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D 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services conducted a follow-up survey and complaint investigation from 08/15/23 to 08/18/23.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to ensure 1 of 3 medication aides (Staff A) completed the medication aide clinical skills checklist prior to administering medications. The findings are: Observation of Staff A on 08/16/23 at 8:00am revealed she was administering medications. Review of Staff A's personnel record revealed:	D 125		

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-Staff A was hired on 05/08/23 as a Medication Aide (MA).
-There was documentation Staff A was previously employed in 2021.
-There was documentation Staff A completed her clinical skills validation on 03/05/21.
-There was documentation Staff A completed her 15-hour medication aide training on 03/15/21.
-There was documentation Staff A passed her Medication Aide Test on 04/14/21.
-There was no documentation Staff A completed her clinical skills validation since she was hired on 05/08/23.

Review of residents' June 2023, July 2023 and August 2023 medication administration records revealed:
-Staff A was documented as administering medications on 06/01/23, 06/02/23 and 06/08/23.
-Staff A was documented as administering medications on 07/04/23, 07/05/23, 07/11/23, 07/12/23, 07/16/23, 07/18/23, 07/19/23, 07/22/23, 07/24/23 and 07/26/23.
-Staff A was documented as administering medications on 08/01/23, 08/08/23, 08/09/23, 08/13/23 and 08/15/23.

Interview with Staff A on 08/17/23 at 3:26pm revealed:
-She worked at the facility as a MA in 2021 and 2022.
-She quit on 05/08/22.
-She did not work as a MA from 05/08/22 until she rehired at the facility on 05/08/23.
-When she returned to work at the facility on 05/08/23 she worked for a few days with 2 other MAs to become reoriented.
-She completed her clinical skills checklist when she trained to be a MA in 2021 but had not complete clinical skills validation again since she

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D 125	Continued From page 2 returned to the facility on 05/08/23. Interview with the Human Resources Manager (HRM) on 08/16/23 at 11:48am revealed: -She was responsible for ensuring staff received all necessary training. Staff A was a MA at the facility in 2021 and 2022, left the facility and returned 05/08/23. -Staff A did not need to complete her clinical skills checklist again since she was gone from the facility for less than two years. -She thought a MA who was rehired only needed to repeat clinical skills validation if it had been more than two years since they had completed it. Interview with the Administrator on 08/17/23 at 3:30pm revealed: -The HRM was responsible for ensuring all training was completed. -She, like the HRM, did not think retraining was necessary if the original training had been within the past two years.	D 125		
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 B VIOLATION	D 269		

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Based on observations, interviews and record reviews, the facility failed to provide personal care to 3 of 7 sampled residents (Residents #4, #6, and #9) according to the residents' care plans related to delays in residents incontinence care (#4 and #6), delays in repositioning (#4), and failing to provide mouth care (#9).

The findings are:

1. Review of Resident #4's current FL2 dated 05/04/23 revealed:
-Diagnoses included moderate dementia without behaviors, benign prostatic hyperplasia (age-associated prostate gland enlargement) with urinary tract symptoms, unspecified fracture of lower end of left tibia (the inner and typically larger of the two bones between the knee and the ankle), and unspecified fracture of the lower end of the right fibula (the outer and usually smaller of the two bones between the knee and the ankle).
-He was incontinent of bladder and bowel.
-The recommended level of care was documented as special care unit (SCU).
-There was an order to apply skin protectant and moisture barrier cream to denuded scrotal area with incontinence care.

Review of Resident #4's Care Plan dated 05/29/23 revealed:
-He was totally dependent on staff for assistance with toileting, ambulation, bathing, dressing, transfers, grooming and personal hygiene.
-He had limited range of motion with his arms.

Review of Resident #4's Nurse Practitioner (NP) order dated 07/14/23 revealed:
-Apply topical zeasorb (used to prevent and treat fungal skin infection) daily to irritated areas of

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abdomen as treatment for fungal infection.
-Please add zinc oxide (used to prevent skin irritation) 20% cream apply to areas of potential skin break down topically daily.

Observation of Resident #4 on 08/15/23 at 9:24am revealed he was lying in bed with the bed linens up to his chest.

Observation of Resident #4 on 08/15/23 at 12:09pm revealed Resident #4 was seated in his wheelchair in the SCU dining room feeding himself a piece of apple pie.

a. Interview with Resident #4 on 08/15/23 at 9:25am revealed:
-His muscles were weak in his legs.
-He experienced muscle spasms in his legs.
-He was unable to get out of the bed or his wheelchair without staff assistance.
-He used his call light to alert staff when he needed assistance.
-It took staff "a long time" to respond when he put his call light on.
-"Sometimes" it took staff an "hour to an hour and a half" to answer his call light.
-Staff on all shifts were slow to respond to his call light.
-Staff did not check on him every 2 hours.
-Staff waited until he put his call light on to check on him.
-He had skin breakdown on his bottom.
-His bottom would feel like it was "on fire" from sitting.
-He felt "tortured" with just "sitting, sitting" in his wheelchair.

Interview with Resident #4 on 08/18/23 at 1:05pm revealed:
-Staff left him in the hall for "hours" in his

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wheelchair.
-He got so chaffed and sore "it hurts so bad you almost have to cry."
-Staff did not pay any attention to the call bells.
-He recently waited 2 hours before his call bell was answered by staff.
-Staff expected residents to go to bed by 8:00pm.
-Staff put him to bed by 8:00pm.
-His mattress stuck to him and it made it impossible for him to turn over in the bed without staff assistance.
-He was very uncomfortable in his bed as he was unable to reposition himself without assistance.
-Staff were not coming around every 2 hours while he was in bed to reposition him.

Review of Resident 4's July 2023 electronic activities of daily living (ADL) log revealed:
-There was an entry for ambulation, lifting, turning, and repositioning resident scheduled every 2 hours from 12:00am to 11:50pm.
-On 07/04/23, there was no documented repositioning from 12:00am to 5:59am (6 hours).
-On 07/11/23, there was no documented repositioning from 12:00am to 5:59am (6 hours).
-On 07/12/23, there was no documented repositioning from 12:00am to 7:59am (8 hours).
-On 07/17/23, there was no documented repositioning from 6:00pm to 11:59pm (6 hours).
-On 07/18/23, there was no documented repositioning from 12:00am to 5:59am (6 hours).
-On 07/24/23, there was no documented repositioning from 6:00pm to 11:59pm (6 hours).
-On 07/26/23, there was no documented repositioning from 12:00am to 7:00am (7 hours).
-There were 7 out of 31 days where there was no documentation of Resident #4 being repositioned for 6 to 8 consecutive hours.

Review of Resident #4's August 2023 ADL log

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dated 08/01/23 to 08/15/23 revealed:
-There was an entry for ambulation, lifting, turning, and repositioning resident scheduled every 2 hours from 12:00am to 11:50pm.
-On 08/01/23, there was no documented repositioning from 12:00am to 5:59am (7 hours).
-On 08/08/23, there was no documented repositioning from 12:00am to 6:59am (7 hours) and from 6:00pm to 11:59pm (6 hours).
-On 08/15/23, there was no documented repositioning from 12:00am to 5:59am (6 hours).
-There were 3 out of 15 days where there was no documentation of Resident #4 being repositioned for 6 to 7 consecutive hours.

Review of Resident #4's facility call light response report dated 08/01/23 to 08/17/23 revealed:
-Resident #4's call light was activated a total of 14 times from 08/02/23 to 08/14/23.
-The maximum response time was 1 hour and 3 minutes.
-The average response time was 20 minutes 23 seconds.
-The minimum response time was 52 seconds.
-There were no call light activations on 08/01/23, 08/03/23, 08/08/23, 08/10/23, 08/13/23, 08/15/23, 08/16/23, and 08/17/23.

Review of Resident #4's outpatient wound center note dated 08/17/23 revealed:
-The patient was found to be in a soiled incontinence brief.
-There was a Stage I (observable pressure related alteration of intact skin with non-blanchable redness of a localized area) pressure ulcer of the left buttock.
-There was a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer) pressure ulcer noted on his left buttock.
-There was a Stage II pressure ulcer noted on his

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right buttock.
-There were multiple sores on the resident's bilateral lower extremities.
-There was no sign of infection or inflammation with any of these wounds.
-All wounds were dressed and bandaged.

According to the National Institute of Health, pressure injuries are defined as the breakdown of skin integrity due to some types of unrelieved pressure.

Interview with a personal care aide (PCA) on 08/16/23 at 12:02pm revealed:
-She worked as a PCA routinely on the 7:00am to 3:00pm shift or 3:00pm to 11:00pm shift.
-Resident #4 required staff assistance with all ADL's except eating.
-She and the other staff checked on Resident #4 every 1 to 2 hours to reposition him.
-She was not aware of any breakdown on Resident #4's bottom.

Telephone interview with a second PCA on 08/15/23 at 8:00pm revealed:
-She had worked as a PCA in the facility for one year.
-The PCAs on the SCU repositioned residents "every one to two hours" on the 3:00pm to 11:00pm and 11:00pm to 7:00am shifts.

Telephone interview with a third PCA on 08/15/23 at 8:08pm revealed:
-She worked primarily on the 3:00pm to 11:00pm shift as a PCA.
-She repositioned dependent residents every one to two hours on the SCU.
-She denied ever witnessing any staff refusing to provide personal care to any resident.

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Interview with the medication aide (MA) Supervisor on 08/17/23 at 9:20am revealed:
-She was not aware of any wounds on Resident #4's bottom.
-She was not aware of Resident #4 having any pressure wounds.
-Resident #4 was evaluated by outpatient wound care "last week" and all the wounds on Resident #4 were "self-inflicted."
-Resident #4 had an appointment to return to outpatient wound care that afternoon (08/17/23).

Interview with the Special Care Coordinator (SCC) on 08/17/23 at 11:16am revealed:
-Resident #4 was admitted to the facility with "a cast and scabs and scarring" on his bilateral legs from an accident he had suffered prior to admission in which he broke both of this legs and received surgical repair of the injuries.
-His other wounds had progressed "later."
-The PCAs were responsible for charting resident ADLs into the ADL log at the end of their shifts.
-When their were missing entries in the ADL logs that meant that the PCAs did not have time to complete the ADL charting for that shift.
-The MA Supervisor was responsible for ensuring appropriate resident care by going around at the end of shifts she worked and checking to see if residents were dry.
-The residents would also "speak up and complain" if they did not receive the help they needed from staff.

Telephone interview with Resident #4's Nurse Practitioner (NP) from the outpatient wound center on 08/17/23 at 9:50am revealed:
-She received a referral for wound care for Resident #4 on 07/28/23.
-She saw Resident #4 for the first wound care visit on 08/09/23.

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D 269	Continued From page 9 -Resident #4 had an area of skin breakdown on his bottom measuring 0.2cm by 0.2cm. -He also had multiple healing wounds on both his legs and feet. -He should be repositioned every 2 hours to relieve pressure or there was the potential it would cause his wounds to get worse. -Delays in repositioning also had the potential to cause additional wounds to develop. Interview with the Administrator on 08/17/23 at 3:10pm revealed: -Staff were expected to check on residents at least every 2 hours and reposition those who were totally dependent on staff for assistance. -She expected staff to respond to call lights "as quickly as possible" to assist residents with their personal care needs. -Resident #4 was able to communicate his needs to staff and he was able to activate his call light without assistance. b. Interview with Resident #4 on 08/15/23 at 9:25am revealed: -He wore incontinence briefs and was totally dependent on staff for incontinence care. -He had skin breakdown on his bottom. -He was unable to get out of the bed or his wheelchair without staff assistance. -He used his call light to alert staff when he needed assistance. -It took staff "a long time" to respond when he put his call light on. -"Sometimes" it took staff an "hour to an hour and a half" to answer his call light. -Staff on all shifts were slow to respond to his call light. -Staff did not check on him every 2 hours. -Staff waited until he put his call light on to check on him.	D 269		

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D 269	Continued From page 10 Interview with Resident #4 on 08/18/23 at 1:05pm revealed: -Staff left him in the hall for "hours" in his wheelchair. -He got so chaffed and sore "it hurts so bad you almost have to cry." -Staff did not pay any attention to the call bells. -He recently waited 2 hours before his call bell was answered by staff. Review of Resident 4's July 2023 electronic activities of daily living (ADL) log revealed: -There was an entry for toileting before each meal scheduled for 7:00am to 8:00am, 11:30am to 12:00pm, and 4:30pm to 5:30pm. -There was an entry for toileting extensive scheduled every 2 hours from 1:00am to 9:00pm. -On 07/01/23, there was no documented toileting from 4:00pm to 7:00pm (3 hours). -On 07/04/23, there was no documented toileting from 1:00am to 7:00am (6 hours). -On 07/11/23, there was no documented toileting from 1:00am to 7:00am (6 hours). -On 07/12/23, there was no documented toileting from 1:00am to 7:00am (6 hours). -On 07/18/23, there was no documented toileting from 1:00am to 7:00am (6 hours). -On 07/26/23, there was no documented toileting from 1:00am to 7:00am (6 hours). -There were 6 out of 31 days where there was no documentation of Resident #4 being toileted for 3 to 6 consecutive hours. Review of Resident #4's August 2023 electronic ADL log from 08/01/23 to 08/15/23 revealed: -There was an entry for toileting before each meal scheduled for 7:00am to 8:00am, 11:30am to 12:00pm, and 4:30pm to 5:30pm. -There was an entry for toileting extensive	D 269		

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scheduled every 2 hours from 1:00am to 9:00pm.
-On 08/01/23, there was no documented toileting from 1:00am to 7:00am (6 hours).
-On 08/15/23, there was no documented toileting from 1:00am to 7:00am (6 hours).
-There were 2 out of 15 days where there was no documentation Resident #4 received incontinence care for up to 6 consecutive hours.

Review of Resident #4's facility call light response report dated 08/01/23 to 08/17/23 revealed:
-Resident #4's call light was activated a total of 14 times from 08/02/23 to 08/14/23.
-The maximum response time was 1 hour and 3 minutes.
-The average response time was 20 minutes 23 seconds.
-The minimum response time was 52 seconds.
-There were no call light activations on 08/01/23, 08/03/23, 08/08/23, 08/10/23, 08/13/23, 08/15/23, 08/16/23, and 08/17/23.

Review of Resident #4's outpatient wound center note dated 08/17/23 revealed:
-The patient was found to be in a soiled incontinence brief.
-There was a Stage I (observable pressure related alteration of intact skin with non-blanchable redness of a localized area) pressure ulcer of the left buttock.
-There was a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer) pressure ulcer noted on his left buttock.
-There was a Stage II pressure ulcer noted on his right buttock.
-There were multiple sores on the resident's bilateral lower extremities.
-There was no sign of infection or inflammation with any of the wounds.

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Telephone interview with a personal care aide (PCA) on 08/15/23 at 8:00pm revealed:
-She had worked as a PCA in the facility for one year.
-The PCAs on the SCU provided incontinence care "every one to two hours" on the 3:00pm to 11:00pm and 11:00pm to 7:00am shifts.

Telephone interview with a second PCA on 08/15/23 at 8:08pm revealed:
-She worked primarily on the 3:00pm to 11:00pm shift as a PCA.
-She provided incontinence care to residents every one to two hours on the SCU.
-She denied ever witnessing any staff refusing to provide personal care to any resident.

Interview with a personal care aide (PCA) on 08/16/23 at 12:02pm revealed:
-She worked as a PCA routinely on the 7:00am to 3:00pm shift or 3:00pm to 11:00pm shift.
-She and the other staff checked on Resident #4 every 1 to 2 hours for incontinence care.
-She was not aware of any breakdown on Resident #4's bottom.

Interview with the medication aide (MA) Supervisor on 08/17/23 at 9:20am revealed:
-Resident #4 was incontinent.
-She was not aware of any wounds on Resident #4's bottom.
-She was not aware of Resident #4 having any pressure wounds.
-Resident #4 was evaluated by outpatient wound care "last week" and all the wounds on Resident #4 were "self-inflicted."
-Resident #4 had an appointment to return to outpatient wound care that afternoon (08/17/23).

Interview with the Special Care Coordinator

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D 269	Continued From page 13 (SCC) on 08/17/23 at 11:16am revealed: -Resident #4 was admitted to the facility with "a cast and scabs and scarring" on his bilateral legs from an accident he had suffered prior to admission in which he broke both of this legs and received surgical repair of the injuries. -His other wounds had progressed "later." -The PCAs were responsible for charting resident ADLs into the ADL log at the end of their shifts. -When their were missing entries in the ADL logs that meant that the PCAs did not have time to complete the ADL charting for that shift. -The MA Supervisor was responsible for ensuring appropriate resident care by going around at the end of shifts she worked and checking to see if residents were dry. -The residents would also "speak up and complain" if they did not receive the help they needed from staff. Telephone interview with Resident #4's Nurse Practitioner (NP) from the outpatient wound center on 08/17/23 at 9:50am revealed: -She received a referral for wound care for Resident #4 on 07/28/23. -She saw Resident #4 for the first wound care visit on 08/09/23. -Resident #4 had an area of skin breakdown on his bottom measuring 0.2cm by 0.2cm. -Delays in incontinence care would cause Resident #4's wounds on his bottom "to get worse." -Delays in incontinence care also had the potential to cause additional wounds to develop. Interview with the Administrator on 08/17/23 at 3:10pm revealed: -Staff were expected to check on residents at least every 2 hours and provide incontinence care.	D 269		

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D 269	Continued From page 14 -She expected staff to respond to call lights "as quickly as possible" to assist residents with their personal care needs. -Resident #4 was able to communicate his needs to staff and he was able to activate his call light without assistance. 2. Review of Resident #9's current FL2 dated 06/21/23 revealed: -Diagnoses included dementia, glaucoma, and arthritis. -The recommended level of care was documented as special care unit (SCU). Review of Resident #9's Care Plan dated 06/21/23 revealed: -She was totally dependent with bathing. -She required extensive assistance with dressing, grooming, and personal hygiene. -She required limited assistance with toileting and transfers. -She had limited range of motion and strength in her arms. Interview with Resident #9 on 08/15/23 at 8:55am revealed: -Staff took her toothbrush and toothpaste. -She had been unable to brush her teeth since she no longer was allowed to keep a toothbrush and toothpaste in her room. -Staff did not tell her why she was no longer allowed to keep the toothbrush and toothpaste in her room. -Staff used to allow her to keep her toothbrush and toothpaste in the bathroom. Observation in Resident #9's shared common bathroom on 08/15/23 at 9:03am revealed: -There were four toothbrushes in the medicine cabinet.	D 269		

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-Two of the toothbrushes were unopened and still in their wrappers.
-The two open toothbrushes were lacking resident labels on them as to identify which resident they belonged to.
-There were two tubes of toothpaste available in the cabinet.

Interview with Resident #9 on 08/16/23 at 3:23pm revealed her teeth were in awful condition and needed to be brushed.

Review of Resident 9's June 2023 electronic activities of daily living (ADL) log revealed:
-There was an entry for oral mouth care extensive scheduled at 8:00am and 7:00pm.
-From 06/01/23 to 06/30/23, there were 26 occurrences of documented mouth care out of 60 opportunities.

Review of Resident #9's July 2023 ADL log revealed:
-There was an entry for oral mouth care extensive scheduled at 8:00am and 7:00pm.
-From 07/01/23 to 07/31/23, there were 40 occurrences of documented mouth care out of 62 opportunities.

Review of Resident #9's August 2023 ADL log revealed:
-There was an entry for oral mouth care extensive scheduled at 8:00am and 7:00pm.
-From 08/01/23 to 08/16/23, there were 20 occurrences of documented mouth care out of 32 opportunities.

Interview with the medication aide (MA) Supervisor on 08/16/23 at 12:05pm revealed:
-The personal care aides (PCAs) on 3:00pm to 11:00pm shift were responsible for assisting

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residents with mouth care right before they assisted residents to bed in the evenings.
-The resident mouth care supplies were stored in a plastic boxes located in the spa room and were labeled with each residents name.

Observation in the Special Care Unit (SCU) spa rooms on 08/16/23 at 12:10pm revealed there were no plastic boxes with resident personal care supplies in the spa areas.

Second interview with the MA Supervisor on 08/16/23 at 12:12pm revealed:
-She could not find the plastic boxes for each resident where there personal care items were stored.
-She would have to ask some of the staff from the 3:00pm to 11:00pm staff where they stored mouth care supplies and personal care supplies for the residents.

Interview with the MA Supervisor on 08/16/23 at 3:55pm revealed:
-Oral care was completed twice a day, before breakfast and at bedtime on the SCU.
-Each resident had toothpaste and a toothbrush in their bathroom.
-Sometimes toothpaste and toothbrushes were kept in the resident's top dresser drawer.
-Extra toothpaste was kept on the linen cart.

Interview with MA on 08/17/23 at 9:55am revealed:
-Toothbrushes for residents in the SCU used to be stored in separate labeled containers.
-She was not sure why staff were not still storing the toothbrushes this way.
-The tooth brushes used to be stored in separate containers labeled with the residents' names, placed in a box together, and the box was stored

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on the linen cart.
-The staff "knew" which toothbrush belonged to each SCU resident even though the toothbrushes were not labeled with the residents' names.

Interview with the Administrator on 08/17/23 at 3:10pm revealed:
-In the past, toothbrushes were kept in separate containers labeled with each resident's name and stored in a container on the linen cart, but staff had stopped doing that at some point.
-She did not know how the toothbrushes and paste started being left in the bathrooms, but the toothbrushes should not be left in the bathrooms due to the risk of a resident accidentally touching another residents toothbrush or trying to use another resident's toothbrush.

3. Review of Resident #6's current FL2 dated 11/15/22 revealed:
-Diagnoses included dementia, depression, gastroesophageal reflux disease, hypertension, general pain, and osteoarthritis.
-He was incontinent of bowel and bladder.
-He was intermittently disoriented.

Review of Resident #6's Care Plan dated 11/15/22 revealed he required extensive assistance with toileting.

Observation of Resident #6 on 08/16/23 at 4:16pm revealed:
-He was sitting in his wheelchair in the doorway of his bedroom.
-There was a large wet spot about six inches in diameter on his pants between his upper right thigh and his groin.
-He was upset and asking for assistance.

Interview with Resident #6 on 08/16/23 at 4:16pm

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revealed he was soaking wet and needed help because he had not been assisted with incontinence care all day.

Interview with a PCA on 08/15/23 at 11:52am revealed:
-Some days, Resident #6 needed more assistance with incontinent care on some days than other days.
-The PCA had no explanation why he needed more incontinent care on some days than others.

Interview with a Medication Aide (MA) Supervisor on 08/17/23 at 11:57am revealed:
-Resident #6 had no skin breakdown that she knew of.
-Resident #6 was easily confused and sometimes thought he was wet, when he was not wet.

Review of Resident #6's July 2023 activities of daily living (ADL) log for toileting revealed:
-There was an entry for toileting before meals from 7:00am-8:00am, 11:30am-12pm and 4:30am-5:00pm.
-There was an entry for extensive toileting from 1:00am-9:00pm.
-On 07/01/23 there was no documented toileting from 10:00am until 4:00pm (6 hours).
-On 07/02/23 there was no documented toileting from 10:00am until 9:00pm (11 hours).
-On 07/03/23 there was no documented toileting from 2:00pm until midnight (10 hours).
-On 07/04/23 there was no documented toileting from midnight until 4:00pm (16 hours).
-On 07/05/23 there was no documented toileting from 3:00am until 4:00pm (13 hours).
-On 07/06/23 there was no documented toileting from 2:00pm until midnight (10 hours).
-On 07/07/23 there was no documented toileting from 3:00am until midnight (21 hours).

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D 269	Continued From page 19 -On 07/09/23 there was no documented toileting from 3:00am until 4:00pm (13 hours). -On 07/10/23 there was no documented toileting from 2:00pm until midnight (10 hours). -On 07/11/23 there was no documented toileting from midnight until 4:00pm (16 hours). -On 07/14/23 there was no documented toileting from 10:00am until midnight (14 hours). -On 07/15/23 there was no documented toileting from 3:00am until 2:00pm (11 hours). -On 07/16/23 there was no documented toileting from 2:00pm until 9:00pm (7 hours). -On 07/19/23 there was no documented toileting from 2:00pm until midnight (10 hours). -On 07/20/23 there was no documented toileting from 2:00pm until midnight (10 hours). -On 07/21/23 there was no documented toileting from 2:00pm until midnight (10 hours). -On 07/23/23 there was no documented toileting from 12:00pm until 9:00pm (9 hours). -On 07/26/23 there was no documented toileting from 2:00pm until midnight (10 hours). -On 07/27/23 there was no documented toileting from 3:00am until 4:00pm (13 hours). -On 07/28/23 there was no documented toileting from 3:00am until midnight (21 hours). -On 07/29/23 there was no documented toileting from 3:00am until 4:00pm (13 hours). -On 07/30/23 there was no documented toileting from 4:00pm until midnight (8 hours). -On 07/31/23 there was no documented toileting from 3:00am until midnight (21 hours). -There were 23 out of 31 days Resident #6 had no documentation for extended periods of time for toileting on his ADL log. Review of Resident #6's August 2023 electronic activities of daily living (ADL) log for toileting revealed: -There was an entry for toileting before meals	D 269		

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from 7:00am-8:00am, 11:30am-12pm and 4:30am-5:00pm.
-There was an entry for extensive toileting from 1:00am-9:00pm.
-On 08/01/23 there was no documented toileting from 12:00pm until midnight (12 hours).
-On 08/04/23 there was no documented toileting from 2:00pm until midnight (10 hours).
-On 08/05/23 there was no documented toileting from 2:00pm until 7:00pm (5 hours).
-On 08/06/23 there was no documented toileting from 3:00am until 9:00pm (18 hours).
-On 08/07/23 there was no documented toileting from 3:00am until midnight (21 hours).
-On 08/08/23 there was no documented toileting for the entire day (24 hours).
-On 08/09/23 there was no documented toileting from midnight until 4:00pm (16 hours).
-On 08/10/23 there was no documented toileting from 2:00pm until midnight (10 hours).
-On 08/11/23 there was no documented toileting from 3:00am until midnight (21 hours).
-On 08/12/23 there was no documented toileting from 3:00am until 4:00pm (13 hours).
-On 08/13/23 there was no documented toileting from 2:00pm until 9:00pm (7 hours).
-On 08/14/23 there was no documented toileting from 3:00am until midnight (21 hours).
-On 08/15/23 there was no documented toileting from 2:00pm until midnight (10 hours).
-On 08/16/23 there was no documented toileting from 3:00am until 4:00pm (13 hours).
-There were 14 out of 17 days Resident #6 had no documentation for extended periods of time for toileting on his ADL log.

Telephone interview with a PCA on 08/15/23 at 8:00pm revealed incontinent rounds were completed every two hours on the 11:00pm to 7:00am shift.

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D 269	Continued From page 21 Telephone interview with another PCA on 08/15/23 at 8:08pm revealed: -She primarily worked on second shift which was 3:00pm to 11:00pm. -Incontinence rounds were completed every 1 to 2 hours. -She had never witnessed any of the staff refuse to provide residents with personal care. Interview with a third PCA on 08/16/23 at 12:02pm revealed: -She worked as a PCA on first shift which was 7:00am to 3:00pm. -Incontinence rounds were completed at least every 2 hours. Interview with the Special Care Coordinator (SCC) on 08/17/23 at 11:16am revealed: -The PCAs were responsible for charting resident ADL's into the ADL log at the end of their shifts. -When their were missing entries in the ADL logs that meant that the PCAs did not have time to complete the ADL charting for that shift. -The MA Supervisor was responsible for ensuring appropriate resident care by going around at the end of shifts she worked and checking to see if residents were dry. Interview with the Administrator on 08/17/23 at 3:10pm revealed: -Staff were expected to check on residents at least every 2 hours. -She expected staff to respond to call lights "as quickly as possible" to assist residents with their personal care needs. Attempted telephone interview with Resident #6's Power of Attorney on 08/15/23 at 12:07pm was unsuccessful.	D 269		

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D 269	Continued From page 22 The facility failed to provide personal care to Resident #4 related to urinary incontinence, resulting in Resident #4 to report he got so chaffed and sore and "it hurt him so bad he wanted to cry"and increasing Resident's #4's risk of worsening wounds on his buttocks and legs. This failure was detrimental to the health, safety, and welfare and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131-34 on 08/17/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 2, 2023.	D 269		
D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches;	D 278		

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D 278	Continued From page 23 (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule);	D 278		

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D 278	Continued From page 24 (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) assessment was completed on 2 of 2 sampled residents (Resident #1 and #4). for identified new task of care of Stage II pressure ulcers. The findings are: 1. Review of Resident #1's FL2 dated 05/12/23 revealed diagnoses included Alzheimer's disease, hypertension, and thrombocytopenia. Review of Resident #1's initial hospice certification dated 06/02/23 revealed the resident was identified to have a 2cm by 3cm sacral decubitus ulcer.	D 278		

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Review of Resident #1's physician orders dated 06/19/23 revealed:
-There were wound care orders for the right great toe which included removing the old dressing, cleansing the wound with wound cleanser, patting dry the wound with gauze, wrapping the right great toe with gauze, and securing the gauze with tape.
-There were wound care orders for the left heel which included removing the old dressing, cleansing the wound with wound cleanser, patting dry the wound with gauze, coat wound with medi-honey (hastens wound healing), wipe surrounding area with skin prep, and apply padded adhesive dressing daily and as needed.

Review of Resident #1's LHPS evaluation dated 06/28/23 revealed:
-The personal care tasks listed were 2 person transfers and ambulation using an assistive device (wheelchair).
-The task of care of pressure ulcers up to and including a Stage II pressure ulcer was not included as a task on the evaluation.
-The task of clean dressing changes was not included as a task on the evaluation.

Telephone interview with Resident #1's hospice Registered Nurse (RN) on 08/16/23 at 9:24am revealed:
-He came in to see Resident #1 on a weekly basis to evaluate him and to change his dressings.
-The facility staff were responsible to perform daily wound dressing changes on the days he did not come to the facility.

Interview with the Special Care Coordinator (SCC) on 08/16/23 at 10:17am revealed:
-She did not notify the LHPS nurse about

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Resident #1's wounds and dressing changes.
-She thought since hospice was following the resident's wound care, she did not need to let the LHPS nurse know about the new task.

Interview with the LHPS Nurse Consultant on 08/17/23 at 9:15am revealed:
-The facility staff did not make him aware of new tasks of wound care on his visit on 06/28/23 to evaluate Resident #1.
-His evaluation of Resident #1 included reviewing the residents electronic Medication Administration Record (eMAR), treatment administration record, and interviewing the staff about how they transferred the resident.
-He did not perform a physical evaluation of Resident #1 because he was unaware of the new wound care and dressing change tasks.
-Upon employment, all of the medication aides were trained and evaluated in their ability to perform clean dressing changes.

Refer to the interview with the SCC on 08/17/23 at 11:16am.

Refer to the interview with the Administrator on 08/17/23 at 3:10pm.

2. Review of Resident #4's current FL2 dated 05/04/23 revealed:
-Diagnoses included moderate dementia without behaviors, benign prostatic hyperplasia with urinary tract symptoms, unspecified fracture of lower end of left tibia (the inner and typically larger of the two bones between the knee and the ankle), and unspecified fracture of the lower end of the right fibula (the outer and usually smaller of the two bones between the knee and the ankle).
-He was incontinent of bladder and bowel.
-The recommended level of care was

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documented as special care unit (SCU).
-There was an order to apply skin protectant and moisture barrier cream to denuded scrotal area with incontinence care.

Review of Resident #1's progress note entry dated 05/16/23 at 10:15pm revealed the resident had an area of breakdown underneath his scrotum.

Review of Resident #1's LHPS evaluation dated 05/30/23 revealed:
-The personal care tasks listed were 2 person transfers and ambulation using an assistive device (wheelchair).
-The task of care of pressure ulcers up to and including a Stage II pressure ulcer was not included as a task on the evaluation.

Interview with the LHPS Nurse Consultant on 08/17/23 at 2:58pm revealed:
-The facility staff did not make him aware of the area of scrotal breakdown on Resident #4 on his visit on 05/30/23.
-His evaluation of Resident #1 included reviewing the residents electronic Medication Administration Record (eMAR), treatment administration record, and interviewing the staff about how they transferred the resident.
-He did not perform a physical evaluation of Resident #4, because he was not aware of any wounds.

Refer to the interview with the SCC on 08/17/23 at 11:16am.

Refer to the interview with the Administrator on 08/17/23 at 3:10pm.

_____
Interview with the Special Care Coordinator

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D 278	Continued From page 28 (SCC) on 08/17/23 at 11:16am revealed: -The day prior to the LHPS nurse's visit to the facility, she was responsible to email the LHPS nurse a list of all the residents who had developed new tasks that he needed to see on his visit. Interview with the Administrator on 08/17/23 at 3:10pm revealed: -The Special Care Coordinator (SCC) was responsible for providing a list of residents and their LHPS tasks to the LHPS Nurse Consultant. -Recently, when the LHPS Nurse Consultant performed LHPS evaluations he had not been involving the MA Supervisor. -She felt it would improve communication if the LHPS Nurse Consultant and the MA Supervisor went around together to do the evaluations. -The MA Supervisor was knowledgeable about recent resident health issues and the current resident orders. -She also expected the LHPS Nurse Consultant and the MA Supervisor to be asking questions of the personal care aides and medication aides about what they observed about each resident to ensure the accuracy of the LHPS evaluation. -She expected the LHPS Nurse Consultant to also physically assess each resident during the evaluation.	D 278		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the	D 366		

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medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observations, interviews and record review the facility failed to ensure the medication aide (MA) observed administration of medications for 1 of 5 residents (Resident #3) related to a topical cream and a topical powder.

The findings are:

Review of Resident #3's current FL2 dated 06/26/23 revealed:
-Diagnoses included history of polio, neurogenic bladder and chronic urinary tract infections.
-An order for calprotect 0.44%-20.6% ointment to be applied to buttocks would twice daily.
-An order for nystatin 100,000 unit/gram powder, 1/2 gram to affected area three times daily.

Observation of Resident #3's room during initial tour on 08/15/23 at 9:31am revealed:
-Resident #3 was lying in the bed.
-There was a bedside table next to her bed.
-There were two small medicine cups on the bedside table.
-One medicine cup contained a powder and the other medicine cup contained a white cream.

Interview with Resident #3 on 08/15/23 at 9:31am revealed:
-She was unable to get out of bed unless she was assisted.
-The cream and powder on her bedside table were used to protect her buttocks.
-Staff applied the cream and the powder when she was changed and turned in the morning.

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-No one had come to apply it yet because there were not as many staff working that morning.

Interview with Resident #3's family member on 08/15/23 at 11:41am revealed Resident #3 recently had a buttocks wound but it was now healed.

Interview with the MA supervisor on 08/15/23 at 2:25pm revealed:
-She did not know why the two medication cups were on Resident #3's bedside table.
-The MA was responsible for applying and documenting administration of the cream and powder to Resident #3.

Interview with a MA on 08/16/23 at 8:21am revealed:
-She was the MA that was working on 08/15/23.
-She left the powder and cream in a medicine cup on Resident #3's bedside table so the personal care aide (PCA) that was working could apply it.
-The PCAs were responsible for applying creams and powders when they provided personal care to residents.
-She told the PCAs when she put the cream and powder in Resident #3's room but they sometimes forgot.
-When she documented administration of the medication on the electronic medication administration record (eMAR) she was documenting that she left the cream and powder for the PCA.

Interview with the Resident Care Coordinator (RCC) on 08/16/23 at 9:37am revealed:
-MAs were trained to administer creams and powders.
-They were not supposed to leave creams and powders for the PCAs to administer.

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D 366	Continued From page 31 Interview with a PCA on 08/16/23 at 9:49am revealed: -Resident #3's creams and powder was put on her buttocks when she was helped with personal care. -She thought the MA administered the cream and powder on 08/15/23. Interview with another PCA on 08/16/23 at 2:38pm revealed: -All the MAs put the cream and powder on Resident #3's bedside table and expected the PCAs to apply it when they were providing personal care. -She did not remember the MA telling her on 08/15/23 that she had left the cream and powder on the bedside table. -She had gone throught the MA training and knew that administering creams and powders were the MA responsibilities but she did it because she wanted to ensure Resident #3 received the treatments that were ordered. Interview with the Administrator on 08/16/23 at 11:13am revealed: -MAs were responsible for observing the administration of all medications. -She was not aware MAs were not observing the administration of creams and powders and were being left for the PCAs to administer.	D 366		
D 611	10A NCAC 13F .1801(b) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (b) The facility's infection and control policies and	D 611		

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D 611	Continued From page 32 procedures shall be implemented by the facility and shall address the following: (1) Standard and transmission-based precautions, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and (4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak.	D 611		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, and interviews the facility failed to implement a written infection control policy consistent with Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the storage of residents' to prevent cross contamination of toothbrushes and razors in the special care unit (SCU).

The findings are:

Review of the facility's infection prevention and control policy dated January 2022 revealed:
-Standard precautions are used for all resident regardless of known or unknown infectious status.
-Standard precautions apply to all body fluids, secretions, and excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucus membranes.

According to the Center for Disease Controls (CDC) recommendations for the handling of toothbrushes dated 03/18/16 revealed:
-Do not share toothbrushes.
-Toothbrushes can have germs on them even after rinsing that could raise the risk of infection.
-After brushing, rinse your toothbrush with tap water until it is completely clean, let it air-dry, and store it in an upright position.
-If more than one brush is stored in the same holder, do not let them touch each other.

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D 611	Continued From page 34 1. Observation of the bathroom between Rooms 146 and 148 in the Special Care Unit (SCU) on 08/16/23 at 3:36pm revealed: -The bathroom was shared by 4 residents that resided in rooms 146 & 148. -There was a cabinet above the bathroom sink that had 4 shelves. -There was one unlabeled toothbrush on the bottom shelf. -The top shelf contained one unlabeled toothbrush under 4 new cellophane-wrapped toothbrushes. Interview with a resident on 08/16/23 at 3:36pm revealed: -She resided in room 146. -The toothbrush on the bottom shelf of the vanity adjoining her bedroom belonged to her. Observation of the bathroom in between Rooms 142 and 144 in the SCU on 08/16/23 at 3:39pm revealed: -The bathroom was shared by 2 residents that resided in rooms 142 and 144. -There was a cabinet above the bathroom sink that had 4 shelves. -There were two unlabeled toothbrushes on the bottom shelf. Observation of the bathroom between Rooms 130 and 132 in the SCU on 08/16/23 at 4:12pm revealed: -The bathroom was shared by 2 residents that resided in rooms 130 and 132. -There was a cabinet above the bathroom sink that had 4 shelves. -There were two unlabeled toothbrushs under 10 oral swabs on the bottom shelf.	D 611		

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D 611	Continued From page 35 Interview with a medication aides (MA) supervisor on 08/16/23 at 3:55pm revealed: -Each resident had a toothbrush in their bathroom. -Sometimes toothbrushes were kept in the resident's top dresser drawer. Interview with SCC (Special Care Coordinator) on 08/17/2023 at 10:20am revealed during the COVID pandemic staff began to store tooth brushes differently due to family concerns over potential cross contamination, from the brushes being stored in the same box on the linen cart. Interview with a MA supervisor on 08/16/23 at 3:25pm revealed all toothbrushes were kept in the Special Care Coordinator's (SCC) office so residents did not have access to them. Interview with a MA on 08/16/23 at 3:26pm revealed: -Each resident used to have a toothbrushes in the shower room under the sink. -Resident toothbrushes were now kept in the SCC's office. Interview with the SCC on 08/16/23 at 3:30pm revealed: -She thought residents' toothbrushes were kept in the resident's bathroom cabinet. -The only oral care supplies kept in her office were supplies for new residents. -In the past, each resident had a container that was kept in the shower room that contained all their personal items such as a toothbrush. -She did not know when the facility changed where personal care items were kept. Interview with a MA on 08/17/2023 at 9:55am revealed:	D 611		

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D 611	Continued From page 36 -Each resident used to have a labeled container that contained their toothbrush. -The labeled containers were stored in a box, and placed on the linen cart. -She was not sure when they stopped storing toothbrushes in individual containers on the linen cart. -Staff "just knew" which toothbrush belonged to which resident. Interview with the Administrator on 08/17/23 at 12:15pm revealed the current staff would need to be trained to be more aware of issues with infection control. Interview with the Administrator on 08/17/23 at 3:10pm revealed: -In the past, residents' toothbrushes were kept in separate containers labeled with each resident's name and stored in a container on the linen cart, but staff had stopped doing that at some point. -She did not know how the toothbrushes started being left in the residents' shared bathrooms, but the toothbrushes should not be left in the bathrooms due to the risk of a resident accidentally trying to use another resident's toothbrush. _____ The facility failed to maintain toothbrushes in a manner to decrease the risk of cross contamination. This failure was detrimental to the health, safety, and welfare of the residents in the SCU and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131-34 on 08/17/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 2,	D 611		

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D 611	Continued From page 37 2023.	D 611		