

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2023
NAME OF PROVIDER OR SUPPLIER CARE INNOVATIONS OF NORTH CAROLINA		STREET ADDRESS, CITY, STATE, ZIP CODE 2409 HORTON ROAD KNIGHTDALE, NC 27545		
(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 02/28/23.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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 interviews and record reviews, the facility failed to ensure health care referral and follow up for 3 of 3 sampled residents (Resident #1) for an appointment with a mental health provider for antipsychotic medication refills, dosage decrease, and a podiatry consult, (Resident #3) for an appointment with a mental health provider for antipsychotic medications and a podiatry consult, (Resident #2) for an appointment with a mental health provider for mental health and a podiatry consult. The findings are: 1. Review of Resident #1's current FL2 dated 10/11/22 revealed: -Diagnoses included schizophrenia, diabetes mellitus 2, hypertension, hyperlipidemia, and vitamin D deficiency. -There was an order for lorazepam (used to treat anxiety disorders) 0.5 mg to be given by mouth once a day. -There was an order for benztropine (used to treat acute agitation or psychosis) 1.0mg to be given by mouth twice a day. -There was an order for haloperidol (Haldol) (used to treat mental disorders) 20mg to be given by mouth twice a day.	C 246	Facility would assure Referral and follow-up to meet routine and acute health care needs of residents. Facility will keep appointments, and documentation of mental health Provider. - Facility would keep documentation of an upcoming Appointment and Visit by Provider.	4/28/23 4/28/23 4/28/23

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

IK @ SEE

TITLE

DIRECTOR

(X6) DATE

4-2-2023

STATE FORM

6889

8P5111

If continuation sheet 1 of 13

RECEIVED AND ACKNOWLEDGED ON 04/06/23 BY

Julia B Nielsen

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C 246	Continued From page 2 Interview with Resident #1 on 02/28/23 at 11:00am revealed: -He did not remember when he last saw the podiatrist. -He tried to keep his feet in "good shape" with lotion and trimming his toenails when they needed it. -He had not had any problems with his feet and knew he had to take care of them because he was a diabetic. Refer to interview with the medication aide (MA) on 02/28/23 at 12:10pm. Attempted telephone interview with Resident #1's mental health provider on 02/28/23 at 12:24pm and 3:39pm were unsuccessful. Refer to interview with the facility's PCP on 02/28/23 at 4:32pm. Refer to interview with the Administrator/Owner on 02/28/23 at 12:15pm. 2. Review of Resident #3's current FL2 dated 03/16/22 revealed: -Diagnoses included dementia, depression, diabetes mellitus 2, hypertension, chronic obstructive pulmonary disease, osteoarthritis, hyperlipidemia, and vitamin D deficiency. -There was an order for Cymbalta (used to treat depression) 60mg to be given by mouth once a day. -There was an order for Risperdal (used to treat schizophrenia and bipolar disorder) 0.5mg two tablets to be given by mouth twice a day. -There was an order for mirtazapine (used to treat depression) 15mg to be given by mouth at bedtime.	C 246	Regular facility Podiatrist - Staff would also help resident to keep feet in good shape.	4/28/23

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C 246	Continued From page 4 Resident #2. Observation of Resident #2's feet on 02/28/23 at 11:30am revealed: -Resident #2's toenails were thick and discolored with jagged edges without breakdown of the skin noted. -The toenails extended over the end of her toes approximately 1/4" - 1/2". -The skin was pink and dry with moderate flaking of the skin. -The first 3 toes on each foot were mycotic (a nail fungus causing thickened, brittle, crumbly and ragged nails). Review of Resident #2's physician's order and physician visit notes revealed: a. -The last psychiatric progress notes were for a visit on 09/07/21 -There was no documentation of an upcoming appointment with the mental health provider. -There was no documentation the mental provider was contacted to change or cancel a scheduled appointment. b. -The last podiatry progress notes were for a visit on 11/10/21. -There was no documentation of an upcoming appointment with the podiatrist. -There was no documentation the podiatrist was contacted to change or cancel a scheduled appointment. Interview with Resident #2 on 02/28/23 at 11:30am revealed: -She did not remember seeing the podiatrist (foot doctor). -She would like to see the podiatrist. -She knew she had to take care her feet because if they got infected, they might be "cut off"	C 246	Facility would assure to meet Routine and acute health care needs of Resident. Facility would follow up promptly with Podiatrist routine visit. Facility shall follow up with physician's order and physician notes for action. Facility would document mental health provider contacted. - Podiatrist upcoming appointment would be confirmed and documented	4/28/23 4/28/23 4/28/23 4/28/23

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C 246	Continued From page 5 (amputated). Interview with the Administrator/Owner on 02/28/23 at 12:15pm revealed: -Resident #2 would refuse to go to the podiatrist. -The resident's refusals were not documented. -The Administrator was trying to get the facility's contracted health care provider to be able to send their podiatrist out to the facility to see all the residents. Refer to interview with the medication aide (MA) on 02/28/23 at 12:10pm. Attempted telephone interview with Resident #2's mental health provider on 02/28/23 at 12:24pm and 3:39pm were unsuccessful. Refer to telephone interview with the facility's PCP on 02/28/23 at 4:32pm. Refer to interview with the Administrator/Owner on 02/28/23 at 12:15pm. Interview with the medication aide (MA) on 02/28/23 at 12:10pm revealed: -She was not sure if the residents had any appointments to see mental health provider or podiatry. -The Administrator/Owner took the residents to appointments if the provider was not able to come to the facility to see the residents. Interview with the Administrator/Owner on 02/28/23 at 12:15pm revealed: -She took all the residents to their appointments if the appointments were outside of the facility. -She had recently changed contracted providers to be able to have a company to provide all service 'In house' for the residents.	C 246	Resident Refusals form would be documented. Facility would Schedule Resident with mental health provider out of facility network Facility would Schedule Resident with Podiatrist out of facility network immediately. Administrator would take residents to out of facility appointment if provider was not able to come to the facility to see the residents.	4/28/23 4/28/23 4/28/23 4/28/23

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C 246	Continued From page 6 -She thought the PCP had contacted the contracted provider for the referrals for mental health and podiatry. -She was not aware the contracted provider did not have a podiatrist or mental health providers in place to come to the facility to see the residents. -If she had known the contracted provider was not able to provide a podiatrist or mental health providers to see the residents, she would have contacted another provider. Telephone interview with the facility's PCP on 02/28/23 at 4:32pm revealed: -Her coworker was the PCP who had seen the residents on 12/14/22 and ordered the podiatry and psychiatry consults. -The PCP being interviewed had seen the residents on 01/20/23 and 02/23/23. -She had informed the Administrator/Owner that her company was just starting up and in the process of hiring all of the needed providers. -The company would be able to provide both podiatry and psychiatry care in the future. -The company did not currently have the psychiatry services available. -The company only had one podiatrist at that time. -The PCP had instructed the Administrator/Owner that the current podiatrist was "booked up" with her current caseload and unsure when the residents at this facility would be able to be seen. -She informed the Administrator/Owner it would be best to find another provider for podiatry and psychiatry services.	C 246	Facility would ensure Residents appointment with a mental health provider for antipsychotic medication refills, dosages decrease and a Podiatry Consult - Out of Network mental health provider and Podiatrist would be contacted when necessary.	4/28/23 4/28/23
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the	C 249		

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C 249	Continued From page 7 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: Based on interviews and record reviews, the facility failed to implement orders for 2 of 3 sampled residents (#2) who had orders for Vitamin B 12 and (#3) had orders for blood work. The findings are: 1. Review of Resident #1's current FL2 dated 10/11/22 revealed diagnoses included schizophrenia, diabetes mellitus 2, hypertension, hyperlipidemia, and vitamin D deficiency. Review of Resident #1's Primary Care Providers (PCP) progress notes dated 01/20/23 revealed the PCP ordered the following blood work: Complete Blood Count (provides information about the cells in a person's blood), Comprehensive Metabolic Panel (Provides important information about your body's chemical balance and metabolism, which is how your body uses food and energy), Vitamin A, Vitamin C and Vitamin D Anemia Panel (used to determine if the person is missing important vitamins in their blood used for health and well-being), Lipid Panel (used to find abnormalities in the cholesterol and fats in the blood) and Thyroid Panel (used to test the level of the hormones produced by the thyroid gland which is a major role in the body's metabolism growth and development).	C 249	Facility would document and follow up Residents records. Written procedures, treatments, Orders from a physician or other licensed health professionals. -Facility would implement procedures and treatment order from a physician or other licensed health professionals. 4/28/23	

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C 249	Continued From page 8 Review of Resident #2's Primary Care Providers (PCP) progress notes dated 12/14/22 revealed: -Resident #2 had bloodwork done for Vitamin B 12 levels with results that showed the resident's level was low. -The PCP ordered Vitamin B 12 1000mg by mouth daily. Review of Resident #2's medication administrations records for December 2022, January 2023 and February 2023 revealed there were no entries for vitamin B12 to be administered as ordered on 12/14/22. Attempted telephone interview with the facility's pharmacy on 02/28/23 at 11:00am was unsuccessful. Refer to interview with the medication aide (MA) on 02/28/23 at 12:10pm. Refer to telephone interview with the facility's PCP on 02/28/23 at 4:32pm. Refer to interview with the Administrator/Owner on 02/28/23 at 12:15pm. 2. Review of Resident #3's current FL2 dated 03/16/22 revealed diagnoses included dementia, depression, diabetes mellitus 2, hypertension, chronic obstructive pulmonary disease, osteoarthritis, hyperlipidemia, and vitamin D deficiency. Review of Resident #3's Primary Care Providers (PCP) progress notes dated 06/07/22 revealed the PCP ordered a colonoscopy (used to detect cancer of the colon/rectum) and prostate specific antigen (PSA) level (used to detect prostate	C 249	Facility would improve on documentation of Laboratory Results. Facility would document, treatment or orders from Physician or other licensed health professional on the Medication administration records as ordered to be administered	4/28/23 4/28/23

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C 249	Continued From page 9 cancer) for Resident #3. Review of Resident #3's record revealed: -There was no documentation for upcoming appointment for the colonoscopy. -There was no documentation the PCP was contacted regarding the resident refusing to have the colonoscopy done. -There were no PSA results. Attempted telephone interview with the facility's laboratory provider on 02/28/23 at 10:43am was unsuccessful. Refer to interview with the medication aide (MA) on 02/28/23 at 12:10pm. Refer to telephone interview with the facility's PCP on 02/28/23 at 4:32pm. Refer to interview with the Administrator/Owner on 02/28/23 at 12:15pm. Interview with the medication aide (MA) on 02/28/23 at 12:10pm revealed: -She was not sure if the residents had any orders for any labs or medications that were not done. -She sent in the orders for medications to the pharmacy. -She would contact the lab for any lab work that needed to be done. Interview with the Administrator/Owner on 02/28/23 at 12:15pm revealed: -She took all the residents to their appointments if the appointments were outside of the facility. -She had recently changed contracted providers to be able to have a company to provide all service 'In house' for the residents. -She was not aware of any lab work ordered that	C 249	Facility would improve on documentation for upcoming procedure treatment, appointments orders from Physicians or other licensed health professional. <i>4/28/23</i> Facility would keep record of Refusal forms <i>4/28/23</i> Residents would be taking to their appointment as ordered from Physicians or other licensed health professional. <i>4/28/23</i>	

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C 249	Continued From page 10 had not been done or medications that were supposed to be ordered that had not been. -The MA would take care of the orders and send to the appropriate place when the orders were given by the PCP. Telephone interview with the facility's PCP on 02/28/23 at 4:32pm revealed: -Her coworker was the PCP who had seen the residents on 12/14/22 and ordered the vitamin B12 based on previous bloodwork. -The PCP who had ordered the PSA bloodwork and colonoscopy was from a different company. -Her concerns had she ordered these would have been that the facility was not following through on orders in general. -The colonoscopy would be beneficial in detecting colorectal cancer early. -The PSA levels would help detect prostate cancer early.	C 249	Facility would ensure follow-up of written procedures, treatment or orders from a physician or other licensed professional to meet the routine and acute health care need of Residents.	4/28/23	
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the	C 254			

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C 254	Continued From page 11 tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed on 3 of 3 sampled residents (#1, #2, and #3) to include the identified tasks of fingerstick blood sugars for diabetic residents The findings are: 1. Review of Resident #1's current FL2 dated 10/11/22 revealed diagnoses included schizophrenia, diabetes mellitus 2, hypertension, hyperlipidemia, and vitamin D deficiency. Review of Resident #1's record revealed there were no Licensed Health Professional Support for the resident since her admission on 09/05/20. Refer to interview with the Administrator/Owner and the LHPS Nurse on 02/28/23 at 4:41pm. 2. Review of Resident #2's current FL2 dated 03/16/22 revealed diagnoses included dementia, diabetes mellitus 2, osteoarthritis, hyperlipidemia, and vitamin D deficiency. Review of Resident #2's record revealed there were no Licensed Health Professional Support for	C 254	Facility would ensure Quarterly Observations, assessment Evaluation, interviews and recommendations based on the progress of the residents by the Licensed Health Professional Support. Licensed Health Professional Support would visit quarterly as recommended. Facility would document and record LHPS Nurse visit properly.	4/28/23 4/28/23 4/28/23	

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C 254	Continued From page 12 the resident since his admission on 06/24/22. 3. Review of Resident #3's current FL2 dated 03/16/22 revealed diagnoses included dementia, depression, diabetes mellitus 2, hypertension, chronic obstructive pulmonary disease, osteoarthritis, hyperlipidemia, and vitamin D deficiency. Review of Resident #3's record revealed there were no Licensed Health Professional Support for the resident since his admission on 11/30/20. Refer to interview with the Administrator/Owner and the LHPS Nurse on 02/28/23 at 4:41pm. Telephone interview with Administrator/Owner and the LHPS Nurse on 02/28/23 at 4:41pm revealed: -She and the Owner were responsible for ensuring LHPS evaluations and reviews were completed. -The residents receiving finger stick blood sugars (FSBS) should have quarterly LHPS done. -The Owner was to let the LHPS RN know the LHPS assessment needed to be completed. -The last time in December 2022 she was scheduled to come but had been on vacation for 2 weeks and was not able to come then.	C 254	Facility would follow up and ensure licensed Health Professional Support Nurse visit quarterly to evaluate the resident's progress to care being provided. Recommend changes in the care of the resident as needed based on the physician assessment and evaluation on the progress of the residents to include the identified tasks of Fingerstick, Blood Sugar for diabetic residents. 4/28/23	