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
	HAL008034	A. BUILDING: _____ B. WING _____	R 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow up survey and complaint investigation on 04/23/24 to 04/24/24.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth. In the statement of deficiencies; the plan of correction is prepared solely as a matter of compliance with State Law.	ddd
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 refer a resident to home health skilled nursing for catheter care per physicians order for 1 of 5 sampled residents (#2). The findings are: ~~Review of Resident #2's FL2 dated 04/10/24~~ revealed: -Diagnosis included dementia and traumatic brain injury. -Resident #2 was incontinent of bladder and had an indwelling catheter. -Resident #2 was semi-ambulatory. -He used a walker as an assistive device. -Resident #2's recommended level of care was special care unit. Review of Resident #2's Resident Register dated 03/22/24 revealed Resident #2 was admitted to the facility on 03/21/24. Review of Resident #2's home health (HH) nursing note dated 03/22/24 revealed: -The nurse went to the facility to conduct an intake assessment.	D 273	**Area Clinical Director in-serviced Care Manager and Executive Director on the importance Referral and Follow-up.** **Upon admission into the facility the Care Manager will review all discharge instructions and orders that are clarified by the current provider and ensure that accommodations are made and followed up on to ensure resident(s) have adequate care.** **Any recommendations or orders should be followed up on in a timely manner. Care manager and Executive Director will review orders and notes for the resident plan of care during daily stand-up. The Care Manager will initiate and follow-up with the prescribed recommendations and the Executive Director will follow-up with the Care Manager to ensure it has been completed.** **All attempts made to follow-up on an order should be documented in Matrix under the resident progress notes with the date, time and response that was given to follow up concerning the order and, reviewed during stand-up daily.** **If the facility is unable to follow-up on an order to meet the residents needs the Care Manager should contact the PCP for further recommendations to provide adequate care.**	05/09/24 05/09/24 05/09/24 05/09/24 05/09/24

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

LaVonna Wilkes, EO 06/03/24

Reviewed and Acknowledged,

Nola G. Dixon 06/05/24

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D 273	Continued From page 1 -Resident #2 would not allow the nurse to complete assessment and was agitated. -She was unable to admit Resident #2 to care because of safety concerns. Review of Resident #2's progress notes dated 03/23/24 at 12:40am revealed Resident #2's primary care provider (PCP) had been contacted and was informed he had removed his urinary catheter. Review of Resident #2's progress notes dated 03/23/24 at 3:31am revealed Resident #2 was sent to the local hospital emergency department (ED). Review of an emergency department discharge summary dated 03/23/24 revealed: -Resident #2 was diagnosed and treated for a urinary tract infection (UTI) associated with an indwelling urethral catheter. -There was an order for ciprofloxacin 500mg one tablet twice daily for 7 days used for urinary tract infection. -Resident #2 was to follow up with his primary care provider (PCP) one week after discharge. Review of Resident #2's PCP progress notes dated 03/26/24 at 11:27am revealed the facility staff reported Resident #2 had pulled out his urinary catheter. Review of Resident #2's physician order dated 04/03/24 revealed there was a referral to home health care for catheter care. Review of an ED summary dated 04/07/24 revealed: -Resident #2 was treated for a urinary catheter problem.	D 273		

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D 273	Continued From page 2 -Resident #2 was administered hydrocodone-acetaminophen and phenazopyridine. -Resident #2 was to follow up with his PCP on 04/08/24. Review of a urology care note dated 04/11/24 revealed: -Resident #2 had urinary retention and had several ED visits for foley trauma. -Resident #2 may have had neurogenic bladder. -The catheter was changed. -An order for urodynamic testing would be placed to assess the function of the bladder and urethra. Interview with a personal care aide (PCA) on 04/24/24 at 1:39pm revealed: -She provided personal care to Resident #2 a few times. -Resident #2 "constantly" pulled and tugged at his urinary catheter. -The resident pulled and tugged the urinary catheter tubing toward the right of his right thigh. -When the resident pulled and tugged at his urinary catheter tubing, he looked frustrated and agitated. -The resident often reported to staff that he needed to urinate. Interview with a second PCA on 04/24/24 at 1:42pm revealed: -The resident always pulled at his catheter tubing and the resident appeared to be irritated and agitated from the urinary catheter. -The resident appeared to be uncomfortable with the urinary catheter and often attempted to urinate standing at the toilet. -The PCA reminded the resident that he had a urinary catheter in and was not able to urinate when standing at the toilet.	D 273		

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D 273	Continued From page 3 -When the resident was agitated and appeared to have discomfort from his urinary catheter, he notified the medication aide (MA) on duty. Interview with a MA on 04/24/24 at 10:36am revealed: -When Resident #2 was admitted to the facility, staff were aware that the resident had a urinary catheter. -Resident #2 had a urinary catheter and the PCAs usually emptied the resident's catheter bag. -The resident pulled on his urinary catheter tube every day and would tell staff "Let me show you something." -The resident appeared to be uncomfortable with his urinary catheter because he was often observed pulling to his groin area and appeared frustrated and agitated with the urinary catheter. -She had reported the resident was uncomfortable with his urinary catheter and pulled on it often to the Special Care Coordinator (SCC) but could not remember what date she reported it to the SCC. -When Resident #2 was sent to the local ED on 04/12/24 the resident was not himself, he did not eat as much breakfast as he usually did and was not as talkative as usual. Telephone interview with a referring home health agency on 04/24/24 at 1:43pm revealed the agency had not received a referral for Resident #2. Telephone interview with a second referring home health agency on 04/24/24 at 1:51pm revealed the agency had not received a referral for Resident #2. Telephone interview with Resident #2's PCP on 04/24/24 at 1:20pm revealed:	D 273		

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D 273	Continued From page 4 -She visited with Resident #2 on 04/10/24 at the facility. -She had been on vacation and a colleague filled in for her until she returned on 04/10/24. -Resident #2 was seen by another PCP on 03/26/24 and was prescribed Ativan to help Resident #2 rest at night. -The PCP reported Resident #2 was restless at night and was walking around the facility knocking on other residents' doors. -She referred Resident #2 to a urologist and for home health services after learning there were issues with his health insurance on 04/10/24. -The urinary catheter as to be changed by a nurse at least once a month. -She had not been provided the 04/11/24 urology summary from the facility. Interview with the SCC on 04/24/24 at 9:51am revealed: -Resident #2 was admitted to the facility on 03/21/24 after a previous hospital stay. -Resident #2 was admitted to the hospital on 04/12/24 due to a UTI and septic shock. -Resident #2 was currently in the hospital. -Resident #2 had been referred to home health for catheter services per the hospital discharge. -A home health agency attempted to complete an assessment on 03/22/24 but due to Resident #2's resistance, the assessment could not be completed. -She did not contact the home health agency to reschedule the appointment. -She received another referral for home health services on 04/11/23. -She did not submit the referral to either of the facility's two preferred home health agencies because of issues with Resident #2's health insurance. -She referred Resident #2 to a skilled facility on	D 273		

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D 273	Continued From page 5 04/02/24. -Resident #2's catheter was to be checked once monthly by home health nurse. Second interview with the SCC on 04/24/24 at 3:44pm revealed: -She called the home health nurse on 03/22/24 and informed her of Resident #2 pulling the foley out prior to the scheduled assessment. -Resident #2 refused to allow the home health Nurse to put in the urinary catheter. -She was with the HH nurse during the assessment on 03/22/24 when Resident #2 removed the urinary catheter and the nurse tried to replace the urinary catheter. -After several attempts by the home health staff trying to place the urinary catheter, it was recommended Resident #2 be sent to the ER if he could not urinate. -She called the home health agency (did not give date) to get their email address to submit another referral but could not obtain the email address. -The home health agency did not accept referrals via fax. -She tried to refer Resident #2 to two other home health agencies but neither agency took Resident #2's health insurance. -She had not contacted Resident #2's PCP per the 03/23/24 and 04/07/24 discharge summaries. -She had not documented Resident #2's referrals to home health agencies. -Resident #2 refused to allow the HH nurse to assess him or replace his urinary catheter; the HH agency had to discharge the resident due to inability to assess the resident. -The HH nurse advised her that if Resident #2 did not urinate in a few hours that she would need to send the resident to the local ED. -The HH nurse informed her that she would need to obtain a new order for the resident's physician	D 273		

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D 273	Continued From page 6 to refer for HH services again with their agency since he was not able to start services on 03/22/24. -She instructed staff to notify Emergency Medical Services (EMS) so the resident could be transported to the local ED. Review of Resident #2's home health nursing note dated 03/22/24 revealed: -The nurse went to the facility to conduct an intake assessment. -Resident #2 would not allow the nurse to complete assessment and was agitated. -Resident #2 was not admitted to home health services because of safety concerns. Interview with the Administrator on 04/24/24 at 2:50pm revealed: -Resident #2 was admitted to the facility with a urinary catheter. -She thought Resident #2 had a history of depression. -She would have preferred for the resident to have home health services coordinated so that the resident could be assessed by home health on the date of his admission instead of the following day. -She was not sure if a referral was made to the home health agency before the resident was admitted. -The SCC informed her that the resident was pulling out his urinary catheter. -She thought the SCC had reported three times that the resident pulled out his urinary catheter. -Resident #2 was sent to the local ED when he pulled out his urinary catheter. -The SCC had also reported to her that the resident had behaviors such as pulling at his urinary catheter tubing and being anxious and agitated.	D 273		

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D 273	Continued From page 7 -She expected there to be communication between all facility staff and providers to provide good communication related to the resident's care. -The SCC or the MA were expected to report any concerns to the resident's PCP to ensure the resident's safety.	D 273		