagnoses included vascular dementia Type II diabetes, left sided hemiplegia and glaucoma. -The resident was documented as non ambulatory in a wheelchair, and disoriented. Review of Resident #3's current Care Plan dated 01/31/22 revealed: -Resident #3 required staff assistance for all dressing and grooming needs, and for weekly showers. -He ambulated in a wheelchair with the	D 276		

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assistance of staff to the dining area and community activities, and transferred with the aid of a lift and 2 person assistance.

Review of Resident #3's primary care provider's (PCP) progress note dated 02/18/22 revealed there was an order for skilled nursing to evaluate and treat the resident's open wound on the left heel twice a week.

Review of Resident #3's Home Health Nursing (HHN) documentation dated 02/23/22 revealed an order for a left foot heel protector to be applied by the staff daily when out of bed, and a pillow under his feet when sitting in the wheelchair to reduce pressure on the heel wounds.

Review of Resident #3's HHN documentation dated 03/03/22 revealed an order for foam foot booties to protect the wound when his foot dragged on the ground.

Review of the Shift Assignment Plans from 03/21/22 through 04/01/22 revealed:
-The Shift Assignment Plans were located in a binder in the common living room and identified tasks for first, second and third shift medication aides (MAs) and personal care aides (PCAs).
-The Plans also listed the tasks for each resident, and the agency staff were to refer to the binder in caring for the personal care needs of each resident.
-There was no entry regarding pressure ulcers on his right and left foot and foam booties to be applied to both feet when out of bed.

Observation on 03/29/22 at 9:25am, at 11:40am and at 12:10pm revealed:
-Resident #3 was sitting in a highback wheelchair in the common living area after breakfast.

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-His legs were dependent and his feet were resting on the floor.
-He had yellow non skid socks on both feet.
-Resident #3 was taken to his room before lunch.
-Staff propelled him in the wheelchair down the hall with his feet dragging on the floor.
-There were no foot pedals applied to the wheelchair.
-Resident #3 was in the dining room for lunch at the back table in his wheelchair.
-He had yellow non skid socks on both feet and his feet were resting on the floor.
-There were no observations during these times that Resident #3 had foam foot booties on his feet for protection of his wounds.

Observation of Resident #3 on 03/29/22 at 3:30pm revealed:
-Resident had been wheeled to his room in his wheelchair by staff.
-Resident had yellow non skid socks on both feet and his feet dragged along the floor as he was propelled down the hall.
-In his bedroom, on a chair at the foot of the bed, were 2 purple foam booties.

Review of Resident #3's February 2022 electronic progress notes revealed there was a physician's order for HHN to evaluate and treat an open wound on the resident's left heel.

Review of Resident #3's March 2022 electronic medication administration record (eMAR) revealed there was no entry for foam booties to be applied daily when the resident was in the wheelchair.

Telephone interview with the previous HHN on 03/30/22 at 11:20am revealed:
-The HH agency received orders from Resident

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D 276	Continued From page 48 #3's primary care provider (PCP) to evaluate a wound on his left heel. -The start of care was on 02/18/22, to be seen 2 days a week. -A left heel protector was ordered and was to be applied by the staff, and a pillow under his feet to offload the pressure when sitting in the wheelchair. -After 3 weeks the wound was still unstageable,. -On two occasions when she visited the facility to provide care, Resident #3 was sitting in his wheelchair with no protective booties on his feet or pillow to offload the pressure on his heels. Review of the second HHN's progress notes dated 03/17/22 revealed: -The left heel wound was an unstageable pressure ulcer and required wound clinic assessment to debride (remove the dead tissue). -The right heel was a stage 2 pressure ulcer, (a shallow and reddened wound with no dead tissue or deeper tissue exposed), with redness and a foul odor, mostly eschar, and required debridement for effective treatment and healing. -In bold letters and underlined to the staff, "strict instructions to keep legs elevated when sitting and wear heel booties while out of bed". Telephone interview with Resident #3's second HHN on 03/30/22 at 9:51am revealed: -On 03/17/22, the HHN assessed Resident #3's left heel and right heel wound. -She implemented the wound orders from the clinic, documented the progress note and informed staff that the resident's heels were not to touch the floor and foam booties were to be on his feet at all times to protect his heels. -She had observed at times when she visited the facility, the resident's booties were not on and his feet were on the floor.	D 276		

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D 276	Continued From page 49 Review of Resident #3's HHN progress note dated 03/27/22 revealed there was a note in large print reminding caregivers to elevate the legs when sitting and keep the heel boots on when the resident was out of bed. Review of Resident #3's wound clinic instructions on 03/17/22 and 03/24/22 revealed: -There was an order at the initial wound clinic visit to wear foam booties daily. -On the follow up visit here was an order to off load the pressure on the heels to optimize healing, wear foam crates for lower extremities and heels. Interview with Resident #3's wound clinic nurse on 03/30/22 at 10:30am revealed: -The assessment plan was as follows: control the edema in the wound area by elevating the resident's legs whenever possible out of bed; and apply santyl daily (a product used to break up and remove dead skin in a wound); padding the heels at all times with foam booties and when he was in the wheelchair with his legs dependent, use a pillow to reduce pressure on the heel wounds. -If he was in the wheelchair with legs dependent and/or not applying foot booties to both feet for protection, this would impede the healing process of the wounds Telephone interview with an agency medication aide (MA) on 03/31/22 at 9:20am revealed: -Resident #3 had wounds on his right and left heel that started about a month ago. -The wound started as a dime size opening on the left heel. -The foam booties which were ordered and left in his room were never on Resident #3's feet when she started her shift. She had to apply the foam	D 276		

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D 276	Continued From page 50 booties. -She had not been back to the facility since then (03/09/22). Interview with Resident #3's primary care provider (PCP) on 03/31/22 at 10:00am revealed: -She had ordered HHN to evaluate and treat Resident #3's left heel wounds on 02/17/22. -She had been informed by the HWC that the facility would change HH agencies since Resident #3's left heel wound was not healing and there was a new wound on the right heel. -She did not know he had foam booties to protect his heel wounds and he was to have a pillow under his feet when in his wheelchair to prevent pressure in the wound area, until he went to the wound clinic on 03/17/22 and she read the physician's summary note. -She expected the staff to apply the foam booties as ordered and the pillow under his feet as ordered by the physician. Interview with the HWC on 04/01/22 at 11:45am revealed: -She was responsible for personal care issues for the residents in the SCU. -She was first aware of Resident #3's left heel wound last month when a PCA reported it to her. -She knew Resident #3 should have foot booties on both feet when he was out of bed and a pillow to off load the pressure under his feet when sitting. -She did not know who generated the information on the assignment sheets and why Resident #3's wounds, booties to be applied, pillow to off load pressure and elevation of legs when sitting in the wheelchair were not included in the weekly assignment sheets for the staff. -She also thought these interventions were included on the eMARs and were the	D 276		

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D 276	Continued From page 51 responsibility of the MAs to ensure the tasks were completed. Interview with the Administrator on 04/01/22 at 3:39pm revealed: -She relied on the nursing staff to manage the clinical needs of the residents. -She did not know staff were not following the orders of the HHN and the wound clinic physician, Attempted telephone interview with the HWD on 04/01/22 at 10:20am was unsuccessful. Attempted telephone interview with Resident #3's responsible family member on 03/30/22 at 11:55am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Refer to interview with the HWC on 03/30/22 at 3:55pm and 04/01/22 at 11:44am. Refer to telephone interview with a second shift PCA on 04/01/22 at 10:50am. Refer to interview with the Administrator on 04/01/22 at 3:39pm. 2. Review of Resident #1's current FL2 dated 07/16/21 revealed diagnoses included unspecified dementia without behaviors. Review of Resident #1's record revealed: -There was a Hospice Interdisciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report dated 01/12/22 which documented bilateral heel wounds with orders for heel protectors and wound care provided weekly. -There was an order dated 03/31/22 for wound	D 276		

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D 276	Continued From page 52 care to left heel - apply protective foam dressing and apply heel protectors to both feet daily to prevent breakdown. Review of Resident #1's current Care Plan dated 12/30/21 revealed: -She had stage 2 pressure ulcers to her heels that were being treated by the facility's Home Health agency. -She was a 2 person transfer. -She was encouraged to elevate her heels while in bed and to wear her foam cushion booties. -She was mainly non-verbal and staff had to anticipate her needs. Review of Resident #1's Licensed Health Professional Support (LHPS) dated 02/02/22 revealed: -She had been transferred from home health services to Hospice care on 01/05/22 for continued wound care to bilateral heel pressure ulcers, decline, and weight loss. -LHPS tasks were transfers and wound care for pressure ulcers. Review of the facility's computer-generated Assignment Plan for Resident #1 revealed: -The resident "has a wound". -The sheet did not specify what type of wound or location of wound. -The sheet did not instruct the staff to use foam heel protectors or leg rests on the wheelchair. Interview with HWD on 03/30/22 at 12:40pm revealed: -There was a facility policy that skin assessments with open wounds should have a follow up flow sheet completed weekly by the HWC that included an assessment of the wound until healed.	D 276		

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D 276	Continued From page 53 -It was the MAs task to apply the foam heel protectors and assure the feet were offloaded with a pillow when she was in bed. -The orders were entered in the eMAR, so it fell on the MA to complete the task. Observation on 03/30/22 at 1:25pm of Resident #1 revealed: -She was in the living room sitting in her high back wheelchair. -She had thick gray and pink socks and her feet were resting directly on the floor. -She was not wearing her foam heel protectors. Observation on 03/31/22 at 9:05am of Resident #1 revealed: -She was in the living room sitting in her wheelchair with white ankle socks on both feet, and no foam heel protectors in place. -Both feet were resting directly on the floor. Observation on 03/31/22 at 11:03am of Resident #1's wounds during the Hospice nurse visit revealed: -There was a scabbed over wound on the left heel with a bordered foam dressing applied. -There was a scabbed over wound on the right heel with a bordered foam dressing applied. Interview on 03/31/22 at 11:03am and 12:00pm with Resident #1's Hospice nurse revealed the order for heel protectors was generated by Hospice and should be worn while in the bed or in the wheelchair with leg rests in place to prevent skin breakdown. Interview with the first shift medication aide (MA) on 03/31/22 at 1:35pm revealed care provided to Resident #1 included application of foam heel protectors to both feet.	D 276		

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D 276	Continued From page 54 Interview with first shift agency personal care aide (PCA) on 3/29/22 at 4:10pm revealed: -She had not been trained by the facility regarding the needs of the residents in a Special Care Unit (SCU). -The staff received an assignment sheet at the beginning of the shift and the previous shift gave report. -If staff had any questions they would go to the MA on the floor. Telephone interview on 04/01/22 at 10:50am with a second shift PCA revealed: -Resident #1 had heel protectors in her room, but she was not sure of the frequency for them to be applied and removed. -She took them off at night and put them on when the resident was up in the wheelchair or in the bed. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's Hospice provider on 03/30/22 at 4:02pm was unsuccessful. Refer to interview with the HWC on 03/30/22 at 3:55pm and 04/01/22 at 11:44am. Refer to telephone interview with a 2nd shift PCA on 04/01/22 at 10:50am. Refer to interview with the Administrator on 04/01/22 at 3:39pm. _____ Interview with the HWC on 03/30/22 at 3:55pm	D 276		

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D 276	Continued From page 55	D 276		

and 04/01/22 at 11:44am revealed:
-She was responsible for receiving orders from physicians and entering on the eMARs, review of the eMAR for accuracy of orders, personal care issues and referral and follow up with the physicians for the residents in the SCU.
-She did not know who generated the information on the assignment sheets and why detailed wound information, and booties to be applied, pillow to offload pressure and elevation of legs when sitting in the wheelchair was not included in the weekly assignment sheets for the staff.
-She also thought these interventions were included on the eMARs and were the responsibility of the MAs to ensure the tasks were completed.
-She had been told by the HWD that wheelchair foot rests were a restraint and that is why she had kept them off all wheelchair bound residents.

Telephone interview with a second shift PCA on 04/01/22 at 10:50am revealed:
-The PCAs would make notes on their computer generated assignment sheets each shift and would turn them into the HWC at the end of each shift for review.
-The assignment sheets informed the PCAs of residents' needs and care plan info.
-PCAs got report at the start of each shift from the first shift PCA in order to know what was going on with each resident.
-Second shift staff also had stand-up meetings daily to discuss resident care and any changes to care needed.

Interview with the Administrator on 04/01/22 at 3:39pm revealed:
-Current wound information and skin breakdown prevention should be listed on the Personal Service Assessment (PSA)/Personal Service Plan

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D 276	Continued From page 56 (PSP). -The daily staff assignment sheets were generated by the information entered on the PSA/PSP. -The assignment sheets were only updated when information in the PSA/PSP was updated. _____ The facility failed to ensure physician orders were implemented for 2 of 3 sampled residents (Residents #3 and #1) with bilateral heel wounds, who had orders for foam protective booties to be applied to each foot, and failure to implement these would impede the healing process of the wounds. This failure was detrimental to the health, safety 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 03/31/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 16, 2022.	D 276		
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	D 358		

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D 358	Continued From page 57 (2) rules in this Section and 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 administer medications as ordered for 2 of 3 residents (Resident #5 and #6) observed during the medication pass related to a pain medication not available for administration (#5) and administering an incorrect dose of an anti-seizure medication (#6). The findings are: The medication error rate was 7% as evidenced by the observation of 2 errors out of 28 opportunities during the medication pass on 03/29/22. Review of the facility's medication policy revealed medication administration shall be provided as prescribed by the resident's physician/healthcare provider. 1. Observation of the medication pass on 03/29/22 at 8:57am revealed Resident #5 did not have Mobic 15mg available on the medication cart for administration. Observation of Resident #5's medications available for administration on 03/29/22 at 8:57am revealed there was no Mobic 15mg available for administration on the medication cart. Interview with the medication aide (MA) on 03/29/22 at 9:00am revealed:	D 358		

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D 358	Continued From page 58 -She had requested a refill for Resident #5's Mobic 15mg on 03/28/22 from the facility's contracted pharmacy. -The medications were delivered at night on the day they were ordered or the following day. -If the medication did not come in today, he would miss the dose. -She did not contact the back-up pharmacy for the medication. Review of Resident #5's current FL2 dated 03/04/22 revealed: -Diagnoses included vascular dementia, muscle spasms, and cerebrovascular accident (CVA). -There was an order for Mobic 15mg (a medication used to treat moderate pain) take one tablet by mouth daily. Review of Resident #5's signed primary care provider's (PCP) order summary report dated 02/25/22 revealed an order for Mobic 15mg take 1 tablet daily for pain. Review of Resident #5's PCP's progress note dated 11/19/21 revealed: -His chief complaint was leg pain and visit type was noted as acute. -The assessment and plan documented back pain, related to a fall several weeks ago. -Diagnoses included multilevel degenerative disc disease of the lumbar spine and low back pain, unspecified. -The prescription for Mobic 15mg daily was initiated at this visit to help treat his back pain. Review of Resident #5's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Mobic 15mg, take 1 tablet daily for pain, scheduled for 8:00am.	D 358		

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D 358	Continued From page 59 -Mobic 15mg was documented as not administered at 8:00am on 03/11/22, 03/12/22, 03/16/22 to 03/19/22, 03/22/22 to 03/26/22, 3/28/22 and 03/29/22. -The reason the medication was not administered was documented as "16 - pharmacy action required" for 03/11/22, 03/12/22, 03/16/22 to 03/19/22, 03/22/22 to 03/26/22, 3/28/22 and 03/29/22. -Mobic 15mg was documented as administered at 8:00am on 03/13/22, 03/14/22, 03/15/22, 03/20/22, 03/21/22, and 03/27/22, even though the medication was not available on the cart. Interview on 03/30/22 at 10:21am with the Health and Wellness Coordinator (HWC) revealed: -Resident #5's Mobic 15mg was dispensed to the facility on 02/27/22, for a quantity of 9 tablets. -The reason Mobic 15mg for a quantity of 9 tablets was dispensed was because the facility was getting ready to start cycle fill, and they were trying to get all medications filled on the same day of the month. -Cycle fill had started in the facility in February 2022. -The pharmacy noted medications had been dispensed for Resident #5, when it had not. -The MAs faxed several requests for refills to the pharmacy, and she would look for the documentation. -She would notify the PCP and pharmacy today (03/30/22) by telephone of the need for a new prescription for Resident #5's Mobic 15mg. -She was not aware that Mobic 15mg was not available for administration for Resident #5. Interview on 03/30/22 at 11:15am with the MA revealed: -The Mobic 15mg for Resident #5 had not been received yet.	D 358		

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D 358	Continued From page 60 -She called the pharmacy again today to request a refill. Interview with the Health and Wellness Director (HWD) on 03/30/22 at 12:30pm revealed: -The MAs requested refills by placing a sticker on a piece of paper and faxing it to the pharmacy each day, or refills could be requested online. -If there was a problem with getting the medications she expected them to notify her and the HWC. -If the MAs contacted the pharmacy or PCP regarding a refill it would be documented in the progress notes, and they would be expected to notify the HWC. -She was not aware that Resident #5's Mobic 15mg was not available for administration. Review of a medication refill request sheet for Resident #5 revealed: -A refill request for Mobic 15mg was faxed to the pharmacy on 03/14/22 at 4:22pm. -There were no other faxed refill requests found. Review of Resident #5's March 2022 progress notes revealed there was no documentation with the PCP or the pharmacy related to Mobic 15mg being unavailable for administration or the need for a refill. Telephone interview on 03/31/22 at 8:39am with a pharmacy technician from the facility's contracted pharmacy revealed: -Mobic 15mg was dispensed on 01/21/22 for a quantity of 30 tablets, and on 02/27/22 for a quantity of 9 tablets only. -A new prescription for Mobic 15mg was needed from the PCP and was received on 03/30/22. -Mobic 15mg was dispensed on 03/30/22 for a quantity of 8 tablets due to cycle fill scheduled to	D 358		

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D 358	Continued From page 61 begin on 04/07/22. Telephone interview on 03/31/22 at 10:20am with Resident #5's primary care provider (PCP) revealed: -She was aware of a refill request made this week by the facility. -The resident took Mobic 15mg daily for generalized musculoskeletal pain. -If the resident was without the medication for 19 days, it would be possible for him to have increased pain. -It would be hard to tell if he was having more pain because the resident was non-verbal most of the time. Attempted telephone interview with Resident #5's responsible party on 03/31/22 at 11:00am was unsuccessful. Telephone interview on 04/01/22 at 10:50am with a second shift personal care aide (PCA) revealed: -Resident #5 had low back pain and refused his pain medication at times. -He notified the medication aide (MA) if he was having pain. -He only complained of pain when he was transferring from the bed to the wheelchair. -She could tell by his grimacing facial expression that the pain was bad at times. Interview on 04/01/22 at 11:44am with the Health and Wellness Coordinator (HWC) revealed she did not have any documentation of the PCP being notified Resident #5 required a new prescription for Mobic 15mg until it was brought to her attention on 03/29/22. Refer to interview with the Health and Wellness Coordinator (HWC) on 04/01/22 at 11:44am.	D 358		

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D 358	Continued From page 62 Refer to interview with the Administrator on 04/01/22 at 3:39pm. 2. Observation of the medication pass on 03/29/22 at 9:15am revealed: -There was an open bubble card of Depakote 125mg with instructions to give 4 capsules by mouth twice daily. -There were 6 capsules left on the bubble card that was dispensed on 03/01/22. -The medication aide (MA) administered Depakote 125mg 2 capsules at 9:15am to Resident #6. -There were 4 capsules left on the bubble card after the medication pass for Resident #6. -The instructions observed on the eMAR were to give Depakote 125mg 4 capsules for seizure activity, total 500mg twice daily. Interview on 03/29/22 at 9:15am with the MA revealed: -The current order for Depakote 125mg was to administer 2 capsules twice daily. -She had been administering 2 capsules in the morning and the second shift MA would administer 2 capsules in the evening. Review of Resident #6's current FL2 dated 04/05/21 revealed: -Diagnoses included seizure disorder and dementia. -Resident #6 was constantly disoriented. -There was an order for Depakote sprinkles 125mg give 4 capsules twice daily (total 500mg). Review of Resident #6's signed primary care provider's (PCP) Order Summary Report dated 02/25/22 revealed an order for Depakote 125mg give 4 capsules for seizure activity, total 500mg	D 358		

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D 358	Continued From page 63 twice daily. Review of Resident #6's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Depakote 125mg, give 4 capsules for seizure activity, total 500mg twice daily, scheduled for 8:00am and 7:00pm. -Depakote 125mg 4 capsules was documented as administered at 8:00am from 03/01/22 to 03/29/22, and at 7:00pm from 03/01/22 to 03/28/22. Observation of Resident #6's medications available for administration on 03/29/22 at 12:00pm revealed: -There was 1 used bubble card of Depakote 125mg with 4 capsules left on the card, with a quantity of 30 capsules dispensed on 03/01/22. -There were 10 un-opened bubble cards of Depakote 125mg for a quantity 30 capsules each, in the overstock drawer on the medication cart. -Seven of the bubble cards were filled on 03/25/22, and three were filled on 03/01/22. -There was a total of 304 Depakote 125mg capsules on the medication cart. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/31/22 at 8:39am revealed: -Depakote 125mg was dispensed on 01/20/22 for a quantity of 240 capsules, no Depakote was dispensed in February 2022, 03/01/22 for a quantity of 240 capsules, and on 03/25/22 for a quantity of 240 capsules. -A verbal order was received from the mental health (MH) PCP on 03/30/22 for Depakote 125mg take 2 capsules twice daily, to start a reduction of the current dose. -The original order dated 08/20/21 was for	D 358		

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D 358	Continued From page 64 Depakote 125mg, take 4 capsules twice daily. Interview with the medication aide (MA) on 03/31/22 at 10:30am revealed: -The MH PCP had mentioned a change in the dose of Depakote 125mg last week to 2 capsules twice daily (250mg twice daily instead of 500mg twice daily). -The MA never received the order to decrease the dose of Depakote, however she chose to decrease the dose on her own. -She was the only MA that spoke to the MH PCP last week, therefore she was the only MA to give the incorrect dose. Telephone interview with Resident #6's primary care provider (PCP) on 03/31/22 at 10:20am revealed: -She was not aware of a recent order change for Depakote made by the MH PCP. -The facility had not notified her of the medication error made on 03/29/22. -Resident #6 would have an increased risk for seizure activity due to a lower dose of her medication. Attempted telephone interview with Resident #6's Power of Attorney (POA) on 03/31/22 at 11:05am was unsuccessful. Refer to interview with the Health and Wellness Coordinator (HWC) on 04/01/22 at 11:44am. Refer to interview with the Administrator on 04/01/22 at 3:39pm. _____ Interview on 04/01/22 at 11:44am with the HWC revealed: -She was responsible for the management of the	D 358		

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D 358	Continued From page 65 MAs, PCAs and Licensed Practical Nurses' (LPNs). -She was notified by the HWD of new orders received from the in house PCP. -Outside provider orders would come in from residents or family members for her or the HWD to process. -She and the facility nurses could enter orders into the eMAR system along with the HWD. -She was responsible to review all orders that were entered on the eMARs after normal business hours and on the weekends. -New orders were entered into the Point Click Care system on the eMARs for the nurses and MAs to view. Interview on 04/01/22 at 3:39pm with the Administrator revealed: -The HWC was responsible to handle all orders for care received by the facility's contracted PCPs or other outside medical providers. -The HWC or HWD was responsible to enter all new orders and care tasks into the eMAR for the medication aides to verify and ensure they were performed by themselves or the PCAs. -She was not aware of the medication errors that had occurred. _____ The facility failed to administer medications as ordered for 2 of 3 residents observed during the medication pass (Resident #5 and #6), related to a medication used to treat moderate pain that was not available for administration and resulted in the resident missing 19 doses in March 2022 and being at substantial risk for increased pain levels (Resident #5), and administering an incorrect dose of a seizure medication, which resulted in the resident getting half of the prescribed dose for several days (Resident #6).	D 358		

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D 358	Continued From page 66 This failure was detrimental to the health, safety and welfare of Resident #5 and #6 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/31/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 16, 2022.	D 358		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by:	D 464		

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D 464	Continued From page 67 TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure a Special Care Unit Resident Profile and Care Plan was completed within 30 days of admission, quarterly and within 10 days following a significant change in the resident's condition for 2 of 3 sampled residents (Resident #1 and #3) with recurrent pressure ulcers on the heels of both feet (Resident #1) and for a second resident with a diagnosis of diabetes mellitus with pressure ulcers on both feet (Resident #3). The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed as a Special Care Unit (SCU) with a capacity of 34 beds. 1. Review of Resident #1's current FL2 dated 07/16/21 revealed diagnoses included unspecified dementia without behaviors. Review of Resident #1's Resident Register revealed she was admitted to the SCU on 01/21/15. Review of Resident #1's current SCU Resident Profile and Care Plan dated 12/30/21 revealed: -She had stage 2 pressure ulcers to her heels that were being treated by the facility's Home Health agency. -She was encouraged to off load her feet while in bed and to wear her foam cushion booties. -She was a 2 person transfer. -She was incontinent of bowel and bladder. -She used a wheelchair for mobility and required staff escort to and from activities.	D 464		

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-She had a diagnosis of dementia and required staff assistance to complete all activities of daily living (ADLs).
-She was mainly non-verbal and staff had to anticipate her needs.
-She currently used Home Health services, but a Hospice consult was being obtained.
-She required limited assistance with transfers and was totally dependent for all other ADLs.

Review of Resident #1's record revealed:
-There was a Hospice Interdisciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report dated 01/12/22 which documented bilateral heel wounds with orders for heel protectors and wound care provided weekly.
-There was a physician's order dated 03/31/22 for wound care to the left heel - apply protective foam dressing and apply heel protectors to both feet daily to prevent breakdown.
-The previous SCU Resident Profile and Care Plan was completed 05/01/21.
-There were no quarterly SCU Resident Profile and Care Plans between May 2021 and December 2021.
-There was no significant change SCU Resident Profile and Care Plan between January 2022 and March 2022.

Review of Resident #1's current Skin Observation form dated 02/03/22 revealed:
-Her skin was documented as intact, with no open areas.
-She was chairfast and completely immobile.
-She had no apparent problem with friction and shear.
-Her Braden Scale for Predicting Pressure Sore Risk (the gold standard tool used to identify risk of developing a pressure injury) was 16.
-A score of 16 or less required prevention

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D 464	Continued From page 69 strategies. -No prevention strategies were listed. -The skin assessment was completed and reviewed by the medication aide (MA). Review of the facility's computer-generated Assignment Plan for Resident #1 revealed: -The resident "has a wound". -The sheet did not specify what type of wound, location of wound, or care to be provided. Observation on 03/30/22 at 4:20pm of Resident #1 revealed: -She was lying in the bed on her right side when the second shift personal care aide (PCA) entered the room. -When the PCA removed her brief, there was a medium size loose bowel movement, which had smeared onto her skin. -There was a bordered foam dressing over the left ischial tuberosity (a rounded bone that extends from the bottom of the pelvis and supports the weight of the body when one is sitting), the edges of the dressing was soiled, but was intact. -The left hip was reddened and had one additional opened area, the size of a dime, with no dressing in place, with no drainage noted. -The sacral area had an open area, the size of a dime, there was no dressing in place, and no drainage noted. -The PCA applied a barrier cream to the sacral and left hip areas. Observation on 03/31/22 at 11:03am of Resident #1's wounds during the Hospice nurse visit revealed: -There was a stage II pressure ulcer on the left ischial tuberosity that measured 2.0cm x 1.5cm x 0.1cm and had medihoney and bordered foam	D 464		

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dressing applied.
-There was a stage II pressure ulcer on the sacrum that measured 1cm x 1cm x 0.2cm, hydrocolloid dressing applied.
-There was a stage I pressure ulcer on the left hip that measured 1.5cm x 0.25cm, with no depth, barrier cream applied.
-There was a scabbed over area on the left heel that measured 5cm x 2cm, with no depth, with bordered foam dressing applied.
-There was a scabbed over area on the right heel that measured 1cm x 1cm, with no depth with bordered foam dressing applied.

Interview on 03/31/22 at 11:03am and 12:00pm with Resident #1's Hospice nurse revealed:
-The order for heel protectors was generated by Hospice and should be worn while in the bed or in the wheelchair with leg rests in place to prevent skin breakdown.
-The facility usually had the heel protectors on Resident #1 when she came to the facility.

Refer to interview with the Administrator on 04/01/22 at 3:39pm.

2. Review of Resident #3's current FL2 dated 03/04/22 revealed:
-Diagnoses included vascular dementia Type II diabetes, left sided hemiplegia and glaucoma.
-The resident was non ambulatory in a wheelchair, and disoriented.

Review of Resident #'3's Resident Register revealed he was admitted to the Special Care Unit (SCU) on 02/27/20.

Review of Resident #3's Home Health Nursing (HHN) documentation revealed:
-On 02/23/22, there was an order for a left foot

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heel protector to be applied by the staff daily when out of bed, and a pillow under his feet when sitting in the wheelchair to reduce pressure on the heel wounds.
-On 03/03/22, there was an order for foam foot booties to protect the wound when his foot dragged on the ground.

Review of Resident #3's most recent Skin Observation Form dated 02/17/22 revealed:
-Skin was documented as "excessive dryness and flakiness", with an open area on the left heel.
-Friction and shearing were documented as "not a problem"
-A Braden Scale was used to predict the risk of developing pressure sores in a resident.
-Resident #3's Braden Scale was 14, indicating a moderate risk for developing pressure sores.
-A Braden Scale score of 16 or less required prevention strategies.
-No prevention strategies were listed.
-An Open Area Flowsheet was to be completed due to the wound noted on the left heel.
-The form was completed by the Health and Wellness Coordinator (HWC).

Review of Resident #3's record revealed:
-There was no documented SCU Resident Profile and Care Plan completed within 30 days of admission and no documented quarterly profiles thereafter.
-The current SCU Resident Profile and Care Plan was dated 01/31/22
-The previous SCU Resident Profile and Care Plan was dated 07/30/21.

Interview with the Health and Wellness Coordinator (HWC) on 04/01/22 at 11:45am revealed:
-It was the responsibility of the HWD to complete

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the quarterly profiles.
-She did not know the quarterly profiles were not completed on Resident #3.
-She expected the staff to follow the assignment sheets for the personal care needs of the residents.
-The assignment sheets were available in a binder in the common living area.
-She did not know who generated the information on the assignment sheets and why Resident #3's wounds, booties to be applied and a pillow to off load pressure was not included in the weekly assignment sheets for the staff.
-She also thought these interventions were included on the eMARs and were the responsibility of the MAs to ensure the tasks were completed.

Interview with HWD on 03/30/22 at 12:40pm revealed:
-It was the responsibility of the HWC to complete the quarterly profiles on the residents in the SCU.
-She provided oversite to the HWC in her tasks.
-She had not reviewed the resident's records recently and did not know that Resident #3's quarterly profiles had not been completed.

Refer to interview with the Administrator on 04/01/22 at 3:39pm.

Interview on 04/01/22 at 3:39pm with the Administrator revealed:
-She was not aware the SCU Resident Profiles and Care Plans had not been updated quarterly.
-The HWD was responsible to complete the quarterly SCU Resident Profiles for all residents.
-The facility's SCU Resident Profiles and Care Plans were the same as the facility's Personal Service Assessment (PSA) and Personal Service

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D 464	Continued From page 73 Plan (PSP) documents. -Current wound findings and skin breakdown prevention should be listed on the PSA/PSP. _____ The facility failed to ensure a Special Care Unit Resident Profile and Care Plan was completed quarterly and within 10 days following a significant change in the resident's condition for 2 of 3 sampled residents (Resident #1 and #3) with recurrent pressure ulcers on the heels of both feet, with orders for protective booties, who obtained 3 additional pressure ulcers on the sacrum and buttocks, and orders to offload pressure to the wounds (Resident #1), and a resident with diabetes who had pressure ulcers on both feet, orders for protective booties and pillows to reduce the pressure on his wounds while sitting in the wheelchair, and was not addressed (Resident #3). This failure was detrimental to the health, safety 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 04/21/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 16, 2022.	D 464		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff	D 468		

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D 468	Continued From page 74 receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure that 2 of 3 sampled staff (Staff A and C) completed 6 hours of orientation for the specific nature and needs of the Special Care Unit (SCU) within the first week of hire. The findings are: Review of the Agency Staff Orientation Resource binder revealed: -Prior to independent assignment, each staff must complete the General Agency Orientation	D 468		

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checklist, State Specific Agency checklist and the review of the documents in the binder.
-The agency personnel were to provide any state specific forms not included in the checklist.
-The 6 hours of orientation for the Special Care Unit (SCU) training was not included in the checklist.

1. Review of Staff A's, medication aide (MA) personnel record revealed:
-Staff A was hired on 12/29/21.
-There was no documentation Staff A completed the required 6-Hour SCU training within the first week of hire.

Telephone interview with Staff A on 04/01/22 at 4:11pm revealed:
-She worked in the SCU at the facility.
-She had not received any SCU specific training from the facility.
-She did not know who was responsible for SCU training at the facility since she did not receive any while employed there.
-She received training from the local staffing agency.

Refer to telephone interview with the staffing agency Registered Nurse (RN) on 04/01/22 at 10:20am.

Refer to interview with the Health and Wellness Coordinator (HWC) on 04/01/2022 at 11:45am.

Refer to interview with the Administrator on 04/01/22 at 3:39pm.

2. Review of Staff C's, medication aide (MA) personnel record revealed:
-Staff C was hired on 02/03/22.
-There was no documentation Staff C completed

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D 468	Continued From page 76 the required 6-Hour SCU training within the first week of hire. Interview with Staff C on 04/01/2022 at 10:00am revealed: -She usually worked first shift from 7:00am to 3:00pm in the facility. -She worked in the SCU at the facility. -She was not aware of any SCU training provided at the facility. -She had not completed any SCU training at the facility. Refer to telephone interview with the staffing agency Registered Nurse (RN) on 04/01/22 at 10:20am. Refer to interview with the Health and Wellness Coordinator (HWC) on 04/01/2022 at 11:45am. Refer to interview with the Administrator on 04/01/22 at 3:39pm. _____ Telephone interview with the staffing agency RN on 04/01/22 at 10:20am revealed she did not provide the 6 hours of SCU orientation and training to the staff at her agency. Interview with the HWC on 04/01/22 at 11:45am revealed: -She had been employed at the facility for the past 3 months. -She was not responsible for coordinating with the staffing agency regarding hiring of staff or training. -She did not provide any SCU training to agency staff. -The Health and Wellness Director (HWD) was responsible for ensuring staff had completed the	D 468		

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D 468	Continued From page 77 training to meet regulatory requirements. Interview with the Administrator on 04/01/22 at 3:39pm revealed: -The facility's RN educator was responsible to check off all agency staff on facility specific training requirements. -She expected the staffing agencies to provide staff training records and credentials to the facility for placement in personnel records. -The SCU training was available online and included the 6-hour and 20-hour requirements.	D 468		
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, and in compliance with relevant federal and state laws and rules and regulations related to Health Care, Medication Aide Training and Competency, Special Care Unit Resident Profile and Care Plan, and Medication Administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure physician orders were implemented for 2 of 3 sampled residents (Residents #1 and #3) who had orders	D912		

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D912	Continued From page 78 for foam protective booties to be applied to each foot when out of bed. [Refer to Tag D276 10A NCAC 13F .0902(c) (3-4) Healthcare (Type B Violation)]. 2. Based on interviews and record reviews the facility failed to ensure 2 of 3 sampled staff (Staff A and C) who administered medications had completed their medication clinical skills competency validation prior to administering medications. [Refer to Tag D935 10A NCAC 13F G.S. 131D-4.5B(b) Medication Aide Training and Competency (Type B Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to ensure a Special Care Unit Resident Profile and Care Plan was completed within 30 days of admission, quarterly and within 10 days following a significant change in the resident's condition for 2 of 3 sampled residents (Resident #1 and #3) with recurrent pressure ulcers on the heels of both feet (Resident #1) and for a second resident with a diagnosis of diabetes mellitus with pressure ulcers on both feet (Resident #3). [Refer to Tag D464 10A NCAC 13F .1307 Special Care Unit Resident Profile and Care Plan (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 residents (Resident #5 and #6) observed during the medication pass related to a pain medication not available for administration (#5) and administering an incorrect dose of an anti-seizure medication (#6). [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		

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	HAL060049	A. BUILDING: _____ B. WING _____	04/01/2022

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D914	Continued From page 79	D914		
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 interviews, observations and record reviews, the facility failed to ensure all residents were free from neglect related to personal care and supervision and health care. The findings are: 1. Based on interviews, observations and record reviews, the facility failed to ensure staff provided personal care assistance to 2 of 3 sampled residents (Residents #3 and #1) including one resident with diabetic pressure ulcer wounds on the heels of both feet and orders to place protective booties, off load pressure to the wounds and not to drag his feet along the floor during ambulation were followed as ordered by the Home Health Nurse (HHN) and wound care physician and not attending to multiple skin tears and nail care on both feet (#3), and a resident with recurrent pressure ulcers on the heel of both feet, orders to place protective booties, who obtained 3 additional wounds on the sacrum and buttocks, and orders to off load pressure to the wounds (#1). [Refer to Tag D269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A1 Violation)]. 2. Based on interviews, observations and record	D914		

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D914	Continued From page 80 reviews, the facility failed to ensure staff provided personal care assistance to 2 of 3 sampled residents (Residents #3 and #1) including one resident with diabetic pressure ulcer wounds on the heels of both feet and orders to place protective booties, off load pressure to the wounds and not to drag his feet along the floor during ambulation were followed as ordered by the Home Health Nurse (HHN) and wound care physician and not attending to multiple skin tears and nail care on both feet (#3), and a resident with recurrent pressure ulcers on the heel of both feet, orders to place protective booties, who obtained 3 additional wounds on the sacrum and buttocks, and orders to off load pressure to the wounds (#1). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if	D935		

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D935	Continued From page 81 applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, and record reviews the facility failed to ensure 2 of 3 sampled staff (Staff A and C) who administered medications had completed the medication clinical skills competency validation prior to administering medications. The findings are: 1. Review of Staff A's, medication aide (MA) personnel record revealed: -Staff A was hired on 12/29/21. -There was documentation she passed the written MA exam on 11/24/2009.	D935		

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D935	Continued From page 82 -There was documentation she completed the 5/10/15 hour training in 01/2022. -There was no documentation Staff A completed the medication clinical skills competency validation. Review of a resident's January 2022 electronic medication administration record (eMAR) revealed Staff A documented administering medications on 01/20/22. Review of another resident's January 2022 eMAR revealed Staff A documented administering medications on 8 days from 01/04/22 to 01/28/22. Review of a resident's February 2022 eMAR revealed Staff A documented administering medications on 12 days from 02/01/22 to 02/21/22. Review of a resident's March 2022 eMAR revealed Staff A documented administering medications on 03/01/22. Interview with Staff A on 04/01/22 at 4:11pm revealed: -She was hired by local a staffing agency in December of 2021 and started at the facility in January 2022. -The local staffing agency made sure that she had the medication competency validation check list completed prior to allowing her to work at the facility. -She had not completed any facility training since hired at the facility. -She did not know who was responsible for training at the facility since she did not receive any training while there. Refer to interview with the Health and Wellness	D935		

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D935	Continued From page 83 Director (HWD) on 03/30/2022 at 12:30pm. Refer to interview with the Administrator on 04/01/2022 at 3:39pm. 2. Review of Staff C's, medication aide (MA) personnel record revealed: -Staff C was hired on 02/03/22. -There was documentation she passed the written MA exam on 09/26/17. -There was documentation she completed the 5/10/15 hour training in 02/2022. -There was no documentation Staff C completed the medication clinical skills competency validation. Review of a resident's February 2022 electronic medication administration record (eMAR) revealed Staff C documented administration of medications on 7 days from 02/03/22 - 02/25/22. Review of another resident's February 2022 eMAR revealed Staff C documented administeration of medications on 02/12/22. Review of a resident's March 2022 eMAR revealed Staff C documented administration of medications on 11 days from 03/02/22 - 03/29/22. Interview with Staff C on 04/01/22 at 10:00am revealed: -She worked as a MA in the facility from a local staffing agency since February 2022. -She had not completed the medication clinical skills competency validation with a Registered Nurse (RN) since she started working at the facility. -She had completed one in-service training since being employed at the facility. -She was not aware of any additional training	D935		

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D935	Continued From page 84 needed. Refer to interview with the Health and Wellness Director (HWD) on 03/30/2022 at 12:30pm. Refer to interview with the Administrator on 04/01/2022 at 3:39pm. Refer to Tag 358, Medication Administration, Type A2 Violation. _____ Interview with the HWD on 03/30/2022 at 12:30pm revealed: -The medication aide training records were emailed to her by the staffing agency, and were not currently in the personnel records. -She would request the training records for the medication aides. -The facility had not completed a medication clinical skills competency validation for agency medication aides. Interview with the Administrator on 04/01/2022 at 3:39pm revealed: -She was not aware of the regulation that the medication competency evaluation was to be validated by a Registered Nurse (RN) prior to administering medications in the facility. -The facility's RN Educator was responsible to check off all agency staff on facility specific training requirements. _____ The facility failed to ensure 2 of 3 sampled staff (Staff A and C), who were administering medications to residents in the facility completed the Medication Administration Clinical Skills Check off prior to administering medications, causing one resident during the medication pass on 03/29/22 to receive the wrong dosage of an anticonvulsant medication. The facility's failure to	D935		

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D935	Continued From page 85 ensure medication aides (MAs) met training requirements prior to the administration of medications resulted in an error which 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 on 04/01/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 16, 2022.	D935		