STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a follow-up survey on 01/31/23 through 02/01/23.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 1 of 1 sampled resident (Resident #3) who had a referral for a dermatology visit related to a lesion on top of the head. The findings are: Review of Resident #3's current FL2 dated 02/21/22 revealed: -Diagnoses included chronic kidney disease and scoliosis. -There was no documentation of orientation status. Review of Resident #3's Care Plan dated 08/22/22 revealed: -Resident #3 was oriented to place. -She could communicate her needs and preferences. -She had short term memory deficit. -There was documentation Resident #3 had a "spot" on her scalp, the primary care provider (PCP) was aware and referred Resident #3 to a dermatologist. Observation of Resident #3 on 01/31/23 at	D 273		

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9:46am revealed she was sitting in a wheelchair in her room and had a bandage taped to the top of her head.

Interview with Resident #3 during the initial tour of the facility on 01/31/23 at 9:46am revealed:
-She had a bandage taped to the top of her head to try to regrow her hair back.
-Approximately 3 weeks prior, a personal care aide (PCA) wanted to assist her with a shower but she wanted to eat dinner instead and the PCA "grabbed" her by the hair and pulled her hair out.
-She needed assistance from staff with showering and washing her hair.
-Another PCA knew how to assist her properly with showering and washing her hair so that it did not cause her head to bleed.

Review of Resident #3's physician's orders revealed there were no orders to apply a dressing to Resident #3's scalp lesion.

Review of Resident #3's care notes revealed:
-There was no documentation of a lesion on Resident #3's scalp.
-There was no documentation of a wound dressing applied to Resident #3's scalp.

Review of Resident #3's physician's progress notes revealed there was no documentation Resident #3 was referred to or seen by a dermatologist.

Interview with the Administrator on 01/31/23 at 12:45pm revealed:
-One of the MAs reported to her the morning of 01/31/23 that Resident #3 tried to cut the lesion off her scalp using a pair of scissors about a week ago.
-There were no physician's orders for a dressing

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to be applied or dressing changes to Resident #3's scalp.
-The PCP was aware of the lesion on Resident #3's scalp and wanted Resident #3 to be seen by a dermatologist.
-Resident #3 refused to see a dermatologist for the lesion on her scalp.

Interview with a first shift MA on 01/31/23 at 2:20pm revealed:
-She did not know why Resident #3 had a dressing on her head.
-She did not ask facility staff why Resident #3 had a dressing applied to the top of her head.
-One of the second shift MAs applied the dressing to Resident #3's head about a week ago.
-Resident #3 had "something" on her head and Resident #3's family was supposed to take Resident #3 to see a dermatologist.
-She did not know if Resident #3 had been seen by a dermatologist.
-If Resident #3 had been seen by a dermatologist, the physician's progress notes would be in Resident #3's record.
-She asked Resident #3 what happened to her head on 01/30/23 and Resident #3 told her she had a dressing because her head was bleeding but did not say what caused the bleeding.

Telephone interview with Resident #3's responsible person on 01/31/23 at 2:57pm revealed:
-Resident #3 wrote a letter dated 01/23/23 and mailed it to a family member about a week ago.
-The letter Resident #3 wrote stated one of the facility's staff members came into her room trying to make her get into the shower and she did not want to, there was a "scuffle", she resisted, and it resulted in Resident #3 cutting her head.

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-He thought the family member called him on 01/27/23 and stated the family member called the Administrator and the Administrator reported she was not aware of the incident.
-The facility did not tell him he needed to schedule a dermatology appointment for Resident #3.
-Resident #3's PCP emailed himself, the Resident Care Coordinator (RCC), and the Health and Wellness Director that Resident #3 needed to be seen by a dermatologist.

Interview with a second shift MA on 01/31/23 at 3:50pm revealed:
-On 01/22/23, a PCA came to get her assistance with Resident #3 and said she found Resident #3 trying to cut the lesion from her head with a pair of scissors.
-Resident #3 had scissors in her hand when she entered the bathroom and Resident #3's head was bleeding "not too bad" so she applied a dressing over the bleeding lesion.
-She did not document the incident or applying a dressing to Resident #3's head.
-She did not notify the PCP of the incident or that the lesion was bleeding.
-The lesion on Resident #3's head was present for at least a couple of months.
-The RCC told her the PCP was aware of the lesion because the family was supposed to make an appointment with a dermatologist.

Second interview with Resident #3 on 01/31/23 at 4:30pm revealed:
-She had a "sore" on her head for several months now.
-She had not seen a dermatologist for the lesion on her head.
-She would go to have the lesion looked at by a dermatologist.

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D 273	Continued From page 4 Second interview with the Administrator on 01/31/23 at 4:35pm revealed: -She was not aware of the incident of Resident #3 cutting the lesion on her head until today (01/31/23). -She knew Resident #3 had a lesion on her head and the PCP wanted Resident #3 to be seen by a dermatologist. -She thought the PCP emailed the family to schedule an appointment with a dermatologist. -She knew Resident #3 had previously refused to go to the dermatologist to have the lesion looked at. Telephone interview with the PCP on 02/01/23 at 9:00am revealed: -She was aware of the lesion on Resident #3's head and thought the lesion was skin cancer. -She advised Resident #3 several times to go see a dermatologist and Resident #3 refused. -She emailed Resident #3's responsible person, the RCC, and Health and Wellness Director on 08/11/22 at 12:55pm about making a dermatologist appointment for Resident #3 to have the lesion checked. -She did not get a response and emailed Resident #3's responsible person, the RCC, and the Health and Wellness Director again on 10/08/23 at 8:43am to follow up on the previous email regarding the dermatology referral. -Resident #3's responsible person responded back to the email on 10/10/22 and said they would schedule an appointment for the dermatologist for Resident #3. -She thought the cancerous lesion needed to be removed for Resident #3's comfort but did not think it would cause serious long-term complications.	D 273		

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D 273	Continued From page 5 Interview with the RCC on 02/01/23 at 9:42am revealed: -Resident #3 had a lesion on her head that would sometimes bleed. -The lesion was present on Resident #3's head for "months". -She did not respond to the email sent by Resident #3's PCP on 08/10/22 because she was under the impression Resident #3's family was scheduling an appointment with a dermatologist. -She talked to Resident #3 and Resident #3 said she was not going to see a dermatologist. -She did not follow-up with Resident #3's family to see why the appointment had not been scheduled. Interview with the Administrator on 02/01/23 at 11:05pm revealed: -The facility did not call to schedule a dermatology appointment for Resident #3 because the PCP directly emailed the family to schedule the appointment. -The RCC and Health and Wellness Director were included in the email but since it was sent directly to Resident #3's family the facility did not intervene and follow-up to see why an appointment had not been made. -The facility would also not attempt to schedule an appointment for Resident #3 to see a dermatologist if Resident #3 refused to go. -There was no documentation Resident #3 refused to see a dermatologist for the lesion on her head.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	D 358		

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preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

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

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

Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 1 of 5 sampled residents (#5) related to a medication to treat allergies and a medication to treat pain.

The findings are:

Review of Resident #5's current FL2 dated 12/16/22 revealed diagnoses included periprosthetic fracture around internal right hip, unspecified falls and difficulty walking.

1. Review of Resident #5's current FL2 dated 12/16/22 revealed an order for extra strength Tylenol (used to treat pain) 2 tablets twice daily.

Interview with Resident #5 on 01/31/23 at 3:10pm and 02/01/23 at 11:38am revealed:
-She was ordered Tylenol twice a day when she was at the rehabilitation facility.
-She did not know why the Tylenol was not ordered when she moved into the facility in December 2022.
-She experienced pain due to her leg surgery and it was worse at night.

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-She requested Tylenol about a month ago, but the Medication Aide (MA) told her she could not have it because she did not have an order.
-The MA did not indicate she would ask her Primary Care Provider (PCP) for an order.

Telephone interview with Resident #5's family member on 01/31/23 at 4:03pm revealed:
-Resident #5 had been taking Tylenol for years due to shoulder pain and more recently due her leg surgery.
-She received Tylenol at the rehabilitation facility after she was weaned off the narcotics she was initially ordered after her leg surgery.
-She did not know why Tylenol was not continued when she moved into the facility in December 2022.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/31/23 at 12:07pm revealed:
-Resident #5's FL2 dated 12/16/22 was received via fax from the facility and included an order for extra strength Tylenol, 2 tablets twice daily.
-The pharmacy dispensed a 13-day supply to the facility on 12/20/22.
-The pharmacy dispensed a 28-day supply to the facility on 12/26/22.
-The pharmacy dispensed a 28-day supply to the facility on 01/23/23.
-The facility was responsible for entering all medications into the electronic medication administration records (eMARs).

Review of Resident #5's December 2022 and January 2023 eMAR revealed there was not an entry for extra strength Tylenol two tablets twice a day.

Observation of Resident #5's medications on

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hand on 01/31/23 at 12:45pm revealed:
-There were 2 medication cards containing a 28-day supply of extra strength Tylenol with instructions to administer 2 tablets twice a day.
-No doses had been removed from either medication card.

Telephone interview with Resident #5's PCP on 02/01/23 at 8:45am revealed:
-Resident #5 had an order for Tylenol to control her pain associated with her recent leg surgery.
-She did not realize the Tylenol order had been left off the eMAR which resulted in Resident #5 not being administered the Tylenol as ordered.
-When she came to the facility to see Resident #5, she obtained a printout of the eMAR from the RCC or the Health and Wellness Director (HWD) so she would know what medications were ordered but had not noticed the tylenol had been left off.
-Resident #5 never indicated she was not receiving Tylenol nor requested an order for Tylenol.
-If Resident #5 requested Tylenol from a MA, she expected the MA to request an order from her or inform the RCC or HWD that an order had been requested.
- Resident #5 would experience more pain if Tylenol was not administered routinely as ordered.

Interview with the Administrator on 02/01/23 at 11:53am revealed:
-When Resident #5 requested Tylenol from the MA, the MA should have contacted the PCP or informed the RCC or HWD about the request.
-Mas were trained to inform the RCC or HWD either verbally or by putting a note under their door when a request was received from a resident.

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D 358	Continued From page 9 Refer to interview with the RCC on 02/01/23 at 9:42am. Refer to interview with the Administrator on 01/31/23 at 2:32pm and 02/01/23 at 11:53am. 2. Review of Resident #5's current FL2 dated 12/16/22 revealed an order for loratadine 10mg (used to treat allergies) 1 tablet each morning. Interview with Resident #5 on 01/31/23 at 3:10pm revealed she had taken loratadine for more than 5 years to control her allergies. Review of Resident #5's December 2022 and January 2023 eMAR revealed there was not an entry for loratadine 10mg daily. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/31/23 at 12:07pm revealed: -Resident #5's FL2 dated 12/16/22 was received via fax from the facility on 12/19/22 and included an order for loratadine 10mg daily. -The pharmacy dispensed a 13-day supply to the facility on 12/20/22. -The pharmacy dispensed a 28-day supply to the facility on 12/26/22. -A fax was received from the facility on 01/23/23 indicating "per [a named medication aide] the loratadine was discontinued effective 01/23/23". -Staff at the facility were responsible for entering all medications into the electronic medication administration records (eMARs). Review of Resident #5's record revealed there was not an order to discontinue loratadine or a copy of a fax sent to the pharmacy on 01/23/23.	D 358		

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D 358	Continued From page 10 Observation of Resident #5's medications on hand on 01/31/23 at 12:45pm revealed loratadine 10mg was not available to administer. Interview with a Medication Aide (MA) on 01/31/23 at 12:45pm revealed: -Resident #5 used to have a medication card with loratadine but it was not on the eMAR, so she never administered it. -She thought the loratadine was discontinued and the medication was sent back to the pharmacy. -The Resident Care Coordinator (RCC) was responsible for entering medications into the eMAR system for all newly admitted residents. Interview with the RCC on 02/01/23 at 9:42am revealed: -She was not working on 01/23/23 and did not know anything about an order being sent to the pharmacy to discontinue Resident #5's loratadine. -The PCP did not give verbal orders. Interview with another MA on 02/01/23 at 10:24am revealed: -She did not remember sending a fax on 01/23/23 to the pharmacy to discontinue Resident #5's loratadine but that did not mean she did not send it. -MAs were allowed to send faxes to the pharmacy if they received an order from the PCP and she did that periodically. -If a verbal order was received from the PCP an order would be written in the resident's record. -When a fax was sent to the pharmacy a copy of the fax was stamped with the time and date and filed in the resident's record. -She did not know why the verbal order and the copy of the fax was missing from Resident #5's record.	D 358		

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D 358	Continued From page 11 Interview with the Administrator on 02/01/23 at 11:53am revealed: -The PCP only gave emergency verbal orders. -The fax sent to the pharmacy on 01/23/23 was an error and Resident #5 should have been administered loratadine 10mg daily as ordered. Telephone interview with Resident #5's PCP on 02/01/23 at 8:45am revealed: -Resident #5 was ordered loratadine due to allergies. -She did not remember giving a verbal order on 01/23/23 to discontinue Resident #5's loratadine. -She only gave verbal orders in an emergency and discontinuing an allergy medication would not be considered an emergency. -Resident #5 would experience allergy symptoms if she was not administered loratadine. -Resident #5's loratadine could be discontinued now since she had gone without it since 12/19/22 and was not experiencing any symptoms. Refer to interview with the RCC on 02/01/23 at 9:42am. Refer to interview with the Administrator on 01/31/23 at 2:32pm and 02/01/23 at 11:53am. _____ Interview with the RCC on 02/01/23 at 9:42am revealed: -She was not working when Resident #5 was admitted in December 2022. -The HWD was responsible for entering Resident #5's medication orders into the eMAR system. -She conducted medication cart audits monthly along with the HWD. -She thought the January 2023 audit was conducted by the HWD prior to her returning to work in January 2023. -When a cart audit was conducted, they checked	D 358		

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D 358	Continued From page 12 to see that medications entered on the eMAR were available, but they did not check to see if there were medications in the cart that were not entered on the eMAR. Interview with the Administrator on 01/31/23 at 2:32pm and 02/01/23 at 11:53am revealed: -The RCC and the HWD were responsible for entering all medications orders into the eMAR system for newly admitted residents. -The RCC was not working when Resident #5 was admitted, and the facility had a temporary Registered Nurse (RN) helping the HWD. -The temporary RN entered Resident #5's medications into the eMAR system but the HWD should have confirmed accuracy. -The HWD and the RCC conducted medication cart audits monthly. -When a medication cart audit was conducted they checked to see that medications entered on the eMAR were available, but they did not check to see that all medications in the cart were listed on the eMAR. -The 3rd shift MA, who was responsible for returning unused medications to the pharmacy after the new medications were delivered monthly, should have informed the RCC or the HWD that Resident #5 had scheduled medications that were being returned because they had not been administered.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.	D 438		

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This Rule is not met as evidenced by:
Based on observation, interviews, and record review, the facility failed to report allegations of physical abuse by staff to the Health Care Personnel Registry within 24 hours of knowledge related to staff accused of causing bleeding to a resident's scalp during personal care (Resident #3).

The findings are:

Review of Resident #3's current FL2 dated 02/21/22 revealed:
-Diagnoses included chronic kidney disease and scoliosis.
-There was no documentation of orientation status.

Observation of Resident #3 on 01/31/23 at 9:46am revealed she was sitting in a wheelchair in her room and had a bandage taped to the hair on top of her head.

Interview with Resident #3 during the initial tour of the facility on 01/31/23 at 9:46am revealed:
-She had a bandage taped to the top of her head to try to regrow her hair back.
-Approximately 3 weeks prior, a personal care aide (PCA) wanted to assist her with a shower, but she wanted to eat dinner instead and the PCA "grabbed" her by the hair and pulled her hair out causing her scalp to bleed.
-She needed assistance from staff with showering and washing her hair.
-Another PCA knew how to assist her properly with showering and washing her hair so that it did not cause a lesion on her head to bleed.

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D 438	Continued From page 14 Review of Resident #3's Care Plan dated 08/22/22 revealed: -Resident #3 was not always oriented to place and had short term memory deficit. -She could communicate her needs and preferences. -Resident #3 required assistance from staff as needed with bathing. -There was documentation Resident #3 had a "spot" on her scalp, the primary care provider (PCP) was aware and referred Resident #3 to a dermatologist. Review of Resident #3's care notes revealed: -There was no documentation of a lesion on Resident #3's scalp. -There was no documentation in the month of January 2023 of an incident that would cause Resident #3's scalp to bleed requiring a wound dressing to be applied. Interview with the Administrator on 01/31/23 at 12:45pm revealed: -There was no documentation in the care notes regarding a lesion or wound on Resident #3's scalp. -She did not know why Resident #3 had a dressing taped to the hair on top of Resident #3's head. -Any dressings applied to a resident were supposed to be documented by the medication aide (MA) in the care notes. -One of the MAs reported to her the morning of 01/31/23 that Resident #3 tried to cut a lesion off her scalp using a pair of scissors about a week ago. -There was no Incident and Accident Report filled out documenting where Resident #3 attempted to cut the lesion from her scalp with a pair of scissors.	D 438		

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D 438	Continued From page 15 Interview with a first shift MA on 01/31/23 at 2:20pm revealed: -She did not know why Resident #3 had a dressing on her head. -One of the second shift MAs applied the dressing to Resident #3's head about a week ago. -Resident #3 had "something" on her head and Resident #3's family was supposed to take Resident #3 to see a dermatologist. -She asked Resident #3 what happened to her head on 01/30/23 and Resident #3 told her she had a dressing because her head was bleeding but did not say what caused the bleeding. Telephone interview with Resident #3's responsible person on 01/31/23 at 2:57pm revealed: -Resident #3 wrote a letter dated 01/23/23 and mailed it to his sibling about a week ago. -The letter Resident #3 wrote stated one of the facility's staff members came into her room trying to make her get into the shower and she did not want to, there was a "scuffle", she resisted, and it resulted in Resident #3 cutting her head. -His brother told him he called the Administrator and the Administrator reported she was not aware of the incident. -Resident #3 was not confused but would sometimes say "off" things. -Resident #3 did not have a diagnosis of dementia or Alzheimer's. Review of a text message sent by Resident #3's responsible person revealed: -There were 2 pictures of a handwritten letter dated 01/23/23 and was signed by Resident #3. -The letter documented Resident #3 was about to go eat dinner on 01/22/23 when a "nurse" entered	D 438		

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and insisted on giving her a shower, pulled her wheelchair into the bathroom, pulled off her clothes, turned on the shower while she was screaming "Help! Help!".
-Resident #3 pulled the call button and the staff member told her she would "rip it out".
-The letter continued to state Resident #3 and a facility staff member had a "physical fight" in which the staff member "won by pulling my hair" causing her head to bleed.
-Another "nurse" entered the room and applied a large bandage to her head to stop the bleeding.

Interview with a second shift MA on 01/31/23 at 3:50pm revealed:
-She was working on 01/22/23 and applied a dressing to Resident #3's head because it was bleeding.
-The PCA called for her assistance with Resident #3 and said she found Resident #3 trying to cut the lesion from her head with a pair of scissors.
-Resident #3 was "upset" when she entered Resident #3's bathroom on 01/22/23.
-Resident #3 told her the PCA was trying to hurt her and said, "help me, help me".
-She did not fill out an Incident and Accident Report.
-She did not notify the PCP of the incident or that Resident #3's head was bleeding.
-She did not notify the Resident Care Coordinator (RCC) or the Administrator of the allegation of physical abuse because the PCA accused of the physical abuse called the RCC to report the incident while she applied the bandage to Resident #3's head.

Interview with the RCC on 02/01/23 at 9:42am revealed:
-On 01/22/23, a second shift MA called to report Resident #3 refused a shower.

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-The MA did not report the PCA for allegations of physical abuse or tell her Resident #3 was upset and saying "help me" when the MA walked into Resident #3's bathroom on 01/22/23.
-The MA told her the PCA walked into Resident #3's bathroom and found Resident #3 trying to cut "dried blood" from her hair.
-She knew to report any allegations of physical abuse by a staff member immediately to the Administrator.

Telephone interview with a second shift PCA on 02/01/23 at 10:41am revealed:
-She normally worked third shift but worked second shift on 01/22/23.
-She went to Resident #3's room on 01/22/23 to assist her with a shower and found Resident #3 in the bathroom cutting the lesion on top of her head with a pair of scissors.
-She took the scissors from Resident #3 and Resident #3 started kicking her.
-She turned the shower on, and Resident #3 was "fighting" her and told her to get out of Resident #3's room.
-She did not "touch" or physically harm Resident #3.
-Resident #3 was mad because she took the scissors away and tried to give Resident #3 a shower.
-The MA asked her to leave Resident #3's room.
-The MA called the RCC to report the incident.

Second interview with the Administrator on 01/31/23 at 4:35pm revealed:
-Staff did not report any allegations of physical abuse towards Resident #3 so she did not report the PCA to the Health Care Personnel Registry.
-Resident #3's responsible person or family member did not contact her about the letter dated 01/23/23 written and mailed by Resident #3 with

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D 438	Continued From page 18 allegations of physical abuse by a facility staff member. -She expected staff to immediately report any allegations of abuse towards a resident. -The facility's policy for allegations of abuse included staff to immediately report the allegation to the RCC, Health and Wellness Director, or herself and she would report the accused staff member to the Health Care Personnel Registry and suspend the staff member while she completed an investigation.	D 438		