Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032001	A. BUILDING: _____ B. WING _____	R 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENO POINTE ASSISTED LIVING	5600 N ROXBORO ROAD DURHAM, NC 27712

(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 conducted a follow up survey on February 7, 2024 to February 8, 2024.	{D 000}		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure physician treatment orders were implemented for 1 of 5 sampled residents (#2) related to physician orders for thrombo-embolic deterrent (TED) hose and wound care. The findings are: Review of Resident #2's current FL2 dated 09/01/23 revealed diagnoses included major neurocognitive disorder, mild dementia, and chronic venous stasis dermatitis of both lower extremities. a. Review of Resident #2's physician's orders dated 11/27/23 revealed an order for TED hose on n the morning and off in the evening as needed for edema. Review of Resident #2's Licensed Home Professional Support (LHPS) review dated	{D 276}	It is the community's standard practice to be compliant with all state rules and regulations. To ensure Med Tech staff are documenting resident refusals of treatments, an in-service was held on 02/21/24 by our RN to review the community's policy on documentation of resident refusals and use of PRNs. Additionally, proper implementation of treatment orders was reviewed including documentation. The community's protocol on receiving written orders was reviewed with the Podiatrist on 02/08/24 to ensure the community timely receives all orders in writing; practitioner agreed to comply. To ensure on-going compliance, documentation of order implementation will be monitored by RN, Resident Care Coordinator or designee, Administrator, or Pharmacist, at least monthly until 100% compliance is achieved and then will be monitored at least quarterly.	2/21/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 02/21/24

Reviewed and acknowledged 02/26/24 KC

Kathleen C Lawson

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{D 276}	Continued From page 1 12/13/23 revealed: -There was documentation Resident #2 had an as needed order for TED hose. -There was no documentation under the assessment as to whether or not he had TED hose on or if he had edema in his legs. Review of Resident #2's primary care provider's (PCP) after visit progress note dated 01/30/24 revealed: -Resident #2 was seen on 01/30/24 for lower extremity edema. -He had been experiencing lower extremity edema for about a week, with the left leg being significantly larger than the right leg. Review of Resident #2's electronic Medication Administration Record (eMAR) for December 2023 revealed: -There was an entry for TED hose on in the morning and off in the evening as needed for edema. -There was no documentation TED hose were applied or removed in the month of December 2023. Review of Resident #2's eMAR January 2024 revealed: -There was an entry for TED hose on in the morning and off in the evening as needed for edema. -There was no documentation TED hose were applied or removed in the month of January 2024. Review of Resident #2's eMAR from 02/01/24 through 02/07/24 revealed: -There was an entry for TED hose on in the morning and off in the evening as needed for edema. -There was no documentation TED hose were	{D 276}		

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{D 276}	Continued From page 2 applied or removed in the month of January 2024. Review of Resident #2's physician's orders dated 02/08/24 revealed an order for TED hose apply daily and remove at night. Observation of Resident #2 on 02/07/24 at 9:41am and 3:37pm revealed: -Resident #2 had on black crew socks, and he was not wearing TED hose. -Both of his legs, ankles, and feet were swollen with more swelling in the left leg, ankle, and foot. Interview with Resident #2 on 02/07/24 at 9:41am revealed: -He was concerned about the swelling in his legs because he did not know why he was having the swelling. -The swelling in his left leg was worrying him because it was more than in the right leg. -He saw his PCP last week and had x-rays. (Take this out unless it has to do with TED hose or x-ray of his legs) -He also saw his PCP on yesterday, 02/06/24, but he could not remember whether the PCP looked at his leg again or not. -He had fluid in his legs, but he was not experiencing any pain. Second interview with Resident #2 on 02/07/24 at 3:37pm revealed: -Staff had not applied TED hose to his legs since they have been swollen over the last week. -He did not remember having any TED hose. Telephone interview with the pharmacy on 02/08/24 revealed: -Resident #2 had an order dated 02/07/24 for TED hose apply in the morning and remove in the evening scheduled daily.	{D 276}		

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-The facility ordered TED hose for Resident #2 on 02/07/24.
-TED hose were last dispensed to the facility on 02/01/2022.

Interview with a medication aide (MA) on 02/08/24 at 9:47am revealed:
-The RCC placed TED hose on Resident #2 on 02/08/24.
-She had not previously seen any TED hose for Resident #2 and TED hose were usually kept on the medication cart for residents.
-She noticed swelling in Resident #2's legs for at least a week and he had been seen by his PCP.
-She saw the entry for TED hose as needed on Resident #2's eMAR when she clicked on Resident #2's medications that were administered as needed, but TED hose did not automatically populate on the eMAR to apply during her shift.
-She understood Resident #2's order or TED hose as needed meant that TED hose were to be applied when Resident #2 had swelling in his legs.
-She had not applied TED hose to Resident #2 since noticing the swelling in his legs because there were none on the medication cart.
-She automatically thought the Resident Care Coordinator (RCC) would order TED hose for Resident #2 or talk to Resident #2's PCP.
-If she had applied Resident #2's TED hose, she would have documented she applied them on his eMAR.

Interview with a second MA on 02/08/24 at 10:25am revealed:
-She noticed swelling in Resident #2's legs last week, but she did not know Resident #2 had an order for TED hose as needed for edema.
-She administered medications and treatments according to the eMAR and she had not seen any

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orders for TED hose on Resident #2's eMAR.
-If the TED hose were to be applied as needed, she would not have known unless she went into the as needed section of the eMAR.
-No one told her Resident #2 had an order for TED hose as needed for edema.
-She would have documented on the eMAR had she applied TED hose for Resident #2.

Interview with the Resident Care Coordinator on 02/08/24 at 10:41am revealed:
-She had Resident #2s original pair of TED hose in a closet in her office and applied them to his legs this morning.
-The MAs should have come to her to get TED hose for Resident #2 when needed for edema.
-Resident #2 often refused care and took his own sponge baths; no staff that went in to provide care for Resident #2 checked his legs because he would not let them.
-Resident #2 refused medications and had refused TED hose.
-Staff had not told her about Resident #2's legs swelling; she noticed the swelling in his legs when he was sitting outside smoking.
-She contacted Resident #2's PCP for him to be seen and she tried to apply his TED hose, but he refused to have them applied.
-She did not document Resident #2 refused to wear his TED hose.
-She and Resident #2's PCP talked to Resident #2 and convinced him to wear his TED hose and she was able to apply the TED hose today.

A second observation of Resident #2 on 02/08/24 at 11:26am revealed he had on white TED hose and black crew socks on top of the TED hose.

Interview with Resident #2's PCP on 02/08/24 at 11:30am revealed:

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-She knew Resident #2 had refused to have TED hose applied in the past.
-She expected staff to attempt to apply Resident #2's TED hose since his legs started swelling.
-If Resident #2 had refused to have his TED hose applied, she would have expected staff to document refusals.
-She ordered a doppler test (on 01/30/24) to assess for blood clots and it was negative.
-She was not pushing too hard for staff to apply the TED hose until she received the results of the doppler test.
-The biggest issues with Resident #2 not having TED hose applied would be edema and skin breakdown, but she recently ordered a medication used to treat fluid retention now.

Interview with the Administrator on 02/08/24 at 11:37am revealed:
-Staff knew Resident #2 had been seen by his PCP for swelling in his legs and knew that he could be belligerent.
-She expected MAs to be in communication about ongoing refusals of TED hose with the RCC and Resident #2's PCP.
-She did not say whether or not she expected MAs to attempt to apply Resident #2's TED hose as needed for edema.

Attempted telephone interview with the LHPS nurse on 02/08/24 at 9:47am was unsuccessful.

b. Review of Resident #2's podiatrist after visit progress note dated 12/07/23 revealed:
-Resident #2 was seen by the podiatrist on 12/05/23 for routine foot care.
-Resident #2 suffered from peripheral vascular problems and complications which warranted care by a trained professional.
-Resident #2 complained of pain on his right

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second toe.
-Resident #2 had been applying a bandage over his toe when in a shoe, but he was not area was an open wound.
-The wound was described as 4 x 4 x 2 millimeters.
-The fat layer was exposed and was a stage 3 ulcer.
-The devitalized tissue with removed.
-There was an order for wound care: remove dressing, wash right second toe with soap and water, pat dry, and apply triple antibiotic ointment and dry dressing to right second toe once daily for 10 days starting on 12/07/23.

Review of Resident #2's licensed home professional support (LHPS) review dated 12/13/23 revealed:
-The task including: clean dressing changes, excluding packing wounds, and application of prescribed enzymatic debriding agents was not checked.
-There was no documentation regarding Resident #2's second right toe or any wound care orders.
-The LHPS review was completed 6 days after Resident #2 ordered wound care.

Review of Resident #2's electronic Medication Administration Records for December 2023 revealed there was not an entry for wound care: remove dressing, wash right second toe with soap and water, pat dry, and apply triple antibiotic ointment and dry dressing to right second toe once daily for 10 days starting on 12/07/23.

Observation of Resident #2's second right toe on 02/08/24 at 11:26am revealed there were no open areas and no signs of infection.

Interview with Resident #2 on 02/07/24 at 3:37pm

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revealed:
-He remembered being seen by a podiatrist, around Christmas time 2023, and had his toe nails clipped.
-He did not remember any staff washing his second right toe, applying an antibiotic ointment, or applying a bandage after he was seen by the podiatrist in December 2023.
-He did not remember applying a bandage to his right second toe himself.

Telephone interview with the pharmacy on 02/08/24 revealed the pharmacy had not received any orders for Resident #2 for wound care.

Interview with a medication aide (MA) on 02/08/24 at 9:47am revealed:
-She had not seen any wound treatment orders or done any wound care for Resident #2.
-She only did what was on the eMAR and she had not seen wound care orders for Resident #2 on the eMAR.
-If she had done wound care for Resident #2, she would have documented it on the eMAR.

Interview with a second MA on 02/08/24 at 10:25am revealed:
-She was not aware of any wound care orders for Resident #2.
-She administered medications and treatments according to the eMAR and she had not seen any treatment orders for wound care on Resident #2's eMAR.
-The Resident Care Coordinator (RCC) was responsible for reviewing provider notes for changes and orders.

Interview with the Resident Care Coordinator on 02/08/24 at 10:41am revealed:
-She was responsible for reviewing provider's

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after visit progress notes.
-She did not remember whether she reviewed Resident #2's podiatrist's note dated 12/05/23 for wound care to start on 12/07/23.
-The facility's PCP and mental health provider (MHP) provided separate orders in addition to orders in their after visit progress notes, so she did not know the podiatrist would only list orders in her after visit progress note.
-Resident #2's podiatrist's after visit progress note dated 12/05/2 should have been sent to the pharmacy to be entered on the eMAR and so that they could send the triple antibiotic ointment.
-Resident #2 had multiple past wound care orders from the podiatrist.
-She knew staff completed wound care for Resident #2, but she did not know if the wound care was from previous orders or from the wound care order that was to start on 12/07/23.
-Resident #2's treatment orders for wound care should have been on his eMAR and documented on his eMAR when completed.
-No staff reported any issues with Resident #2's second right toe.

Telephone interview with Resident #2's podiatrist on 02/08/24 at 10:45am revealed:
-Resident #2 had severe deformity of his feet and hammered toes.
-Resident #2 had wounds on his feet a couple times a year and she ordered wound care for him.
-She saw Resident #2 on 12/05/23 and he had an ulcer on his right second toe.
-She ordered wound care: remove dressing, wash right second toe with soap and water, pat dry; apply triple antibiotic ointment and dry dressing to right second toe once daily for 10 days starting on 12/07/23.
-Staff was to contact her if there were any signs or symptoms of infection.

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{D 276}	Continued From page 9 -She expected staff to start the wound care to Resident #2's right second toe for 10 days as ordered. -Not providing wound care as ordered could have resulted in infection of his right second toe. Interview with Resident #2's PCP on 02/08/24 at 11:30am revealed she expected staff to follow Resident #2's wound care orders and to document application on the eMAR. Interview with the Administrator on 02/08/24 at 11:37am revealed: -She recalled Resident #2 having an order to cleanse his toe with soap and water and remembered it being done. -She expected staff to document wound care treatment on the eMAR or in the resident's progress notes. -She did not know staff had not documented wound care was provided as ordered for 10 days starting 12/07/2023. -The RCC was responsible for reviewing after visit progress notes from providers for orders. -Most providers who visited the facility handed a written order to the RCC and discussed the order with her. -Resident #2's podiatrist had never left a written order with the RCC. Attempted telephone interview with the licensed home professional support (LHPS) nurse on 02/08/24 at 9:47am was unsuccessful.	{D 276}		