STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	R 07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on July 25, 2024 to July 26, 2024.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 7 sampled residents (#4) with a history of repeated falls, who sustained an unwitnessed fall, and lay on the floor for an unknown period of time between the hours of 10:15pm and 7:00am the next morning. The findings are: Review of the facility's Fall Management Policy revealed: -The policy was revised on 01/2024. -Under Policy Overview, residents had the potential to fall and therefore the facility identified universal fall precautions applicable to residents. A fall risk evaluation was completed at the time of move in/admission or per state regulations. A witnessed or reported unwitnessed fall, with or without injury, was reported in the facility's	D 270		

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D 270	Continued From page 1 incident reporting system. Residents who sustained a fall had a post fall evaluation completed to consider possible interventions to reduce the risk for future falls and injury. -The definition of a fall referred to unintentionally coming to rest on the ground, floor, or other lower level either witnessed or unwitnessed, with or without injury. -Policy Detail outlined, the Administrator was responsible for verifying that associates had completed the facility's fall management training course during orientation and should have reviewed annually thereafter. -A fall risk evaluation was completed at the time of move-in or per state regulation for assisted living. -Resident falls were noted in the resident record and entered in the facility's incident reporting system. -A post fall evaluation was completed after a resident fall, individualized interventions were considered, and the evaluation was a part of the resident's record. -When a fall occurred in assisted living (AL), the resident was assisted and first aid was provided or emergency services was called as indicated and the directions of the emergency services operator were followed. -The Health and Wellness Director (HWD)/nurse/designee and Administrator were notified. -The resident's primary care provider (PCP) was notified for evaluation, care, and treatment if indicated and documented in the resident's record. -The resident's family/responsible party was notified and documented in the resident record. -The resident fall/injuries, resident response, and interventions taken in the progress notes (Alert charting notes) were documented.	D 270		

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D 270	Continued From page 2	D 270		

-The service plan was reviewed for potential fall interventions and updated as necessary.
-The fall was reviewed at the next stand-up meeting.
-The resident falls were discussed at the next collaborative care review meeting.

Review of the Supervision and Monitoring of Residents Policy revealed:
-The policy was revised 01/19/21.
-Under Policy Overview, the supervision and monitoring of residents would be done by associates as indicated based on the resident's needs and service plan. Associates would be available in sufficient numbers with adequate training to provide for the well-being of residents while honoring resident rights and preferences.
-Policy Detail outlined, residents would be evaluated prior to move in and a temporary care plan would be implemented upon admission/move-in. A comprehensive service plan would be completed within 14 days after admission/move-in.
-Residents would be monitored by providing daily observation and maintaining a general awareness of the resident's whereabouts while in the community.
-The following events permit periodic observation and monitoring of resident's activities of daily living by the: attendance at meals, administration of medications specific to each resident, attendance at community programs and activities and associate conducting night checks every 4 to 6 hours, as needed.
-If there were significant changes in a resident's physical, emotional or mental functioning, that required changes in supervision and monitoring, the service plan would be updated to reflect these changes.
-Associates were trained on supervision and

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	HAL096026	A. BUILDING: _____ B. WING _____	R 07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

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D 270	Continued From page 3	D 270		

monitoring during Foundations Training and Orientation. Orientation and training should have been completed within one month of date of hire.

Review of the facility's Night Check Policy revealed:
-The policy was revised 11/2018.
-Under Policy Overview, resident care staff made night checks of the residents. A resident or his/her legally responsible party may have chosen not to have the associates perform night checks. The choice not to receive night checks would have been documented in a Negotiated Risk Agreement, where permitted by state regulation, and on the resident's Service Plan.
-Policy Detail outlined, associates performed night checks approximately every four to six hours or as determined by the resident's need.
-When performing a night check associates opened the door to the resident's apartment quietly and observed the resident from a reasonable distance. Assistance was provided as necessary.
-For residents who had signed a Negotiated Risk Agreement choosing that night checks not be performed, associates stopped outside the door to the apartment and listened briefly outside the closed door for any unusual sound. If any unusual sounds, the apartment was entered, and the resident checked. Associates documented in the resident log of electronic progress notes the reason the room was entered and the outcome.

Review of Resident #4's current FL-2 dated 02/26/24 revealed:
-Diagnoses included repeated falls, insomnia, benign positional vertigo, osteoarthritis, anemia, hypertension, chronic kidney disease, chronic obstructive pulmonary disease, and generalized pain.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

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D 270	Continued From page 4 -The resident was documented as ambulatory. Review of Resident #4's Resident Register revealed she was admitted on 02/19/24. Review of Resident #4's care plan signed by the Health and Wellness Director (HWD) and dated 07/15/24 revealed: -The resident was oriented to person, place and time. -The resident used a walker as a mobility aid. -The resident was independent going to and from the dining room or community activities. -The resident used a shower chair. -The resident was able to put on/take off socks/hose and shoes with staff attention and/or verbal prompts as needed. -The resident did not require bathroom assistance. -The resident could communicate needs and preferences. -The resident was receiving physical therapy from the facility's contracted home health agency. Review of Resident #4's electronic incident/accident (I/A) report dated 07/23/24 revealed: -The incident time was 7:05am. -The location of the incident was Resident #4's room/apartment bathroom. -The nature of the incident was an unwitnessed fall. -The type of injury was a fracture. -Body parts injured were left hip and left shoulder. -Emergency medical services (EMS) were contacted, and Resident #4 was checked for injury. -The Resident Care Coordinator (RCC), Resident #4's responsible party (RP) and Resident #4's PCP were notified on 07/23/24.	D 270		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 5 -The I/A report was acknowledged and approved by the HWD on 07/24/24 at 3:01pm. Review of Resident #4's electronic progress notes entered 07/23/24 revealed: -The progress note type was "alert charting note/ post-fall initial". -Witness/Encounter narrative: Resident fall occurred on 07/23/24 at 7:00am, in her bathroom, near the toilet. -The first person on the scene following the fall was a personal care aide (PCA). -The fall details were documented by the HWD. -Resident narrative: Resident #4 said "change into my pajamas arm and hip hurt". -Resident #4 reported she was in pain. -There were no physical signs of head injury. -Resident #4's refused vital signs. -Resident #4 was not able to move all extremities compared to normal pre-fall baseline. -Resident #4's healthcare provider was contacted about her fall, and she was sent to the hospital by EMS. -Resident #4's RP was notified of her fall. Review of Resident #4's emergency department (ED) provider note dated 07/23/24 revealed: -Resident #4 said she went to use the bathroom around 8:30pm last night (07/22/24) and fell. -Resident #4's RP was present and advised he was with the resident last night (07/22/24). -Resident #4's RP advised the resident seemed to be at her neurological baseline. -Resident #4 complained of left shoulder and left hip pain. -The computed tomography (CT scan) showed there was a severe left femur fracture with surrounding swelling and bleeding. -The x-ray of the left humerus showed an acute left humerus (long bone in the upper arm)	D 270		

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BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

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D 270	Continued From page 6	D 270		

fracture.
-Final diagnoses were closed left hip fracture, closed fracture of left humerus and sepsis due to unspecified organism.
-Resident #4 was admitted to the hospital.

Review of Resident #4's ED supervising physician attestation note dated 07/23/24 revealed the resident arrived hypothermic to 34.5 C (94.1 F).

Review of Resident #4's hospital course history and physical revealed:
-The resident said she was trying to walk to the bathroom overnight when she tripped and fell onto her left side.
-The resident said she was down on her bathroom floor for no more than 30 minutes before help arrived.
-Resident #4's lactic acid was elevated to 7.5 and improved to 6.4 after sepsis bolus in the ED (high levels of lactic acid can indicate sepsis, a potentially life threatening condition related to the body's response for infection).
-Orthopedic surgery was consulted and planned for operative management of the left femur fracture complicated by hemorrhage.
-Orthopedic surgery was consulted and planned for non-operative management of left humerus fracture.

Review of the Initial Allegation Report signed by the Administrator on 07/23/24 revealed:
-Allegation/Incident Type was resident neglect.
-The incident occurred on 07/22/24.
-The facility became aware of the incident on 07/22/24 at 10:15am.
-Resident #4 was found on the floor of her bathroom at 7:00am on 07/22/24.
-Resident #4 reported to staff that she had fallen

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D 270	Continued From page 7	D 270		

earlier that night and had been on the bathroom floor all night.
-Resident #4 was triaged and was complaining of pain in her left shoulder and left hip.
-EMS was called and Resident #4 was transported to the hospital for evaluation.
-Hospital confirmed left shoulder and left hip fracture.

Review of an interview questionnaire dated 07/23/24 revealed:
-The medication aide (MA) was interviewed at 3:50pm.
-The MA worked both B-side and C-side (Resident #4's side).
-The MA checked on residents when she gave medications.
-The MA did not round on every resident.
-The MA rounded with another MA when the shift ended.

Review of an interview questionnaire dated 07/23/24 revealed:
-The PCA was interviewed at 4:20pm.
-The PCA was assigned to C-side (Resident #4's side).
-The PCA rounded at 6:00am.
-The PCA skipped Resident #4's room.
-The PCA did not round on every resident.
-The PCA did not round with a co-worker at the end/start of the shift.

Interview with a PCA on 07/26/24 at 1:30pm revealed:
-She worked 1st shift on 07/23/24.
-She saw Resident #4 four to five days a week.
-She checked on all residents but paid special attention to Resident #4 because she felt she was high risk due to her age.
-She found Resident #4 just before 7:00am on

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

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D 270	Continued From page 8 07/23/24. -She went to wake Resident #4 up for breakfast and her TV was on, but she was not in bed. -Resident #4's phone and glasses were on her walker and her walker was by the recliner. -She heard Resident #4 say "help I'm here". -Resident #4's head was by the toilet and her hands were resting up by her head. -Resident #4's pants were twisted around her feet. -Resident #4 was wearing a chunky heel shoe that she had never seen her wear before. -Resident #4 said she tripped and fell while going to the bathroom. -She asked Resident #4 if she was hurt, and she said yes. -Resident #4 said her hip and arm hurt "really bad." -She called the code used to let staff know something was wrong and to come now on the walkie talkie. -She called the MA and the MA and RCC both came quickly. -She never saw Resident #4 without her walker. -Resident #4 used her walker for everything and walked very slowly. -Resident #4 did not have her button (alert necklace) on. -Resident #4's alert necklace was hanging on her headboard. -She told Resident #4 many times that she had to wear the alert necklace, but she did not wear it. -Rounds were usually done every 2 hours but she checked on the residents she felt were high risk every 1 and a half hour. -Resident #4 was not on increased supervision at the time of the fall. -There was no change in Resident #4's baseline prior to the fall.	D 270		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 9 Interview with a MA on 07/26/24 at 12:50pm revealed: -Resident #4 fell on 07/23/24 prior to her shift. -Resident #4 was ambulatory and required limited assistance. -Resident #4 got ready on her own and ambulated to the dining room for meals. -There were no changes in Resident #4's baseline prior to her fall. Telephone interview with Resident #4's RP on 07/26/24 at 3:40pm and 4:28pm revealed: -He was with Resident #4 Monday night (07/22/24) and left a little after 9:00pm. -The 2nd shift MA brought Resident #4 her 9:00pm medication after he left because Resident #4 did not want to take the medication while he was there. -Resident #4 put her pajamas on and went to the bathroom and fell. -No one checked on Resident #4 from 11:00pm to 7:00am. -The 7:00am staff found Resident #4 and called him no more than 10 minutes later. -When he arrived at the facility, EMS was bringing Resident #4 up the hall. -The HWD told him 3rd shift staff did not check on Resident #4. -The HWD told him the 11:00pm round on Resident #4 was not noted. -The HWD and the Administrator interviewed staff about checking on Resident #4. -Prior to the fall, Resident #4 was becoming more independent, walking around with the walker and going out onto the porch. -Resident #4 did not have her alert necklace on when she fell. -He knew staff normally checked on Resident #4 because she told him staff came in with a flashlight in the middle of the night to check on	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

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D 270	Continued From page 10	D 270		

her.
-Resident #4 had hip surgery on Wednesday (07/24/24).
-Resident #4's left shoulder was put in a sling to heal.
-Resident #4 had not been mobile since the surgery.
-Resident #4 would go to a rehabilitation facility for physical therapy after she was discharged from the hospital.
-Resident #4 would return to the facility after her discharge from the rehabilitation facility.
-Resident #4 had been disoriented since the incident and could not tell him what happened.

Interview with the HWD on 07/26/24 at 5:02pm and 7:12pm revealed:
-She was notified on 07/23/24 around 7:30am by the RCC that Resident #4 fell.
-The 1st shift PCA found Resident #4 in the bathroom on the floor.
-Resident #4 made a statement to the RCC that she had been on the floor since 8:30pm the night before (07/22/24).
-Resident #4's RP did not leave until 9pm so Resident #4 could not have been on the floor since 8:30pm the night before (07/22/24).
-She and the Administrator interviewed all 2nd and 3rd shift staff that day.
-The 2nd shift MA stated she saw Resident #4's RP leave.
-The 2nd shift MA gave Resident #4 her medication after the RP left.
-The 2nd shift PCA made rounds to pull trash around 10:00pm or 10:15pm and saw Resident #4 in her recliner in her day clothes watching TV.
-The 3rd shift PCA that was assigned to C-side (Resident #4's side) said he did not round on all his residents and had no reason why he did not round.

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BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

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D 270	Continued From page 11 -The 3rd shift PCA that was assigned to C-side (Resident #4's side) said he did not round on Resident #4. -The 3rd shift MA said she did not have to give medication to Resident #4, so she did not see her. -The 3rd shift MA was unsure if the 3rd shift PCA for C-side completed his rounds. -The 3rd shift MA was responsible for completing rounds and ensuring that the PCAs completed their rounds. -Resident #4 was found with her pajamas on. -She could not say how long Resident #4 was on the floor because rounds were not done. -Hospital notes stated Resident #4 said she got up in the middle of the night to use the bathroom and was on the floor for less than 30 minutes. -There had been no changes in Resident #4's baseline prior to the fall. -The Initial Allegation Report had been submitted. -The District Director of Clinical Services (DDCS) had not conducted an in service. -The DDCS talked to the management team (the HWD, Health and Wellness Coordinator (HWC) and RCC) about what in-service was needed and those were implemented. -She did an in service on rounding and the early signs of fall risks. -All 3rd shift staff were a part of the mandatory in service training. -There was no supervision policy. -There was a Night Check Policy that stated rounds were to be done every 4 to 6 hours, unless the resident had a Negotiated Risk Agreement. -Resident #4 did not have a Negotiated Risk Agreement. -She expected rounds to be done every 2 to 4 hours. -She and the Administrator conducted random	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE COUNTRY DAY ROAD	380 COUNTRY DAY ROAD GOLDSBORO, NC 27530

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D 270	Continued From page 12 3rd shift checks. -There was no set schedule for the rotation of management conducting the random 3rd shift checks. -There was no log or documentation of when the random 3rd shift checks were conducted and who/what was checked. -The HWD was on call 24 hours a day, 7 days a week. -The HWCs were on call on a rotating schedule, for 24 hours a day, 7 days a week Monday to Sunday. Interview with the RCC on 07/26/24 at 6:45pm revealed: -She came in at 6:45am. -She had been at work for about 15 minutes when the PCA called Autumn Leaves on the walkie talkie for Resident #4 and called the MA. -The PCA said "I think you have to call EMS." -Resident #4 was on the floor in the bathroom in the fetal position with her shoes and pajama top on and her pajama bottoms were around the bottom of her legs. -Resident #4 said her hip and arm were hurting. -Resident #4 said she had been on the floor all night. -A pillow was placed under Resident #4's head. -EMS and Resident #4's RP were called. -Resident #4 did not have her alert necklace on and did not use her walker to get to the bathroom. -She saw Resident #4 daily. -Resident #4 would go to breakfast with her walker, unassisted and would sit in the lobby. -There was no change in Resident #4's baseline prior to her fall. -Rounding was not documented anywhere. -The supervisor, who was the MA, was responsible for rounding at shift change (MAs report to each other on each resident), when she	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	R 07/26/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13	D 270		

came in and when she got off.
-No one checked behind the supervisor.
-The HWD was responsible for making sure anything put in place was done.
-She was unsure if the HWD did any in-service with the MAs.
-Stand-up meetings were held at 9:30am and 3:15pm.
-The Administrator was present for the stand-up meetings.
-The HWD was constantly telling the PCAs and MAs, in stand-up meetings, to make sure they were rounding and saw all residents.
-She came in on the 3rd shift, sometimes, to help if a MA was sick.
-She watched staff to ensure rounds were done when she came in on 3rd shift.
-The PCAs and MAs were supposed to round on the residents and make sure they were taken care of.

Interview with the Administrator on 07/26/24 at 7:54pm revealed every resident should have been rounded on for the on coming and off going shift.

Attempted telephone interview with the MA that was on duty on 07/22/23 for 3rd shift on 07/26/24 at 4:56pm was unsuccessful.

Attempted telephone interview with the PCA that was on duty on 07/22/23 for 3rd shift on 07/26/24 at 4:56pm was unsuccessful.

Attempted telephone interview with another PCA that was on duty on 07/22/23 for 3rd shift on 07/26/24 at 4:56pm was unsuccessful.

_____

The facility failed to provide supervision for 1 of 7 sampled residents (#4) who had diagnoses of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096026	A. BUILDING: _____ B. WING _____	R 07/26/2024

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D 270	Continued From page 14 repeated falls, insomnia and benign positional vertigo. The resident was found on the floor in the bathroom after a fall without being checked on between the hours of 10:15pm and 7:00am. The resident was admitted to the emergency department with a temperature of 94.1, hospitalized with a fractured left femur that required surgery and a fractured left humerus; and required in-patient rehabilitation after discharge from the hospital. This failure resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 07/26/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED August 25, 2024.	D 270		
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 record reviews and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 7 sampled residents (#2) with orders for dressing changes.	D 276		

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D 276	Continued From page 15 The findings are: Review of Resident #2's current FL-2 dated 06/27/24 revealed diagnoses included chronic pain, hypertension and Type II diabetes. Review of Resident #2's primary care provider (PCP) triage note dated 06/06/24 revealed: -Resident #2 hit his toe and had an abrasion. -There was an order to cleanse the toe with normal saline, pat dry, apply antibiotic ointment and a non-stick bandage and to change daily and as needed. Review of Resident #2's PCP triage note dated 06/20/24 revealed there was an order for home health to evaluate and treat ulcerations. Review of Resident #2's PCP triage note dated 06/24/24 revealed: -There was an order to apply betadine to third right toe daily and secure with tape and to change daily. -There was an order to apply betadine to other areas of the feet and toes daily and leave open to air. Review of Resident #2's PCP triage note dated 07/17/24 revealed there was an order to discontinue wound care orders for facility to complete as he was being seen by outpatient wound clinic and home health. Review of Resident #2's electronic medication administration record (eMAR) for June 2024 revealed: -There was a computerized entry to cleanse toe with normal saline, pat dry, apply antibiotic ointment and a nonstick bandage and to change daily and as needed.	D 276		

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D 276	Continued From page 16	D 276		

-There was documentation the dressing was completed each day at 8:00am on 06/12/24 through 06/30/24.
-There was no entry to apply betadine to third right toe daily and secure with tape and to change daily.
-There was no entry to apply betadine to other areas of the feet and toes daily and leave open to air.

Review of Resident #2's electronic eMAR for July 2024 revealed:
-There was a computerized entry to cleanse toe with normal saline, pat dry, apply antibiotic ointment and a nonstick bandage and to change daily and as needed.
-There was documentation the dressing was completed each day at 8:00am on 07/01/24 through 07/17/24.
-There was no entry to apply betadine to third right toe daily and secure with tape and to change daily.
-There was no entry to apply betadine to other areas of the feet and toes daily and leave open to air.

Interview with a medication aide (MA) on 07/26/24 at 3:54pm revealed:
-She last completed a dressing change for Resident #2's toes approximately 3 weeks before.
-She cleansed the area with normal saline, applied antibiotic ointment and wrapped it in gauze.

Telephone interview with Resident #2's PCP on 07/26/24 at 2:12pm revealed:
-Resident #2 had venous stasis ulcers on his feet.
-She ordered a home health evaluation of Resident #2's wounds on 06/20/24.
-She received a call from the home health nurse

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D 276	Continued From page 17	D 276		

on 06/24/24 who recommended to paint the areas with betadine so she wrote the order on 06/24/24.
-The facility staff should have implemented the order until home health evaluated and wrote their plan of care.
-The order for wound care that included betadine superceded the order written that included the antibiotic ointment.

Telephone interview with the clinical manager for Resident #2's home health nurse on 07/26/24 at 2:42pm revealed:
-Home health completed Resident #2's intake on 06/22/24 and the plan of care included the orders for betadine to third right toe daily and secure with tape and to change daily and to apply betadine to other areas of the feet and toes daily and leave open to air.
-The orders for betadine to treat the wound did not require a skilled nurse to complete.
-There was documentation the facility staff were educated on the orders for dressing changes.
-The facility staff should have been completing the betadine dressing changes as ordered.

Interview with the Health and Wellness Coordinator (HWC) on 07/26/24 at 6:35pm revealed:
-She and other nurses were responsible for entering new orders into the eMAR.
-She remembered seeing the order for betadine wound care from Resident #2's PCP dated 06/24/24 but home health was already seeing Resident #2 so the order was not sent to pharmacy or entered onto the eMAR as should have been.
-She had not seen the plan of care from home health for Resident #2 because there had been communication issues with home health.
-There had been no education completed by

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D 276	Continued From page 18 home health regarding dressing changes for Resident #2. Interview with the Health and Wellness Director (HWD) on 07/26/24 at 5:02pm revealed: -The HWC was responsible for entering the new orders into the eMAR. -The HWC was also responsible for reviewing the plan of care for residents receiving home health services but the facility had not been receiving visit notes from the contracted home health agency. -She would be the one the home health nurse would have educated regarding the dressing and that had not been done. -She was not sure how the PCP order for betadine dressing changes was missed. -She found the betadine order from the PCP on 07/17/24 and contacted the PCP to have would care discontinued since Resident #2 was being seen by home health. -She thought the home health nurse was the only one that was suppose to be completing the dressing changes for Resident #2. -Resident #2 could have increased risk of infection if he was not receiving the wound care as ordered.	D 276		