

PRINTED: 07/30/2024
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL003005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/17/2024
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF CHESTNUT GROVE**158 CHESTNUT GROVE CHURCH ROAD
SPARTA, NC 28675**

(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 and the Alleghany County Department of Social Services conducted an annual survey and complaint investigation from 07/16/24 to 07/17/24.	D 000	Responses to the cited deficiencies do not constitute an admission by the facility of the truth or facts alleged or conclusions set forth in the statement of deficiencies corrective action report. The plan of correction is prepared solely as a matter of compliance of state law.	
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's	D 255		

Division of Health Service Regulation

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

TITLE

(X6) DATE

*Angela Wheeler**Administrator**8-20-2024*

STATE FORM

6809

4HZJ11

If continuation sheet 1 of 10

Reviewed and Acknowledged by MH on 08/22/2024

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D 255	Continued From page 1 disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident. This Rule is not met as evidenced by: Based on observations, interviews and records reviews the facility failed to ensure an assessment was completed within 10 days following a significant change in the resident's condition for 1 of 5 sampled residents (Resident #4) who received a new order for an indwelling catheter and required assistance. The findings are: Review of Resident #4's current FL-2 dated 04/03/24 revealed: -Diagnoses included urinary incontinence, diabetes and mild cognitive impairment. -Resident #4 was intermittently disoriented. Review of the Resident Register for Resident #3 revealed the resident was admitted to the facility on 10/10/23. Review of Resident #4's signed physician order dated 05/29/24 revealed an order for home health skilled nursing to evaluate and treat for a foley catheter.	D 255		

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D 255	Continued From page 2 Review of a Primary Care Physician (PCP) visit note for Resident #4 dated 05/29/24 revealed a late entry on 06/03/24 which read in part: -Patient went to the emergency department and was diagnosed with hematuria and a urinary tract infection. -Patient currently has a foley catheter in place. -Staff at the facility have been instructed to monitor the patient's catheter and urine bag for any changes in color or consistency. -A home health nurse had been ordered to evaluate and treat the patient's catheter care and monitor for any changes. Observation of Resident #4 on 07/16/24 at 9:40am revealed he had an indwelling catheter. Review of Resident #4's previous care plan dated 10/16/23 revealed: -The field marked bladder was documented as normal. -Resident #4 did not have a catheter. Review of Resident #3's current care plan dated 07/17/24 revealed: -Resident #4 needed limited assistance with bathing, toileting and grooming/personal hygiene. -Resident #4 had a foley catheter. -He was unable to provide self-care of catheter. -He required licensed health professional support (LHPS) task of positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter. Interview with the Resident Care Coordinator (RCC) on 07/17/24 at 12:25pm revealed: -She realized when looking for Resident #4's care plan today 07/17/24, that she had missed updating the resident assessment and care plan for a significant change.	D 255		

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D 255	Continued From page 3 -She would do the significant change assessment and care plan in conjunction with the LHPS tasks. A second interview with the RCC on 07/19/24 at 5:01pm revealed: -She was responsible for completing resident care plans. -She was aware when a resident had a significant change, the care plan/assessment should have been updated when the resident returned from the hospital on 05/28/24. Interview with the facilities contracted Primary Care Physician (PCP) on 07/17/24 at 12:45pm revealed Resident #4 presented to the emergency department in May with urinary retention, hematuria and confusion. Interview with the Administrator on 07/17/24 at 5:15pm revealed: -The RCC was responsible for completing resident care plans. -She was unsure how this significant change got missed for Resident #4. -It was her expectation that care plans are prioritized and done correctly and significant change assessments were completed.	D 255	10A NCAC 13F .0801 (C) (1) Resident Assessment The Executive Director will review care plans completed by the RCC for the next 30 days to ensure accuracy and more specifically for any significant changes. Both the Executive Director and RCC will continue to audit care plans quarterly as part of Quality Assurance for acuity and validity. The Executive Director and/or Resident Care Coordinator will conduct daily staff meetings with all departments to identify any notable changes in condition for all residents. Any notable changes in condition will be reported to the Primary Care Provider to follow up on continuity of care, in addition to, follow up on any care plan updates. 7/19/2024 and ongoing. The Clinical Nurse Consultant will provide an in-service related to Resident Care Plan Assessment and Changes in Condition to the Resident Care Coordinator to ensure proper protocols are being followed and observed pursuant to regulatory guidelines.	
D 262	10A NCAC 13F .0802 (d) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (d) The assessor shall sign the care plan upon its completion. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the care plan was signed by the assessor upon completion (#1, #2, and	D 262	Inservice to be conducted by 9-1-2024	

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STATE FORM

6899

4HZJ11

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D 262	Continued From page 4 #3). The findings are: 1. Review of Resident #1's current FL2 dated 04/03/24 revealed: -Diagnoses included anxiety disorder, chronic pain syndrome, muscle weakness, end stage renal disease, renal dialysis, depression, and chronic obstructive pulmonary disease (COPD). -Resident #1 was admitted to the facility on 06/28/22. Review of Resident #1's Care Plan dated 03/28/24 revealed: -Resident #1 was independent with ambulation, transfers, and toileting. -Resident #1 required supervision with bathing, dressing, and grooming. -The care plan was not signed by the assessor. Refer to the interview with the Resident Care Coordinator (RCC) on 07/17/24 at 4:58pm. Refer to the interview with the Administrator on 07/17/24 at 5:15pm. 2. Review of Resident #2's current FL2 dated 04/10/24 revealed: -Diagnoses included hypertension and history of pulmonary embolism (a blood clot in the lung). -Resident #2 was admitted to the facility on 09/29/23. -Resident #2 was intermittently disoriented. Review of Resident #2's Care Plan dated 04/02/24 revealed: -Resident #2 was independent with ambulation, transfers, dressing and grooming. -Resident #2 required supervision with toileting	D 262		

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D 262	Continued From page 5 and bathing. -The care plan was not signed by the assessor. Refer to the interview with the Resident Care Coordinator (RCC) on 07/17/24 at 4:58pm. Refer to the interview with the Administrator on 07/17/24 at 5:15pm. 3. Review of Resident #3's current FL2 dated 04/10/24 revealed: -Diagnoses included diabetes mellitus type 2, hypertension, and chronic kidney disease. -Resident #3 was admitted to the facility on 06/30/22. Review of Resident #3's Care Plan dated 04/02/24 revealed: -Resident #3 was independent with ambulation, transfers, toileting, dressing and grooming. -Resident #3 required supervision with bathing. -The care plan was not signed by the assessor. Refer to the interview with the Resident Care Coordinator (RCC) on 07/17/24 at 4:58pm. Refer to the interview with the Administrator on 07/17/24 at 5:15pm. Interview with the Resident Care Coordinator (RCC) on 07/17/24 at 4:58pm revealed: -She was responsible for completing resident care plans. -She was trained by the corporate Registered Nurse (RN) to complete the care plan assessment and have the resident's Primary Care Provider (PCP) sign it. -She thought she may have been instructed by the corporate RN to sign the care plan, but she was not certain.	D 262		

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D 262	Continued From page 6 Interview with the Administrator on 07/17/24 at 5:15pm revealed: -The RCC was responsible for completing and signing resident care plans and ensuring they were signed by the resident's PCP. -She audited approximately five randomly selected resident care plans every three months for accuracy and completeness, including signatures. -She was aware the person completing the care plan was to sign it.	D 262	10A NCAC 13F .0802 Resident Care Plan The Executive Director will review care plans completed by the RCC for the next 30 days to ensure care plans are signed by the RCC and PCP. Both the Executive Director and RCC will continue to audit care plans quarterly as part of Quality Assurance for acuity and validity. 7/19/2024 and ongoing.	
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs	D 280		

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D 280	Continued From page 7 (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed within 30 days for 1 of 5 sampled residents (Resident #4) with LHPS tasks related to a urinary catheter care (Resident #4). The findings are: Review of Resident #4's current FL-2 dated 04/03/24 revealed: -Diagnoses included urinary incontinence, diabetes and mild cognitive impairment. -Resident #4 was intermittently disoriented. Review of the Resident Register for Resident #4 revealed the resident was admitted to the facility on 10/10/23. Observation of Resident #4 on 07/16/24 at 9:40am revealed he had an indwelling catheter. Review of Resident #4's current care plan dated 07/17/24 revealed: -Resident #4 required limited assistance with bathing, toileting and grooming/personal hygiene. -Resident #4 had a foley catheter. -He was unable to provide self-care of catheter. -He required LHPS task of positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter. Review of Resident #4's LHPS assessments revealed: -The most current LHPS assessment was signed by the LHPS Nurse on 07/17/24. -Positioning and emptying of the urinary catheter	D 280		

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D 280	Continued From page 8 bag and cleaning around the urinary catheter was identified as a task for Resident #4. -The previous LHPS assessment was signed by the LHPS Nurse on 04/24/24. Review of a primary care provider (PCP) visit note for Resident #4 dated 05/29/24 revealed a late entry on 06/03/24 which read in part: -Patient went to the emergency department and was diagnosed with hematuria and a urinary tract infection. -Patient currently has a foley catheter in place. -Staff at the facility have been instructed to monitor the patient's catheter and urine bag for any changes in color or consistency. -A home health nurse had been ordered to evaluate and treat the patient's catheter care and monitor for any changes. Review of Resident #4's signed PCP order dated 05/29/24 revealed an order for home health skilled nursing to evaluate and treat for a foley catheter. Interview with the residential care coordinator (RCC) on 07/17/24 at 9:25am and 12:25pm revealed: -She kept a binder for the LHPS Nurse to review for newly assigned tasks. -The LHPS Nurse was responsible for ensuring the LHPS assessments are complete. -The LHPS Nurse was behind in signing the assessments. -She could not recall the last time the LHPS Nurse was at the facility. -She thought the LHPS Nurse would be at the facility on 07/18/24. -The LHPS Nurse used to come weekly but had several facilities she worked at which had decreased her time at the facility.	D 280		

Division of Health Service Regulation

STATE FORM

6509

4HZJ11

If continuation sheet 9 of 10

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D 280	Continued From page 9 A review of the LHPS Nurse binder on 07/17/24 revealed: -A blank copy of the LHPS assessment tool. -There was no documentation related to Resident #4's catheter. A second interview with the RCC on 07/19/24 at 5:01pm revealed: -The facility had not had a consistent LHPS Nurse for several months. -The LHPS Nurse was responsible for ensuring the assessments were completed when they were due. -She had notified the LHPS Nurse some of the assessments were due but could not recall the exact date. -Resident #4's LHPS evaluation should have been completed after he had the indwelling catheter. Interview with the Administrator on 07/17/24 at 5:15pm revealed: -The LHPS Nurse was responsible to complete the LHPS evaluation when the evaluations are due. -The RCC was responsible to inform the LHPS Nurse when new tasks are needed. -It was her expectation for the LHPS Nurse to provide the nursing services the facility needs. Attempted telephone call with the LHPS Nurse on 07/17/24 at 5:33pm was unsuccessful.	D 280	10A NCAC13F .0903(c) Licensed Health Professional Support Care Manager will review all resident charts for last LHPS assessment. Care Manager will make a list of any resident with past due LHPS assessments. Care Manager will notify the Clinical Nurse Consultant for any new resident or changes to LHPS tasks within one week, using Care Manager's list for Clinical Nurse Consultant form. Clinical Nurse Consultant will check the Clinical Nurse Consultant form each week and complete the LHPS assessment timely. 7/19/2024 and ongoing.	