

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092131	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/06/2024
NAME OF PROVIDER OR SUPPLIER PHOENIX ASSISTED CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WEST HIGH STREET CARY, NC 27513		
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D 000	Initial Comments The Adult Care Licensure Section and Wake County Department of Social Services conducted an annual, follow-up and complaint investigation on September 5 and 6, 2024.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide a safe and clean environment related to the presence of live and dead cockroaches and cockroach excrement throughout the facility. The findings are: Review of the United States Environmental Protection Agency's (EPA) cockroach information sheet dated 11/14/23 revealed: -Cockroaches and their droppings, saliva, eggs, and outer coverings can cause allergic reactions to humans, particularly those with a history of asthma or other respiratory conditions. -Cockroaches carry bacteria on their bodies, which could cause salmonella, staphylococcus, or streptococcus if cockroaches come in contact with food.	D 079	QI Director contacted Pest Control company immediately to request inspection of the facility and recommendations of how to eliminate any vermin. All recommendations of the pest control professional will be implemented by the facility upon receipt. Director/Designee inspected rooms for signs of pests. Rooms identified with activity were deep cleaned to eliminate clutter to prevent further issues. Housekeeping staff will inspect rooms daily for signs of pest and report to Director. Director will immediately report to QI director and pest control company. Director will complete walk throughs (including interviewing residents) at least 3 times per week to ensure staff are following through with procedures for vermin and any other pests are eradicated.	10/21/2024

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

Constantina Dutch

TITLE

Executive Director

(X6) DATE

10/15/24

STATE FORM

6899

BXEO11

If continuation sheet 1 of 69

Jamaal Willis

Reviewed and Acknowledged 10/17/24

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D 079	Continued From page 1 Observation of the facility from 09/04/24 to 09/05/24 revealed there were 51 residents residing on the assisted living (AL) halls and 20 residents residing on the Special Care Unit (SCU). Review of the facility's food establishment inspection report dated 07/05/24 revealed: -The facility's inspection score was 93. -There was an observation of active bugs on the wall in the dishwashing area. -There was an observation of dead bugs in the food preparation sink. Review of the facility's 2024 pest control records revealed: -The facility received pest control service on 01/27/24, 02/24/24, 04/25/24, 05/24/24, 06/24/24, 07/25/24, and 08/25/24. -The type of service marked for each visit was regular commercial monthly service. -The comment section for each visit indicated the kitchen and dining areas were treated, along with a list of resident rooms treated for general pests. -The comment section for each visit indicated there was no activity reported. Observation of resident room 37 on 09/04/24 at 9:20am revealed: -There were 2 dead cockroaches on the floor under the heating and air conditioning unit. -There was dried cockroach excrement on the floor under the heating and air conditioning unit. -There was 1 cockroach crawling under the closet door. -There were 2 dead cockroaches on the floor in the bathroom. Observation of resident room 38 on 09/04/24 at	D 079		

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D 079	Continued From page 2 9:32am revealed: -There was 1 cockroach crawling on the heating and air conditioning unit. -There were 2 cockroaches crawling on the dresser. -There were 2 cockroaches crawling on the bathroom wall. -There was 1 cockroach crawling out of the electrical outlet in the bathroom. -There was dried roach excrement on the electrical outlet in the bathroom. -There were 2 glue insect traps with multiple dead cockroaches. Observation of resident room 41 on 09/04/24 at 1:18pm revealed: -The dresser drawers contained bandage supplies, a plastic bin, papers, and various personal items. -The contents of the dresser drawers were heavily soiled with dried cockroach excrement. -There was dried cockroach excrement on top of the dresser. Observation in the hallway near resident room 67 on 09/04/24 at 2:46pm revealed a cockroach crawled on the floor from the resident's room and into the hallway and under the surveyor's foot as the surveyor was walking down the hall. Observation of resident room 67 on 09/04/24 at 2:50pm revealed: -There was an incontinence pad lining the bottom of the top left drawer of the dresser. -There were some items and an empty plastic wrap from a pack of snack crackers in the drawer. -There was dried black cockroach excrement throughout the top left drawer. -There was a black roach trap in the top drawer	D 079		

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D 079	Continued From page 3 and a dead cockroach lying next to the trap. -There was a cockroach crawling around in the top left drawer among the items. -There was an incontinence pad lining the bottom of the second drawer on the left side of the dresser. -There were some items in the second drawer and an opened pack of saltine crackers. -There was dried black cockroach excrement throughout the second drawer. Observation of the AL dining room on 09/05/24 at 8:09am revealed: -There were 26 residents seated in the dining room for the breakfast meal. -There were 2 cockroaches crawling near one of the exit doors. -There was 1 dead cockroach near one of the exit doors. -There were 2 cockroaches crawling near the entrance to the kitchen. Interview with the resident residing in room 37 on 09/04/24 at 9:20am revealed: -He had lived at the facility since 2017. -He saw cockroaches in his room frequently. -He felt as though his room was covered in cockroaches. -He was unsure how long there had been cockroaches in his room, but it had been a long time. -His room was sprayed by an exterminator but did not seem to help with the cockroaches. -He had to kill cockroaches in his room daily. Interview with the resident residing in room 38 on 09/04/24 at 9:32am revealed: -She had lived at the facility for several months. -There had been cockroaches since she moved in, but there were more cockroaches now.	D 079		

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D 079	Continued From page 4 -She bought her own glue insect traps to kill the cockroaches. -Her room was sprayed by the exterminator approximately a week ago, but did not help with the cockroaches. -She thought there were more cockroaches since her room was sprayed by the exterminator. Interview with the resident residing in room 41 on 09/04/24 at 1:18pm revealed: -He had lived at the facility for several months. -He could not use his dresser for clothing because it was full of cockroach excrement. -He had to kill cockroaches in his room every day. -He killed 6 cockroaches in his room this morning, 09/04/24. -He had reported the cockroaches in his room to the Executive Director (ED). -His room was sprayed by an exterminator but did not seem to help with the cockroaches. Interview with the resident residing in resident room 67 on 09/04/24 at 2:49pm revealed: -He saw cockroaches in his room crawling on the floor in the dresser drawers. -The cockroaches "come and go". -The facility staff had put some roach traps in the dresser drawers (could not recall when). -The exterminator last came and sprayed his room about a month ago. Interview with a housekeeper on 09/04/24 at 2:46pm revealed: -He had worked at the facility for 2 weeks. -He was not sure of the exact source of the cockroaches. -He had seen cockroaches in various places in the facility since he started working 2 weeks ago. -He saw cockroaches crawling on the mop when he was dry mopping in the facility.	D 079		

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D 079	Continued From page 5 -The exterminator came to the facility about a week ago. Interview with a second housekeeper on 09/05/24 at 10:37am revealed: -She started working at the facility on 09/04/24. -She had seen live and dead cockroaches in the facility. -She was instructed to deep clean each resident's room weekly. -Deep cleaning the residents' rooms consisted of using a disinfectant spray to clean the toilet and sink, moving the furniture to sweep, and mopping the floors of the room and bathroom with a disinfectant cleaner. -She reported any cockroaches she saw to the Maintenance Director. Interview with a medication aide (MA) on 09/05/24 at 9:08am revealed: -She saw cockroaches crawling on the outside of the medication carts. -She saw the cockroaches crawling on the side and on the drawers on the front of the medication carts. -The medication carts were in the medication room on the assisted living (AL) side of the facility when she saw the cockroaches crawling on the carts about a month ago. -She had not seen any cockroaches crawling inside of the medication carts. Second interview with a MA on 09/05/24 at 10:50am revealed: -She had worked at the facility for 6 years. -She had seen cockroaches at the facility since she started working there. -When she saw cockroaches, she reported it to the ED and Maintenance Director. -Some residents complained about the	D 079			

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D 079	Continued From page 6 cockroaches, and she reported the complaints to the ED. -She had seen an exterminator at the facility but was unsure when the last time was. Interview with the Maintenance Director on 09/05/24 at 11:12am revealed: -He had been employed at the facility for 2 years. -There have been cockroaches at the facility since he started working there. -The pest control technician serviced the facility monthly. -There were 6-8 resident rooms that were sprayed monthly because the residents often ate in their rooms and had more cockroaches. -When he received a report of cockroaches in a resident's room, the room was deep cleaned as soon as possible. -When the resident's rooms were deep cleaned, all surfaces were cleaned with a disinfectant, the floors were mopped, and clothes and linens were washed. -He reported the issues with cockroaches to the facility's corporate office but had not been told to increase the frequency of the pest control service. -The facility did not have housekeepers for 4-5 months because the facility was unable to fill the positions. -He was performing his regular maintenance duties and cleaning residents' rooms while the facility did not have housekeepers. -There were several housekeepers hired in the last month. -The cockroaches were a concern because having pests was a cleanliness issue. Interview with the Special Care Coordinator (SCC) on 09/05/24 at 11:44am revealed: -She was hired in June 2023 as the SCC. -There was not currently a Resident Care	D 079			

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D 079	Continued From page 7 Coordinator (RCC) at the facility, so she assisted with some of those duties. -She had not received any complaints from residents about cockroaches in the facility. -She saw a few cockroaches in the facility. -If she saw cockroaches, she reported it to the Executive Director (ED). -The pest control technician was at the facility in the last couple of weeks, but she was unsure of the date. Interview with the Executive Director (ED) on 09/05/24 at 3:33pm revealed: -She had been employed at the facility for 1 year. -There had been roaches at the facility since she had been employed. -The facility received monthly pest control services. -She had not requested for the facility to have more frequent pest control services. -She had instructed residents not to leave unopened food or dirty dishes in their rooms. -The housekeeping staff checked rooms twice daily, especially if the room had cockroaches. -The rooms were cleaned with a disinfectant. -She notified the pest control company if she received complaints from the residents about cockroaches. -She had not reported any concerns about cockroaches to the facility's corporate office. Interview with the Administrator on 09/05/24 at 5:08pm revealed: -She was employed by the company as a traveling Administrator. -She had assisted the facility for the past couple of months since the Executive Director (ED) was working in place of the dietary manager. -She was usually at the facility 4 days per week. -She was aware the facility had some	D 079		

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D 079	Continued From page 8 cockroaches but was unaware of the extent of the problem. -She recalled seeing a live cockroach in the kitchen on the date of the kitchen's health inspection, which was 07/05/24. -She saw a few dead cockroaches at various locations in the facility. -The facility received monthly pest control services. -The facility now had a housekeeping staff, so the facility was being cleaned regularly. -The housekeepers deep cleaned all the residents' rooms at least once a month. -The housekeepers used a disinfectant spray to clean the resident's rooms and a disinfectant solution to mop the floors in the facility. -The facility's corporate office was aware the facility had cockroaches but was unaware of the extent of the problem. -The facility staff should report to the ED when cockroaches were seen. -She was concerned about the cockroaches in the facility because residents should not have to live with pests in the facility. Interview with the facility's pest control technician on 09/05/24 at 9:29am revealed: -He had performed pest control services at the facility for 3-4 years. -He was scheduled for regular monthly maintenance for pest control at the facility. -When he arrived at the facility each month, he received a list of residents' rooms to treat. -The pest control chemicals used at the facility were used for general pest control and should kill cockroaches. -He normally treated the list of residents' rooms, bathrooms, common areas, staff breakroom, kitchen, and dining room. -The treatment consisted of spraying a chemical	D 079		

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D 079	Continued From page 9 along the baseboards and using a residual bait, which should kill cockroaches for 14 days. -He had advised the facility to clean the residents' rooms, especially if the residents kept food in their rooms. -He saw dead cockroaches at the facility while performing monthly pest control services. -He was not aware the facility had live cockroach activity. -If there were live cockroaches in the facility, there could be a concern with the cockroaches getting into the residents' food supply. Interview with the facility's contracted primary care provider (PCP) on 09/05/24 at 9:49am revealed: -She was not aware there were cockroaches in the facility. -She had not received any reports from residents about the facility having cockroaches. -The facility needed to ensure the rooms were clean and contact pest control. -She was concerned about the cockroaches because most of the residents were elderly, and some were immunocompromised and should not be exposed to pests. The facility failed to ensure a safe and clean environment free from hazards as evidenced by the presence of live and dead cockroaches and cockroach excrement throughout the facility. The live and dead cockroaches were located in the residents' rooms, bathrooms, hallways, kitchen, and in the dining area while residents were seated for a meal. Cockroaches as well as their saliva, excrement, and eggs carry bacteria and place the residents at risk for respiratory and gastrointestinal illnesses. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.	D 079		

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D 079	Continued From page 10 The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/05/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 21, 2024.	D 079		
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 Based on observations, interviews and record reviews, the facility failed to provide personal care assistance for 2 of 6 sampled residents (#1, #6) who required staff assistance with toenail care (#1) and a resident who required assistance with bathing and dressing who refused personal care and had soiled gauze dressings on her feet and body odor (#6). The findings are: 1. Review of Resident #6's current FL-2 dated 06/05/24 revealed: -Diagnoses included lymphedema, tremor, degenerative disease of nerve, bradycardia, acute respiratory disease, hypertension, anemia,	D 269		

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D 269	Continued From page 11 and schizophrenia. -The resident was documented as oriented. -The resident was documented as semi-ambulatory and used a rollator walker. -The resident was documented as needing assistance with bathing, feeding, and dressing. -The resident was documented as incontinent of bladder and bowel (at times). Review of Resident #6's Resident Register revealed: -The resident was admitted to the facility on 11/30/20 from another assisted living facility. -The resident required assistance by staff for bathing, hair/grooming, and scheduling appointments. -The resident was forgetful and needed reminders. -The resident had a walker. Review of Resident #6's current assessment and care plan dated 04/03/24 revealed: -The resident was ambulatory and used a rollator walker. -The resident had limited range of motion in her upper extremities. -The resident had swollen legs. -The resident had occasional incontinence of bowel and bladder. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident required limited assistance by staff with ambulation and transferring. -The resident required extensive assistance by staff with eating, toileting, bathing (staff assist with entire body), dressing (staff assist with shoes, socks, buttons, and zippers), and grooming (staff brush hair, trim nails, and shave as needed). -The resident would refuse care such as	D 269	Personal Care Aides were re-trained to provide personal care including toileting, bathing, etc according to the needs of the residents and frequency, identified on their care plan. Personal Care Aides/ qualified staff will provide personal care including toileting, bathing, etc according to the needs of residents and frequency, identified on their care plan. Supervisor In Charge/Special Care Unit Coordinator will monitor daily to ensure personal care tasks are being completed on including toileting, bathing, etc according to the needs of residents and frequency, identified on their care plan. Outside agencies will be notified for residents needing additional orders to address personal care needs. Director will do random interviews with residents to ensure staff are addressing issues identified on the care plan.	10/21/2024

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D 269	Continued From page 12 showers. -Sometimes the resident could be redirected. -The resident was being seen by a mental health provider (MHP). Observation of Resident #6 in the hallway on 09/05/24 at 9:07am revealed: -The resident was independently ambulating down the hall using a rollator walker. -The resident was walking very slowly, taking very small steps. -The resident was wearing black opened-toed slide shoes. -There was a yellow, non-skid sock on the right foot that was torn and covered only the toes and right side of the right foot. -There was a black sock covering only the toes of the left foot. -The resident had gauze dressings wrapped in multiple layers on both feet. -The gauze dressings were soiled with reddish brown drainage seeping through to the outside of the dressings on the back of the left heel and on the inner to medial area of the right foot. -The resident had a strong, pungent odor. Review of Resident #6's August 2024 personal care aide (PCA) weekly task report dated 08/01/24 - 08/31/24 revealed: -There was a section for bathing / personal hygiene with several tasks under the heading including sponge bath and skin care (includes face, hands, feet). -Staff documented a sponge bath was completed on 08/02/24, 08/04/24, 08/05/24, 08/14/24, 08/16/24, 08/18/24, 08/19/24, 08/21/24, 08/23/24, 08/25/24, 08/26/24, 08/28/24, and 08/30/24. -Staff documented Resident #6 refused a shower on 08/01/24, 08/03/24, 08/06/24, 08/22/24, 08/24/24, 08/27/24, 08/29/24, and 08/31/24.	D 269		

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NAME OF PROVIDER OR SUPPLIER PHOENIX ASSISTED CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WEST HIGH STREET CARY, NC 27513		
(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 269	Continued From page 13 -Staff documented skin care (including face, hands, and feet) was completed daily from 08/01/24 - 08/06/24, 08/14/24 - 08/31/24. -There was a section for dressing that included the tasks of shoes/clothing off and shoes/clothing on. -Staff documented both of these tasks were completed daily from 08/01/24 - 08/06/24, 08/14/24 - 08/31/24. -There was no PCA weekly task report provided for 08/07/24 - 08/13/24. -There was no documentation of any concerns about the resident's condition from 08/01/24 - 08/31/24. Review of Resident #6's September 2024 PCA weekly task report dated 09/01/24 - 09/03/24 revealed: -There was a section for bathing / personal hygiene with several tasks under the heading including sponge bath and skin care (includes face, hands, feet). -Staff documented a sponge bath was completed on 09/01/24 and 09/02/24. -Staff documented the resident refused a shower on 09/03/24. -Staff documented skin care (including face, hands, and feet) was completed daily from 09/01/24 - 09/03/24. -There was a section for dressing that included the tasks of shoes/clothing off and shoes/clothing on. -Staff documented both of these tasks were completed daily from 09/01/24- 09/03/24. -There was no documentation of any concerns about the resident's condition from 09/01/24 - 09/03/24. Review of Resident #6's primary care provider (PCP) visit note dated 05/02/24 revealed:	D 269			

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D 269	Continued From page 14 -The resident was being seen due to reported foul odor to bilateral lower extremities. -The resident had a diagnosis of schizophrenia and often refused baths and hygiene care. -Staff advised the resident finally had a bath and bilateral extremities noted to have worsened. -There was a concern for decreased to no circulation of bilateral extremities. -The PCP ordered the resident go to the emergency room (ER) for further evaluation. Review of Resident #6's hospital discharge summary dated 05/07/24 revealed: -The resident was admitted to the hospital on 05/02/24 and discharged on 05/07/24. -The resident's discharge diagnoses included right foot infection. -The resident was treated with antibiotics and discharged with orders for wound care and home health services. Review of Resident #6's home health care note dated 05/08/24 revealed the resident was seen for wound care to bilateral feet. Review of Resident #6's home health care note dated 07/30/24 revealed: -The resident was seen today for discharge from home health. -The resident's wounds were healed. -There was no documentation to indicate if any dressings were applied or left on the resident's legs/feet. Review of Resident #6's MHP visit notes dated 06/12/24 revealed: -The resident had schizophrenia and the resident had cognitive impairment and communication deficits due to dementia state. -The resident was guarded when questioned but	D 269		

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D 269	Continued From page 15 reported feeling well overall. -The resident was cooperative with staff care, allowing them to assist her with personal hygiene tasks and clothing changes without combativeness. -No behavioral concerns were reported. Review of Resident #6's MHP visit notes dated 07/10/24 revealed: -There was no documentation of staff reporting any resident behaviors. -There was no documentation of staff reporting the resident had refused bathing or any other personal care tasks. Review of Resident #6's PCP visit note dated 07/18/24 revealed: -Staff reported the resident refused hygiene care and baths. -The resident had lymphedema to bilateral legs and feet. -Staff reported the wound on the resident's right foot had healed. Review of Resident #6's MHP visit notes dated 08/05/24 revealed: -The resident was guarded and found sitting in her bedroom. -There was no documentation of staff reporting any resident behaviors. -There was no documentation of staff reporting the resident had refused bathing or any other personal care tasks. Review of Resident #6's PCP visit note dated 08/15/24 revealed: -Staff reported the resident refused hygiene care and baths. -The resident was to continue to be monitored, and staff was to notify the provider of any	D 269		

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D 269	Continued From page 16 changes in condition. Review of Resident #6's PCP visit note dated 09/05/24 revealed: -The resident was seen per staff request. -The resident was initially seen to order a home health consult due to possible wound infection and dressing changes. -There was an attempt to examine the resident, however, the resident refused. -The resident had a history of refusing dressing changes, home health wound care, and showers related to diagnosis of schizophrenia. -The resident had bilateral lower extremities wrapped in saturated and soiled dressing. -Due to the nature of the resident's previous wounds and the fact that the dressings on her feet were completely soiled and saturated, the PCP was sending the resident to the ER for further evaluation and treatment. -The resident denied any pain and refused to allow the PCP to complete the examination. Review of Resident #6's ER visit notes dated 09/05/24 revealed: -The resident was seen for concern for lower leg infection. -The resident had notably swollen and thickened skin to bilateral lower extremities with chronic skin overgrowth and poor hygiene. -The resident was prescribed an antibiotic for infection and there was a referral for wound care. Second observation of Resident #6 in the hallway on 09/05/24 at 12:04pm revealed: -The resident was independently ambulating down the hall using a rollator walker. -The resident was walking very slowly, taking very small steps. -The resident was walking with a limp.	D 269		

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D 269	Continued From page 17 -The resident was still wearing the same soiled gauze dressings on both feet as the previous day, 09/04/24. -The bandages were soiled with reddish brown drainage seeping through to the outside of the bandage on the back of the left heel and on the inner to medial area of the right foot. -The resident had on the same clothing, including the same socks and shoes as the previous day, 09/04/24. -The resident had a strong, pungent odor. Interview with Resident #6 on 09/05/24 at 12:04pm revealed: -She thought a nurse had put the gauze dressings on her feet a few weeks ago. -The facility MAs did not help with her the gauze dressings. -She could not reach her legs/feet to wrap them herself. -Her legs were leaking fluid some but "not that bad". -Her legs hurt but mostly her right leg hurt. -Her legs hurt more when she walked. -She thought it was nerve pain. -Her legs started hurting a few days ago. -The pain in her legs and feet caused her to walk slower. -She could bathe herself and did not need assistance. Interview with a medication aide (MA) on 09/05/24 at 11:54am revealed: -She saw gauze dressings on Resident #6's feet yesterday, 09/04/24. -She reported the gauze dressings to the Administrator, who was going to take care of it. -She saw dried, red stains on the dressings on the resident's feet. -The resident would usually deny having any pain.	D 269		

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D 269	Continued From page 18 -She could tell the resident was in pain because the resident was walking slower than normal. -Prior to yesterday, she had not noticed the gauze dressings on the resident's feet, so she did not know how long the dressings had been there. -She had not put any gauze dressings on the resident's feet. -The resident had left over home health wound supplies in her room. -She did not think the resident was physically able to reach down and put the bandages on herself. -Resident #6 needed staff assistance with showers but the resident refused to take showers. -The staff did not document skin assessments when they bathed residents. -It had been over 3 months since she had assisted the resident with a shower. -She noticed the resident had a body odor yesterday, 09/04/24. Interviews with a PCA on 09/05/24 at 2:45pm and 09/06/24 at 1:47pm revealed: -Resident #6 would sit and try to put bandages on herself. -The resident could bend over and reach her feet. -There were wound supplies in the resident's room left over from when she was receiving home health services. -The resident's last shower was around the end of July 2024 when the resident was still receiving home health services. -She remembered that because the staff would have to put plastic bags over the resident's dressings before she took a shower. -The resident refused showers but would try to "wipe" herself off at times. -The resident would change clothes about once a week and staff would wash the resident's clothes. -She observed the gauze dressings on Resident	D 269			

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D 269	Continued From page 19 #6's feet about 5 days ago. -She observed the resident in her room pulling socks over the gauze dressing. -The resident would put the sock on the floor, then worked her foot into the sock, and then would bend down and pull the rest of the sock over her foot. -She did not notice any drainage or soiling on the gauze dressings at that time. -The dressing at the top part of the resident's feet looked wet because the resident would get her feet wet when she messed with the water in the shower. -The resident only smiled when she asked the resident about the dressings on her feet. -She could not remember if she reported the resident's gauze dressings to anyone when she first saw them about 5 days ago. -She told the resident she needed to take the dressings off her feet but the resident did not take them off. -The resident would not complain of pain, but she could tell the resident was in pain because yesterday, 09/05/24, the resident walked really slow and stopped a lot. -On 09/04/24, she reported the resident's gauze dressings to the MA on duty. -They tried to get the resident to take a shower on 09/04/24, but the resident would not take one. -The PCAs were supposed to notify the MA if a resident refused personal care, and the MA would try to assist them. -The MA was responsible for reporting refusals to the resident's provider, but she was not sure which providers were supposed to be notified. -The PCAs documented personal care on the personal care records. -For sponge bath and skin care, it was documented as completed on the personal care records because the resident tried to do those	D 269		

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D 269	Continued From page 20 things herself. -The resident would go in the bathroom and close the door, so staff did not see the resident when she was supposedly doing her own personal care. Telephone interview with the Special Care Coordinator (SCC) on 09/06/24 at 2:35pm revealed: -Resident #6's gauze dressings on her feet were first reported to her by the Administrator on 09/04/24. -She contacted the PCP and made the PCP aware of the dressings. -The PCP planned to see the resident when she was at the facility the next day, 09/05/24 and order a referral to home health. -The PCP saw the resident on 09/05/24 and had the resident sent to the ER. -No one had reported the resident's gauze dressings prior to 09/04/24. -If a resident required extensive assistance with personal care tasks, the facility staff should assist the resident. -If a resident refused personal care, the staff were supposed to document it on the resident's personal care record and notify her if a resident continued to refuse. -She would notify the PCP of personal care refusals. -She did not know if Resident #6's MHP was notified of the resident's refusal of personal care. Telephone interview with the Executive Director (ED) on 09/06/24 at 3:27pm revealed: -Resident #6 usually had on socks and she had not noticed the gauze dressing wrapped on the resident's feet. -None of the facility staff had reported the gauze dressing wrapped on Resident #6's feet.	D 269		

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D 269	Continued From page 21 -She was made aware of the gauze dressing on the resident's feet by surveyors on 09/04/24. -If a resident refused bathing, the PCA should try 3 times, then let the supervisor on duty know. -The SCC would notify the resident's PCP. -If the resident was having behaviors of refusing personal care, the facility staff should also notify the resident's MHP. Interview with the Administrator on 09/05/24 at 6:24pm revealed: -For any resident who refused assistance by staff with personal care, staff were supposed to attempt 3 times, then get another staff person to try. -If cleanliness was a health concern for a resident, staff should notify the resident's provider of personal care refusals. -She did not know who put the gauze dressings on Resident #6's feet or how long they had been there. -The MAs could do clean dressing changes, usually to skin tears. -If a resident had a wound, staff would notify the provider and get order for home health. Telephone interview with the Administrator on 09/06/24 at 2:14pm revealed: -The PCAs should assist Resident #6 with her sponge baths. -The PCAs should notify a supervisor when the resident refused personal care. -If a behavior was associated with the resident's refusal, the resident's PCP and MHP should be notified of the refusals. -If staff knew the resident was not bathing and it could affect her health, like a skin infection, they should notify the PCP and the MHP. Telephone interview with Resident #6's legal	D 269		

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D 269	Continued From page 22 guardian on 09/06/24 at 11:56am revealed: -She last visited the resident about 2 weeks ago. -The resident did not have gauze dressing wrapped on her feet at that time to her knowledge. -She was notified by the facility staff yesterday, 09/05/24, that the resident was sent to the hospital ER for swelling in her feet. -She was not aware there was gauze dressing wrapped around the resident's feet when she went to the ER on 09/05/24. -The resident could not physically reach her feet to put the gauze dressings on her feet. -The resident did not usually communicate with her during visits if the resident was having any kind of issues. -She usually had to ask the resident questions to find out things. -She was aware the resident would not allow staff to assist with showers. -The resident usually let the water run over her and tried to do her bathing on her own. -The resident's clothing was usually clean when she visited the resident, and she did not recall ever smelling any body odor. Interview with Resident #6's PCP on 09/05/24 at 10:16am revealed: -Resident #6 was in the hospital from 05/02/24 - 05/07/24 for a foot infection. -The resident often refused bathing and hygiene care. -The resident's feet needed to be cleaned to help prevent infections. Telephone interview with Resident #6's PCP on 09/06/24 at 12:18pm revealed: -Due to the resident's schizophrenia, the resident was not "about cleaning or bathing". -Resident #6 had a history of cellulitis.	D 269		

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D 269	Continued From page 23 -She did not know who put the gauze dressings on the resident's feet. -She did not think the resident had the mental or physical capacity to put gauze dressings on the resident's feet. -When she observed the gauze dressings on 09/05/24, it appeared the gauze dressings had been on for at least a few days. -The resident had an odor, but she could not distinguish if it was from a wound or due to lack of hygiene. -She was aware that the resident refused personal care and it had been a never-ending battle due to the resident's mental health issues. Telephone interview with Resident #6's MHP on 09/06/24 at 1:19pm revealed: -Resident #6 was usually dressed in layers when she saw the resident. -She usually sat across the room from the resident during their visits. -She had not noticed the resident having any odors. -The facility staff just reported to her today, 09/06/24, that Resident #6 refused personal care tasks. -Prior to today, 09/06/24, she was not aware the resident was refusing to take showers. -The facility staff should have notified her that Resident #6 was refusing to take showers. -She would have given facility staff tips on how to bathe the resident. -She would have counseled the resident on taking showers and the importance of personal care. -She could have addressed the resident's refusals of personal care as part of the resident's mental health care plan. Attempted telephone interview with Resident #6's	D 269		

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D 269	Continued From page 24 former home health nurse on 09/06/24 at 11:03am was unsuccessful. 2. Review of Resident #1's current FL-2 dated 02/20/24 revealed: -Diagnoses included dementia, depression, post-traumatic stress disorder, cervical stenosis status post decompression and fusion, normocytic anemia, bilateral knee osteoarthritis, hypertension, and chronic obstructive pulmonary disease. -The resident was documented as constantly disoriented. -The resident was documented as non-ambulatory. -The resident was documented as incontinent of bowel and bladder. -The resident required assistance with bathing and dressing. Review of Resident #1's Resident Register revealed: -The resident was admitted to the facility on 02/20/24. -The resident required assistance by staff for dressing, bathing, nail care, ambulation, getting in/out of bed, toileting, positioning/turning, scheduling appointments, and orientation to time and place. -The resident had significant memory loss and must be directed. -The resident had a wheelchair. Review of Resident #1's current assessment and care plan dated 03/18/24 revealed: -The resident was non-ambulatory, used a wheelchair, and had a hooyer lift for assistance. -The resident had limited range of motion in his upper extremities. -The resident was incontinent of bowel and	D 269			

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D 269	Continued From page 25 bladder daily. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident would sometimes holler out loudly when he was being assisted by staff and state he was hurting in his legs. -The resident required limited assistance by staff with eating, ambulation, and transferring. -The resident required extensive assistance by staff with toileting, bathing (staff wash entire body), dressing, and grooming (staff wash hair, trim nails, and shave as needed). Observation of Resident #1 in his room on 09/04/24 at 9:52am revealed: -The resident's great toenail on his right foot was yellowish brown, thick, and 1/2 - 3/4 inch long. -The resident's second and third toenails on his right foot were yellow, thick, and 1/2 inch long. -The resident's fourth and fifth toenails on his left foot were yellow, thick, and 1/2 inch long. -There was a dime-sized scab on top of his left foot. -The resident had dry, peeling skin hanging between the toes of each foot. -The resident had dry, peeling skin on the heel of both of his feet. Review of Resident #1's August 2024 personal care record for activities of daily living (ADLs) revealed: -There was a section for personal hygiene that included shower, bath, shampoo, nail care, grooming, and shave. -This entry had 3 rows with first, second, and third shifts and a row underneath each shift to indicate if the tasks were completed. -The resident's personal hygiene tasks (which included nail care) were documented as "C" (ADL task completed) for all 3 shifts each day from	D 269		

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NAME OF PROVIDER OR SUPPLIER PHOENIX ASSISTED CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WEST HIGH STREET CARY, NC 27513		
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D 269	Continued From page 26 08/01/24 - 08/31/24 except third shift on 08/31/24 was blank. -There were no refusals documented for any ADLs for Resident #1. Review of Resident #1's September 2024 personal care record for ADLs revealed: -There was a section for personal hygiene that included shower, bath, shampoo, nail care, grooming, and shave. -This entry had 3 rows with first, second, and third shifts and a row underneath each shift to indicate if the tasks were completed. -The resident's personal hygiene (which included nail care) tasks were documented as "C" (ADL task completed) for all 3 shifts each day from 09/01/24 - 09/06/24 (second shift). -There were no refusals documented for any ADLs for Resident #1. Interviews with Resident #1 on 09/04/24 at 9:52am and 09/05/24 at 4:03pm revealed: -He was at a point where he thought he was doing better and did not need staff assistance all the time. -He was unable to say how often he was bathed or offered assistance with bathing and grooming. -No one cut or trimmed his toenails. -He needed foot care. -He denied pain or discomfort in his toes or feet. Observation of Resident #1 in his room on 09/05/24 at 4:03pm revealed: -The resident was lying in bed on his side. -The resident's toenails on both feet had been trimmed. Interview with a medication aide (MA) on 09/05/24 at 4:03pm revealed: -A personal care aide (PCA) trimmed Resident	D 269			

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D 269	Continued From page 27 #1's toenails yesterday, 09/04/24. -He could not recall what time the PCA trimmed the resident's toenails. -He did not know why the resident's toenails had not been trimmed prior to yesterday, 09/04/24. Telephone interview with a PCA on 09/06/24 at 12:42pm revealed: -Resident #1 required two-person assistance with bathing and dressing. -Resident #1 usually got a bed bath because when he had a foot wound, his feet could not get wet. -His foot wound was healed currently. -Resident #1 was bathed on second shift 3 times a week. -The PCAs could trim resident's toenails if the resident was not diabetic. -She tried to check residents' toenails every 1 to 1.5 weeks. -She trimmed Resident #1's toenails in the past; she thought about 2 weeks ago. -She did not document when she trimmed the resident's toenails. -Resident #1's toenails were thick, and he sometimes refused to let her trim them. -She noticed his toenails were long again on 09/04/24, so she cut them on 09/04/24. -She used the facility's heavy duty scissor clippers to trim his toenails because they were so thick. -She usually cleaned between the resident's toes and she last cleaned between his toes this week (could not give specific date). Interview with the Special Care Coordinator (SCC) on 09/05/24 at 5:19pm revealed: -The PCAs could provide nail care, including trimming for resident's who were not diabetic. -Resident #1 was not diabetic so the facility PCAs	D 269		

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D 269	Continued From page 28 could trim his nails when they bathed him. -She was not sure if the PCAs trimmed Resident #1's nails. -Resident #1 sometimes would not let staff provide personal care to him. -The PCAs should document any refusals of care on the resident's personal care records. -No staff had reported to her that Resident #1 had long toenails. Interview with the Administrator on 09/05/24 at 6:00pm revealed: -The PCAs should observe and monitor residents' feet when they assist with showers/bathing. -If a resident was not diabetic, the PCAs could trim the resident's toenails but filing was preferred. -Resident #1 was not diabetic so the PCAs could trim or at least file his toenails. -The facility had toenail clippers and scissor clippers for thicker nails that the PCAs used. -The PCAs should be cleaning between the resident's toes to remove any dry, flaky skin when they bathed the resident. Telephone interview with Resident #1's family member on 09/06/24 at 3:59pm revealed: -When she visited the facility, the resident "could be a little cleaner". -The resident's toenails were long, thick, and in need of care. The facility failed to provide personal care assistance including bathing and dressing to Resident #6 who had a history of leg and foot wounds and infections. Resident #6 had gauze dressings soiled with dried, reddish-brown drainage on both feet that were first noticed by staff about 5 days ago and the resident was sent to the hospital and diagnosed with a skin	D 269		

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D 269	Continued From page 29 infection. Resident #6, who was diagnosed with schizophrenia, had her last shower around the end of July 2024 due to the resident refusing personal care assistance and resulting in the resident having body odor and putting the resident at continued risk of skin infections. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/06/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 21, 2024.	D 269		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination and follow-up for 3 of 6 sampled residents (#1, #4, #6) including seeking care for a resident with a history of cellulitis who had bandages on her legs and feet that were soiled with reddish brown drainage (#6), notifying the primary care provider of a resident missing multiple medications on dialysis days (#4), and failing to coordinate a podiatry referral for a resident with yellow, thick, long toenails that	D 273		

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D 273	Continued From page 30 needed trimming (#1). The findings are: 1. Review of Resident #6's current FL-2 dated 06/05/24 revealed: -Diagnoses included lymphedema, tremor, degenerative disease of nerve, bradycardia, acute respiratory disease, hypertension, anemia, and schizophrenia. -The resident was documented as oriented. -The resident was documented as semi-ambulatory and used a rollator walker. -The resident was documented as needing assistance with bathing, feeding, and dressing. -incontinent of bladder and bowel (at times). Review of Resident #6's Resident Register revealed: -The resident was admitted to the facility on 11/30/20 from another assisted living facility. -The resident required assistance by staff for bathing, hair/grooming, and scheduling appointments. -The resident was forgetful and needed reminders. -The resident had a walker. Review of Resident #6's current assessment and care plan dated 04/03/24 revealed: -The resident was ambulatory and used a rollator walker. -The resident had limited range of motion in her upper extremities. -The resident had swollen legs. -The resident had occasional incontinence of bowel and bladder. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident required limited assistance by staff	D 273	Director re-trained staff on reporting change in conditions to physicians with all direct care staff. SIC will notify physician of change in condition within a reasonable amount of time, depending on the routine and acute (as soon as possible) health care needs of residents, as needed; any orders obtained will be implemented timely. SCUC and/or designee will review new orders x 5 days per week to ensure each order is referred to and appropriate agency if indicated. Director/Designee audited all orders once per week x4 weeks, then once per month ongoing to assure any orders needing to be referred to outside agencies or providers are completed.	10/21/2024

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D 273	Continued From page 31 with ambulation and transferring. -The resident required extensive assistance by staff with eating, toileting, bathing (staff assist with entire body), dressing (staff assist with shoes, socks, buttons, and zippers), and grooming (staff brush hair, trim nails, and shave as needed). -The resident would refuse care such as showers. -Sometimes the resident could be redirected. Review of Resident #6's primary care provider (PCP) visit note dated 05/02/24 revealed: -The resident was being seen due to reported foul odor to bilateral lower extremities. -The resident had a diagnosis of schizophrenia and often refused baths and hygiene care. -Staff advised the resident finally had a bath and bilateral extremities noted to have worsened. -There was a concern for decreased to no circulation of bilateral extremities. -The PCP ordered the resident go to the emergency room (ER) for further evaluation. Review of Resident #6's hospital discharge summary dated 05/07/24 revealed: -The resident was admitted to the hospital on 05/02/24 and discharged on 05/07/24. -The resident's discharge diagnoses included right foot infection. -The resident was treated with antibiotics and discharged with orders for wound care and home health services. Review of Resident #6's home health care note dated 05/08/24 revealed the resident was seen for wound care to bilateral feet. Review of Resident #6's PCP visit note dated 07/18/24 revealed:	D 273		

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D 273	Continued From page 32 -The resident was seen for evaluation of chronic medical conditions. -The resident did not appear to have any pain or discomfort. -The resident did not voice any concerns at the time of the visit. -Staff reported the resident refused hygiene care and baths. -The resident had lymphedema to bilateral legs and feet. -Staff reported the wound on the resident's right foot had healed. -The resident was to continue to be monitored, and staff was to notify the provider of any changes in condition. Review of Resident #6's home health care note dated 07/30/24 revealed: -The resident was seen today for discharge from home health. -The resident's wounds were healed. -There was no documentation to indicate if any dressings were applied or left on the resident's legs/feet. Observation of Resident #6 in the hallway on 09/05/24 at 9:07am revealed: -The resident was independently ambulating down the hall using a rollator walker. -The resident was walking very slowly, taking very small steps. -The resident had gauze dressings wrapped in multiple layers on both feet. -The gauze dressings were soiled with reddish brown drainage seeping through to the outside of the dressings on the back of the left heel and on the inner to medial area of the right foot. -The resident had a strong, pungent odor. Review of Resident #6's facility care notes	D 273		

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D 273	Continued From page 33 revealed: -09/04/24 (no time): resident had redness on foot; notified PCP; PCP would see resident at next visit and refer to home health. -09/05/24 (no time): per PCP request, the resident was being sent out for bilateral feet due to refusal of examination. Second observation of Resident #6 in the hallway on 09/05/24 at 12:04pm revealed: -The resident was independently ambulating down the hall using a rollator walker. -The resident was walking very slowly, taking very small steps. -The resident was walking with a limp. -The resident was still wearing the same bandages on both feet as the previous day, 09/04/24. -The bandages were soiled with reddish brown drainage seeping through to the outside of the bandage on the back of the left heel and on the inner to medial area of the right foot. -The resident had on the same clothing, including the same socks and shoes as the previous day, 09/04/24. -The resident had a strong, pungent odor. Interview with Resident #6 on 09/05/24 at 12:04pm revealed: -She thought a nurse had put the dressings on her feet a few weeks ago. -The facility MAs did not help with the dressings. -She could not reach her legs/feet to wrap them herself. -Her legs were leaking fluid some but "not that bad". -Her legs hurt but mostly her right leg hurt. -Her legs hurt more when she walked -She thought it was nerve pain. -Her legs started hurting a few days ago.	D 273		

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D 273	Continued From page 34 -The pain in her legs and feet caused her to walk slower. Interview with a medication aide (MA) on 09/05/24 at 11:54am revealed: -She saw gauze dressings on Resident #6's feet yesterday, 09/04/24. -She reported the dressings to the Administrator, who was going to take care of it. -She saw dried, red stains on the dressings on the resident's feet. -The resident usually denied she was in pain. -She could tell the resident was in pain because the resident was walking slower than normal. -Prior to yesterday, she had not noticed the dressings on the resident's feet, so she did not know how long the dressings had been there. -She had not put any dressings on the resident's feet. -The resident had left over home health wound supplies in her room. -She did not think the resident was physically able to reach down and put the bandages on herself. Interviews with a personal care aide (PCA) on 09/05/24 at 2:45pm and 09/06/24 at 1:47pm revealed: -She observed the gauze dressings on Resident #6's feet about 5 days ago. -She did not notice any drainage or soiling on the gauze dressings at that time. -The dressing at the top part of the resident's feet looked wet because the resident would get her feet wet when she messed with the water in the shower. -The resident only smiled when she asked the resident about the dressings on her feet. -She could not remember if she reported the resident's gauze dressings to anyone when she first saw them about 5 days ago.	D 273			

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D 273	Continued From page 35 -She told the resident she needed to take the dressings off her feet but the resident did not take them off. -The resident would not complain of pain, but she could tell the resident was in pain because yesterday, 09/05/24, the resident walked really slow and stopped a lot. -The PCAs were supposed to notify the MA if there was a change in a resident's condition. Review of Resident #6's PCP visit note dated 09/05/24 revealed: -The resident was seen per staff request. -The resident was initially seen to order a home health consult due to possible wound infection and dressing changes. -There was an attempt to examine the resident, however, the resident refused. -The resident had a history of refusing dressing changes, home health wound care, and showers related to diagnosis of schizophrenia. -The resident had bilateral lower extremities wrapped in saturated and soiled dressing. -Due to the nature of the resident's previous wounds and the fact that the dressings on her feet were completely soiled and saturated, the PCP was sending the resident to the ER for further evaluation and treatment. -The resident denied any pain and refused to allow the PCP to complete the examination. Review of Resident #6's ER visit notes dated 09/05/24 revealed: -The resident was seen for concern for lower leg infection. -The resident was seen for fluid retention and swelling of her legs and bacterial infection of the skin, known as cellulitis. -The resident was hospitalized for cellulitis/right foot infection in May 2024.	D 273			

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D 273	Continued From page 36 -The resident stated she had chronic leg swelling and pain. -The ER provider did not see confluent erythema (redness) or purulent (containing pus) discharge from her wounds. -The resident had notably swollen and thickened skin to bilateral lower extremities with chronic skin overgrowth and poor hygiene. -The resident had significant chronic changes of her lower extremity, and she was encouraged to follow-up with wound care. -Due to her increased pain, the ER provider prescribed an antibiotic for possible cellulitis. -The resident was prescribed an antibiotic for infection and there was a referral for wound care. Review of Resident #6's facility care notes revealed: -09/05/24 at 11:19pm: resident returned from hospital; resident had new order for an antibiotic that would be sent to the back up pharmacy. -09/06/24 (8:45am): orders were given to transporter to schedule appointment for wound care. -09/06/24 (8:56 am/pm not specified): orders for home health were scanned to the home health provider. Interview with the Special Care Coordinator (SCC) on 09/05/24 at 5:48pm revealed: -One of the medication aides (MAs) reported to the Administrator yesterday, 09/04/24, that Resident #6 had dressings on her feet. -She called the PCP yesterday, 09/04/24, and the PCP wanted to see the resident today, 09/05/24, during her visit to the facility. -The PCAs should report any resident skin concerns to her. -No one had reported any concerns about Resident #6's feet until yesterday, 09/04/24.	D 273			

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D 273	Continued From page 37 Telephone interview with the Executive Director (ED) on 09/06/24 at 3:27pm revealed: -Resident #6 usually had on socks and she had not noticed the gauze dressing wrapped on the resident's feet. -None of the facility staff had reported the gauze dressing wrapped on Resident #6's feet. -She was made aware of the gauze dressing on the resident's feet by surveyors on 09/04/24. -The PCAs should notify the MA Supervisor, the SCC, or herself when there was a change in a resident's condition. Interview with the Administrator on 09/05/24 at 6:24pm revealed: -She did not know who put the gauze dressings on Resident #6's feet or how long they had been there. -The MAs could do clean dressing changes, usually to skin tears. -If a resident had a wound, staff would notify the provider and get order for home health. Second interview with the Administrator on 09/05/24 at 7:29pm revealed: -She had just spoken on the telephone with the charge nurse at the hospital ER regarding Resident #6. -The nurse reported the resident had cellulitis in both legs and they were starting the resident on some antibiotics. -The resident would return to the facility tonight, 09/05/24. Interview with Resident #6's PCP on 09/05/24 at 10:16am revealed: -When she saw the resident on 05/02/24, the resident's right foot had an odor, but the resident refused to let the PCP look at her feet, so the	D 273		

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D 273	Continued From page 38 resident was sent to the hospital. -Resident #6 was in the hospital from 05/02/24 - 05/07/24 for a foot infection. -The facility staff sent a message to her yesterday, 09/04/24, asking if she could see the resident today, 09/05/24. -Resident #6 was not diabetic but she had a history of foot/leg infections. -The facility staff should have notified her sooner, when they first saw the gauze dressings on the resident's feet. -She would probably have the resident sent out to the hospital ER today, 09/05/24, for further evaluation after she examined the resident herself. Telephone interview with Resident #6's PCP on 09/06/24 at 12:18pm revealed: -Resident #6 had a history of cellulitis. -She was not aware the resident had returned to the facility from the hospital on 09/05/24 and was being treated with antibiotics for an infection. Attempted telephone interview with Resident #6's former home health nurse on 09/06/24 at 11:03am was unsuccessful. 2. Review of Resident #1's current FL-2 dated 02/20/24 revealed: -Diagnoses included dementia, depression, post-traumatic stress disorder, cervical stenosis status post decompression and fusion, normocytic anemia, bilateral knee osteoarthritis, hypertension, and chronic obstructive pulmonary disease. -The resident was documented as constantly disoriented. -The resident was documented as non-ambulatory. -The resident was documented as incontinent of	D 273		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092131	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/06/2024
NAME OF PROVIDER OR SUPPLIER PHOENIX ASSISTED CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WEST HIGH STREET CARY, NC 27513		
(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 273	Continued From page 39 bowel and bladder. -The resident required assistance with bathing and dressing. Review of Resident #1's Resident Register revealed: -The resident was admitted to the facility on 02/20/24 from a veteran's hospital. -The resident required assistance by staff for dressing, bathing, nail care, ambulation, getting in/out of bed, toileting, positioning/turning, scheduling appointments, and orientation to time and place. -The resident had significant memory loss and must be directed. -The resident had a wheelchair. Review of Resident #1's current assessment and care plan dated 03/18/24 revealed: -The resident was non-ambulatory, used a wheelchair, and had a hooyer lift for assistance. -The resident had limited range of motion in his upper extremities. -The resident had daily incontinence of bowel and bladder. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident would sometimes holler out loudly when he was being assisted by staff and state he was hurting in his legs. -The resident required limited assistance by staff with eating, ambulation, and transferring. -The resident required extensive assistance by staff with toileting, bathing (staff wash entire body), dressing, and grooming (staff wash hair, trim nails, and shave as needed). Observation of Resident #1 in his room on 09/04/24 at 9:52am revealed: -The resident's great toenail on his right foot was	D 273		

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D 273	Continued From page 40 yellowish brown, thick, and about ½ - ¾ inch long. -The resident's second and third toenails on his right foot were yellow, thick, and about ½ inch long. -The resident's fourth and fifth toenails on his left foot were yellow, thick, and about ½ inch long. -There was a dime-sized scab on top of his left foot. -The resident had dry, peeling skin hanging between the toes of each foot. -The resident had dry, peeling skin on the heel of both of his feet. Review of Resident #1's primary care provider (PCP) visit note dated 07/18/24 revealed the PCP ordered a referral for outpatient podiatry nail care. Review of Resident #1's provider visits notes revealed no documentation the resident had been seen by a podiatrist as ordered on 07/18/24. Review of Resident #1's facility progress notes revealed no documentation regarding the podiatry referral ordered on 07/18/24. Interviews with Resident #1 on 09/04/24 at 9:52am and 09/05/24 at 4:03pm revealed: -No one cut or trimmed his toenails. -He had not seen a podiatrist, but he needed foot care. -He denied pain or discomfort in his toes or feet. Interview with the Special Care Coordinator (SCC) on 09/05/24 at 5:19pm revealed: -She was not sure, but she thought they were waiting for prior approval for a podiatry visit for Resident #1 through his veteran's provider. -She was not sure how the veteran's provider services worked, and the facility's transporter usually handled referrals.	D 273		

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D 273	Continued From page 41 -The facility's transporter would be responsible for forwarding the referral to the provider and setting up the appointment. -She checked behind the transporter "periodically". -The facility's newly contracted podiatry provider came to the facility a couple of weeks ago but the resident was not in the system to be seen for some reason. -She could not locate any documentation regarding attempts to get a podiatry referral for Resident #1. Telephone interview with the facility's transporter on 09/05/24 at 5:27pm revealed: -She had faxed Resident #1's podiatry referral to an outside podiatry provider (could not recall date). -She was waiting for the resident's veteran's provider to approve or authorize an outside podiatry visit. -She sometimes took the resident to a veteran's provider for primary care. -She was not sure if the veteran's provider had an in-house podiatrist the resident could see and she had not thought to check on that. Telephone interview with Resident #1's family member on 09/06/24 at 3:59pm revealed: -She thought the facility had a podiatrist who would take care of the resident's toenails. -The resident's toenails were long, thick, and in need of care. Interview with Resident #1's facility PCP on 09/05/24 at 10:08am revealed: -She ordered the podiatry referral on 07/18/24 for the resident because his toenails were long and needed podiatry care. -She was not made aware by facility staff that the	D 273			

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D 273	Continued From page 42 resident had not seen a podiatrist yet. -If the facility's in-house podiatry provider was unable to see the resident, the facility needed to find an outside podiatry provider to see the resident. 2. Review of Resident #4's current FL2 dated 12/21/23 revealed diagnoses included colostomy reversal, diverticulitis, dialysis, end stage renal failure. a. Review of Resident #4's primary care provider's order dated 05/02/24 revealed there was an order for Eliquis 5mg one tablet twice a day (Eliquis is used to prevent strokes and blood clots). Review of Resident #4's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Eliquis 5mg take one tablet twice a day scheduled at 8:00am and 8:00pm. -On 07/02/24, 07/05/24, 07/09/24, 07/11/24, 07/13/24, 07/15/24, 07/17/24, 07/18/24, 07/22/24, 07/24/24, 07/26/24, 07/29/24, and 07/31/24 at 8:00am there were initials circled on the eMAR with documentation "out of the facility". Review of Resident #4's August 2024 eMAR revealed: -There was an entry for Eliquis 5mg take one tablet twice a day scheduled at 8:00am and 8:00pm. -On 08/02/24, 08/06/24, 08/07/24, 08/09/24, 08/12/24, 08/14/24, 08/19/24, 08/20/24, 08/21/24, 08/22/24, 08/23/24, 08/25/24, 08/28/24, 08/29/24, 08/30/24 at 8:00am, there were initials circled on the eMAR with documentation "out of the facility". -On 08/05/24, there were initials circled on the	D 273		

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D 273	Continued From page 43 eMAR with documentation "off to dialysis". Review of Resident #4's September 2024 eMAR revealed: -There was an entry for Eliquis 5mg take one tablet twice a day scheduled at 8:00am and 8:00pm. -On 09/02/24 and 09/04/24, there were initials circled on the eMAR with documentation "out of the facility". b. Review of Resident #4's primary care provider's order dated 05/02/24 revealed there was an order for Midodrine 10mg one tablet three times a day, hold for systolic blood pressure greater than 120. Review of Resident #4's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Midodrine 10mg one tablet three times a day, hold for systolic blood pressure greater than 120 scheduled at 8:00am, 2:00pm, and 8:00pm. -On 07/02/24, 07/05/24, 07/09/24, 07/11/24, 07/13/24, 07/15/24, 07/17/24, 07/18/24, 07/22/24, 07/24/24, 07/26/24, 07/29/24, and 07/31/24 at 8:00am there were initials circled on the eMAR with documentation "out of the facility". Review of Resident #4's August 2024 eMAR revealed: -There was an entry for Midodrine 10mg one tablet three times a day, hold for systolic blood pressure greater than 120. -On 08/02/24, 08/06/24, 08/07/24, 08/09/24, 08/12/24, 08/14/24, 08/19/24, 08/20/24, 08/21/24, 08/22/24, 08/23/24, 08/25/24, 08/28/24, 08/29/24, 08/30/24 at 8:00am, there were initials circled on the eMAR with documentation "out of the facility".	D 273		

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D 273	Continued From page 44 -On 08/05/24, there were initials circled on the eMAR with documentation "off to dialysis". Review of Resident #4's September 2024 eMAR revealed: -There was an entry for Midodrine 10mg one tablet three times a day, hold for systolic blood pressure greater than 120. -On 09/02/24 and 09/04/24, there were initials circled on the eMAR with documentation "out of the facility". c. Review of Resident #4's physician's order dated 05/31/24 revealed there was an order for Renvela 800mg take two tablets three times daily with meals (Renvela is a medication used to help control phosphorus levels in the blood). Review of Resident #4's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Renvela 800mg two tablets three times daily with meals scheduled at 8:00am, 12:00pm, and 5:00pm. -On 07/02/24, 07/05/24, 07/09/24, 07/11/24 at 8:00am there were initials circled on the eMAR with documentation "out of the facility". Review of Resident #4's physician's order dated 07/11/24 revealed there was an order for Renvela 800mg take three tablets three times daily with meals. Review of Resident #4's July 2024 eMAR revealed: -There was an entry for Renvela 800mg two tablets three times daily with meals scheduled at 8:00am, 12:00pm, and 5:00pm beginning 07/12/24. -On 07/13/24, 07/15/24, 07/17/24, 07/18/24,	D 273			

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D 273	Continued From page 45 07/22/24, 07/24/24, 07/26/24, 07/29/24, and 07/31/24 at 8:00am there were initials circled on the eMAR with documentation "out of the facility". Review of Resident #4's August 2024 eMAR revealed: -There was an entry for Renvela 800mg two tablets three times daily with meals scheduled at 8:00am, 12:00pm, and 5:00pm. -On 08/02/24, 08/06/24, 08/07/24, 08/09/24, 08/12/24, 08/14/24, 08/19/24, 08/20/24, 08/21/24, 08/22/24, 08/23/24, 08/25/24, 08/28/24, 08/29/24, 08/30/24 at 8:00am, there were initials circled on the eMAR with documentation "out of the facility". -On 08/05/24, there were initials circled on the eMAR with documentation "off to dialysis". Review of Resident #4's September 2024 eMAR revealed: -There was an entry for Renvela 800mg two tablets three times daily with meals scheduled at 8:00am, 12:00pm, and 5:00pm -On 09/02/24 and 09/04/24, there were initials circled on the eMAR with documentation "out of the facility". d. Review of Resident #4's primary care provider's order dated 05/02/24 revealed there was an order for Omeprazole 40mg take one capsule twice a day (Omeprazole is used to treat heartburn and acid reflux). Review of Resident #4's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Omeprazole 40mg scheduled for 8:00am and 8:00pm. -On 07/02/24, 07/05/24, 07/09/24, 07/11/24, 07/13/24, 07/15/24, 07/17/24, 07/18/24, 07/22/24, 07/24/24, 07/26/24, 07/29/24, and 07/31/24 at 8:00am there were initials circled on the eMAR	D 273		

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D 273	Continued From page 46 with documentation "out of the facility". Review of Resident #4's August 2024 eMAR revealed: -There was an entry for Omeprazole 40mg scheduled for 8:00am and 8:00pm. -On 08/02/24, 08/06/24, 08/07/24, 08/09/24, 08/12/24, 08/14/24, 08/19/24, 08/20/24, 08/21/24, 08/22/24, 08/23/24, 08/25/24, 08/28/24, 08/29/24, 08/30/24 at 8:00am, there were initials circled on the eMAR with documentation "out of the facility". -On 08/05/24, there were initials circled on the eMAR with documentation "off to dialysis". Review of Resident #4's September 2024 eMAR revealed: -There was an entry for Omeprazole 40mg scheduled for 8:00am and 8:00pm. -On 09/02/24 and 09/04/24, there were initials circled on the eMAR with documentation "out of the facility". e. Review of Resident #4's primary care provider's order dated 05/02/24 revealed there was an order for Enteric Coated (EC) Aspirin 81mg one tablet daily (Enteric Coated Aspirin 81mg is used for prevention of heart attacks and strokes). Review of Resident #4's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for EC Aspirin 81mg take one tablet daily scheduled at 8:00am. -On 07/02/24, 07/05/24, 07/09/24, 07/11/24, 07/13/24, 07/15/24, 07/17/24, 07/18/24, 07/22/24, 07/24/24, 07/26/24, 07/29/24, and 07/31/24 at 8:00am there were initials circled on the eMAR with documentation "out of the facility".	D 273		

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D 273	Continued From page 47 Review of Resident #4's August 2024 eMAR revealed: -There was an entry for EC Aspirin 81mg take one tablet daily scheduled at 8:00am. -On 08/02/24, 08/06/24, 08/07/24, 08/09/24, 08/12/24, 08/14/24, 08/19/24, 08/20/24, 08/21/24, 08/22/24, 08/23/24, 08/25/24, 08/28/24, 08/29/24, 08/30/24 at 8:00am, there were initials circled on the eMAR with documentation "out of the facility". -On 08/05/24, there were initials circled on the eMAR with documentation "off to dialysis". Review of Resident #4's September 2024 eMAR revealed: -There was an entry for EC Aspirin 81mg take one tablet daily scheduled at 8:00am. -On 09/02/24 and 09/04/24, there were initials circled on the eMAR with documentation "out of the facility". f. Review of Resident #4's primary care provider's order dated 05/02/24 revealed there was an order for Docusate Sodium 100mg take one capsule twice a day (Docusate Sodium is used to treat or prevent constipation). Review of Resident #4's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Docusate Sodium 100mg take one capsule twice a day scheduled at 8:00am and 8:00pm. -On 07/02/24, 07/05/24, 07/09/24, 07/11/24, 07/13/24, 07/15/24, 07/17/24, 07/18/24, 07/22/24, 07/24/24, 07/26/24, 07/29/24, and 07/31/24 at 8:00am there were initials circled on the eMAR with documentation "out of the facility". Review of Resident #4's August 2024 eMAR revealed:	D 273		

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D 273	Continued From page 48 -There was an entry for Docusate Sodium 100mg take one capsule twice a day scheduled at 8:00am and 8:00pm. -On 08/02/24, 08/06/24, 08/07/24, 08/09/24, 08/12/24, 08/14/24, 08/19/24, 08/20/24, 08/21/24, 08/22/24, 08/23/24, 08/25/24, 08/28/24, 08/29/24, 08/30/24 at 8:00am, there were initials circled on the eMAR with documentation "out of the facility". -On 08/05/24 at 8:00am, there were initials circled on the eMAR with documentation "off to dialysis". Review of Resident #4's September 2024 eMAR revealed: -There was an entry for Docusate Sodium 100mg take one capsule twice a day scheduled at 8:00am and 8:00pm. -On 09/02/24 and 09/04/24 at 8:00am, there were initials circled on the eMAR with documentation "out of the facility". Interview with Resident #4 on 09/04/24 at 1:18pm revealed: -He used to go to dialysis on Tuesday, Thursday, and Saturday each week. -He had recently switched his dialysis schedule to Monday, Wednesday, and Friday each week. -Sometimes his dialysis schedule varied when there was a holiday or during the transition of switching dialysis scheduled days. -The city's public transportation system offered transportation to dialysis clinics, and he utilized this service. -The bus usually arrived around 5:30am to take him to the dialysis clinic. -He did not take any medications before he left the facility on the days he went to dialysis. -He probably missed some doses of his medication because he was not here on the mornings he went to dialysis. -He usually returned to the facility around	D 273		

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D 273	Continued From page 49 12:00pm on the days he had dialysis. -He took some medications on the days he returned from dialysis, but he did not know the names of the medications. Interview with a medication aide (MA) on 09/05/24 at 10:50am revealed: -She usually worked 7:00am-3:00pm. -Resident #4 had already left for dialysis most days when she arrived for her shift. -Resident #4 did not take his 8:00am medications on the days he had dialysis because he was not at the facility. -She documented on the electronic medication administration record (eMAR) when Resident #4 was out of the facility. -Initials circled on the eMAR indicated the medications were not administered. -She had not notified Resident #4's primary care provider (PCP) that he had not been taking his medications scheduled for 8:00am on the days he went to dialysis. -MAs should notify the Resident Care Coordinator (RCC) if a resident did not take medications for multiple days. -The Special Care Coordinator (SCC) was currently acting as the RCC for the facility. -The PCP should be notified if medications are not administered to a resident for multiple days. Interview with the SCC on 09/05/24 at 11:44am revealed: -She was hired as the SCC in June 2023. -There was not currently a RCC at the facility, so she assisted with some of those duties. -She was aware Resident #4 went to dialysis 3 times per week. -Resident #4 usually left the facility early in the morning, but she was unsure what time. -She was unsure what medications Resident #4	D 273		

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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 273	Continued From page 50 was currently taking. -She was not aware Resident #4 was not getting his 8:00am medications on the days he went to dialysis. -Resident #4 should get his medications daily since the medications were ordered by his PCP. -Resident #4's PCP should have been notified if he did not receive his medications. -She tried to check the eMARs each month but there was no specific schedule to check the residents' eMARs. Interview with the Executive Director (ED) on 09/05/24 at 3:33pm revealed: -Resident #4 usually left the facility for dialysis around 5:30am three days per week. -She was not aware Resident #4 was not getting his 8:00am medications on the days he went to dialysis. -The facility should have checked with Resident #4's PCP to see if the times the medications were scheduled could be changed. -There was a concern for Resident #4 not taking his medications because he was on medicines for blood pressure and to prevent blood clots. -Resident #4 was at risk for blood pressure issues and blood clots if he did not take his medications as ordered by the PCP. Interview with the Administrator on 09/05/24 at 5:08pm revealed: -Medication aides (MA) were responsible for ensuring residents received their medications as ordered by their PCP. -If a resident was consistently out of the facility during the medication pass, the MAs should inform the resident's PCP. -Resident #4's PCP should have been notified for further directions regarding whether his medications should be given at a different time or	D 273		

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D 273	Continued From page 51 held on the days he went to dialysis. -It was important for Resident #4 to receive his medications as ordered by his PCP. Interview with a pharmacist at the facility's contracted pharmacy on 09/04/24 at 4:55pm revealed the time on Resident #4's medications should be changed so he could take the medications as ordered by his PCP. Interview with Resident #4's PCP on 09/05/24 at 9:49am revealed: -She was not aware Resident #4 was not receiving his morning medications on the days he went to dialysis. -The facility should inform her when residents do not receive their medications as ordered. -The times of the medications could be changed so that Resident #4 would get the medications as ordered. -Any medications that are ordered should be given according to the order. The facility failed to ensure health care referral and follow-up for 3 sampled residents. Resident #6 had a history of foot infection requiring a hospitalization and antibiotic treatment and staff failed to immediately notify the resident's primary care provider (PCP) when gauze dressings soiled with drainage were first observed by staff wrapped around the resident's feet about 5 days ago. Resident #6 was sent to the hospital emergency room and diagnosed with an infection again and required antibiotics for treatment. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/06/24 for	D 273		

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D 273	Continued From page 52 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 21, 2024.	D 273		
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 interviews and record reviews, the facility failed to ensure documentation and implementation for 1 of 5 sampled residents (#1) including orders for blood pressure checks and weights. The findings are: Review of Resident #1's current FL-2 dated 02/20/24 revealed diagnoses included dementia, depression, post-traumatic stress disorder, cervical stenosis status post decompression and fusion, normocytic anemia, bilateral knee osteoarthritis, hypertension, and chronic obstructive pulmonary disease. Review of Resident #1's primary care provider (PCP) order dated 07/25/24 revealed an order for weekly blood pressures and weights.	D 276	All Medication Aides/SIC completed training for implementation of procedures, orders and treatment as per physician's orders. SCUC/Designee will review MARs weekly to ensure documentation is completed for procedures, orders and treatment as per physician's orders. Director will audit to twice monthly x2 months then randomly thereafter, to ensure documentation is completed for procedures, orders and treatment as per physician's orders.	10/21/2024

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D 276	Continued From page 53 Review of Resident #1's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for blood pressure and weight check weekly. -The blood pressure and weight checks were scheduled to be done on the evening shift. -There were no blood pressures or weights for this entry documented from 07/01/24 - 07/31/24. Review of Resident #1's August 2024 eMAR revealed: -There was an entry for blood pressure and weight check weekly. -The blood pressure and weight checks were scheduled to be done on the evening shift. -There were no blood pressures or weights for this entry documented from 08/01/24 - 08/30/24. Review of Resident #1's September 2024 eMAR dated 09/01/24 - 09/04/24 revealed: -There was an entry for blood pressure and weight check weekly. -The blood pressure and weight checks were scheduled to be done on the evening shift. -There were no blood pressures or weights for this entry documented from 09/01/24 - 09/04/24. Review of Resident #1's 2024 monthly vital signs record revealed: -The resident's blood pressure was 128/75 in July 2024 and 130/87 in August 2024. -The resident's weight was 191 pounds in July 2024 and 190 pounds in August 2024. -There were no recordings documented for September 2024. Interview with Resident #1 on 09/05/24 at 4:03pm revealed: -He thought the facility staff checked his blood	D 276			

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D 276	Continued From page 54 pressure and weight about 2 days ago. -That was the first time he recalled his blood pressure and weight being checked at the facility, but he was not sure. Interview with a medication aide (MA) on 09/05/24 at 1:06pm revealed: -He sometimes worked on evening shift. -He did not recall an entry to check Resident #1's blood pressure or weights weekly coming up on the eMAR screen. -If the entry did not come up on the eMAR screen, the MAs would not know to check the resident's blood pressure or weights weekly. Telephone interview with the facility's contracted pharmacy provider on 09/05/24 at 4:34pm revealed: -The pharmacy entered medication orders into the eMAR system and the facility staff had to approve the medication orders. -The facility staff would be responsible for entering non-medication orders, such as vital signs and weights, into the eMAR system. Interview with the Special Care Coordinator (SCC) on 09/05/24 at 5:19pm revealed: -She usually entered non-medication orders into the eMAR system. -She was not sure why Resident #1's blood pressure and weights were not being done weekly. -She tried to check the eMARs periodically every day but she did not check all residents' eMAR every day. Interview with the Executive Director (ED) on 09/05/24 at 6:00pm revealed: -Resident #1's blood pressure and weight should be checked weekly as ordered.	D 276		

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D 276	Continued From page 55 -The Resident Care Coordinator (RCC) and SCC were responsible for checking the MARs every month to make sure orders were being implemented. Interview with the Administrator on 09/05/24 at 2:32pm revealed: -She was not sure why the weekly weights and blood pressure checks were not being completed and documented in the eMAR system. -Resident #1's weights and blood pressure checks should be done weekly as ordered. Telephone interview with Resident #1's PCP on 09/06/24 at 12:18pm revealed: -When she first started seeing Resident #1, the resident's blood pressure was high. -She needed to know the resident's blood pressure so she could determine if his blood pressure was in normal limits or if she needed to change the dosage of his blood pressure medications. -The resident's weight had been stable to her knowledge.	D 276			
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide 14 hours of planned group activities per week for active	D 317			

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D 317	Continued From page 56 involvement of residents. The findings are: Interview with a resident on 09/04/24 at 9:20am revealed: -She lived in assisted living (AL). -There was not many activities being offered in the facility. -There was a therapy dog on Mondays and bingo offered on Thursdays. -She would like to be offered more activities. Interview with a second resident on 09/04/24 at 9:30am revealed: -She lived on the AL. -There was a therapy dog on Mondays and a church group came in and played bingo on Thursdays. -She would like to be offered more activities. Observation of the facility on 09/04/24 at 9:53am revealed: -The August activities calendar was posted on the assisted living side of the facility. -There was no September activities calendar posted on the assisted living side of the facility. -The August and September calendars were posted in the special care unit (SCU). Review of the facility's activity calendar on 09/04/24 at 1:45pm revealed: -The September activities calendar was posted on the AL side of the community. -Bible study was scheduled on the activities calendar from 1:00pm to 2:00pm. -An outing to Walmart was scheduled from 3:00pm to 4:00pm. -Observation of the facility between 1:00pm and 1:30pm revealed there was no bible study	D 317	Activities Coordinator developed scheduled activities of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Director/designee will ensure that there are at least 14 hours of activities each week. QI department/Compliance director will conduct audits of facility at least quarterly to ensure a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression increased knowledge and learning of new skills.	10/21/2024

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D 317	Continued From page 57 observed. -Observation of the facility between 3:00pm and 4:00pm revealed there was no Walmart outing observed. Review of the facility's activity calendar on 09/05/24 revealed, daily chronicles was scheduled from 9:00am to 10:00am. -Observation of the facility at 9:20am revealed there was no daily chronicles observed. Interview with a medication aide (MA) on 09/05/24 at 10:30am revealed: -The facility did not have an activity coordinator. -The facility has not been offering any activities to residents. -A church group came to the facility every Thursday and did bingo with the residents. -There was a therapy dog that was brought to the facility on Mondays. -Those were the only two activities that were done consistently. Interview with a personal care aide (PCA) on 09/05/24 at 3:20pm revealed: -She worked on the special care unit. -The PCAs would do an exercise activity and listen to music with residents. -The facility did not offer 14 hours of activities each week to residents in the special care unit. Interview with the Executive Director (ED) on 09/05/24 at 3:30pm revealed: -Fourteen hours of activities per week were not being done for residents. -The facility did not have an activity coordinator. -A church group came to the facility every Thursday and did bingo with the residents. -There was a therapy dog that was brought to the facility on Mondays.	D 317		

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D 317	Continued From page 58 Interview with the Administrator on 09/05/24 at 4:20pm revealed: -The facility did not have an activity coordinator. -She expected a minimum of 14 hours of activities to be offered to residents each week. -There were community partners that offered bingo and a therapy dog in the facility weekly. -She was not sure why activities had not been done consistently.	D 317		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 residents (#1, #4) sampled including errors with an antibiotic for infection (#1), an inhaler used to treat chronic obstructive pulmonary disease (#1), and a medication used to treat low blood pressure (#4). The findings are: 1.Review of Resident #1's current FL-2 dated 02/20/24 revealed diagnoses included dementia, depression, post-traumatic stress disorder,	D 358		

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D 358	Continued From page 59 cervical stenosis status post decompression and fusion, normocytic anemia, bilateral knee osteoarthritis, hypertension, and chronic obstructive pulmonary disease. a. Review of Resident #1's primary care provider (PCP) order dated 08/08/24 revealed an order for Keflex 500mg 1 capsule 3 times a day for 10 days for wound on top of left foot. (Keflex is an antibiotic used to treat infections.) Review of Resident #1's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Keflex 500mg take 1 capsule 3 times a day for 10 days scheduled for 8:00am, 2:00pm, and 8:00pm. -Keflex was documented as not administered from 8:00am on 08/09/24 through 2:00pm on 08/11/24 and 8:00am and 2:00pm on 08/12/24 due to the medication being unavailable. -There were 20 doses of Keflex documented as administered from 08/11/24 - 08/18/24. -There were no doses documented as administered after 8:00pm on 08/18/24. -Only 20 of 30 doses were documented as administered. Observation of Resident #1's medications on hand on 09/05/24 at 1:06pm revealed there was no Keflex available for administration. Observation of Resident #1 in his room on 09/04/24 at 9:52am revealed: -There was a dime-sized scab on top of his left foot. -There was no open area on the resident's feet. Interview with Resident #1 on 09/05/24 at 4:03pm revealed he could not recall all medications he	D 358	Director/Designee retrained Med Aides on medication administration and medications errors SCUC/Designee audited MARs to ensure they match all current orders. SCUC will assure that all physicians orders are added to MARs upon receipt of new order. SCUC/Designee will conduct cart audits once per week x 4 weeks, then once per month ongoing to assure staff are giving medications per physicians' orders. Director will audit orders monthly to ensure that MARs match current orders.	10/21/2024

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D 358	Continued From page 60 received, and he did not know if he received any Keflex. Interview with a medication aide (MA) on 09/05/24 at 1:06pm revealed: -He was not sure why there was a delay in starting Resident #1's Keflex. -The resident had finished taking the Keflex and there was none currently on hand. Telephone interview with the Quality Assurance Specialist at the facility's contracted pharmacy on 09/05/24 at 4:34pm revealed: -The pharmacy received Resident #1's Keflex order on 08/08/24 but only put it on profile because they did not usually dispense the resident's medications. -The resident's record was flagged that his medication usually came from a veteran's pharmacy. -The facility had to request and approve medications for the resident before the pharmacy could send them. -The facility did not request or approve for the pharmacy to send the resident's Keflex until 08/12/24. -The pharmacy dispensed and sent Keflex to the facility on 08/12/24. Interview with the Special Care Coordinator (SCC) on 09/05/24 at 5:19pm revealed: -She discovered while reviewing orders that Resident #1's Keflex order dated 08/08/24 was not in the facility. -She called the facility's contracted pharmacy and they said it had been profiled only and they did not know they needed to send the Keflex since the resident medications usually came from a veteran's pharmacy. -The MAs should have notified the facility's	D 358		

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D 358	Continued From page 61 contracted pharmacy to dispense the Keflex when the order was sent to the pharmacy on 08/08/24. -She did not know if the resident received the full 10-day dosage of Keflex. Interview with the Administrator on 09/05/24 at 6:00pm revealed: -Antibiotics should be started as soon as possible, usually within 24 hours of the order unless the order had "stat", then it should be started immediately. -The resident should have been administered the antibiotic for 10 days. Interview with Resident #1's PCP on 09/05/24 at 10:08am revealed: -The Keflex was ordered for a foot wound. -She was not sure why there was a delay in starting the antibiotic, but the MAs should have adjusted the dates once the dosages were started to make sure Keflex was administered for the full 10-day course. -The resident's foot wound had healed to her knowledge. b. Review of Resident #1 physician's order dated 05/16/24 revealed an order for Advair Diskus 250/50mcg inhale 1 puff every 12 hours for chronic obstructive pulmonary disease. (Advair Diskus is used to treat chronic obstructive lung disease. According to the manufacturer, the expiration date for Advair Diskus is 30 days after opening the foil pouch or when the dose counter reads 0, whichever comes first.) Review of Resident #1's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Advair Diskus 250/50mcg	D 358		

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D 358	Continued From page 62 administer 1 inhalation twice daily, rinse mouth after use scheduled for 8:00am and 8:00pm. -Advair Diskus was documented as administered twice daily from 07/01/24 - 07/31/24. Review of Resident #1's August 2024 eMAR revealed: -There was an entry for Advair Diskus 250/50mcg administer 1 inhalation twice daily, rinse mouth after use scheduled for 8:00am and 8:00pm. -Advair Diskus was documented as administered twice daily from 08/01/24 - 08/31/24. Review of Resident #1's September 2024 eMAR revealed: -There was an entry for Advair Diskus 250/50mcg administer 1 inhalation twice daily, rinse mouth after use scheduled for 8:00am and 8:00pm. -Advair Diskus was documented as administered twice daily from 09/01/24 - 09/04/24 (8:00am). Observation of Resident #1's medications on hand on 09/05/24 at 1:06pm revealed: -There was an Advair 250/50mcg inhaler with a handwritten open date of 07/12/24 and a handwritten expiration date of 08/12/24. -There was a second Advair 250/50mcg inhaler in the resident's back up supply of medication that had not been opened. Interview with Resident #1 on 09/05/24 at 4:03pm revealed: -He received an inhaler, but he could not recall which one. -He denied any current breathing problems. Interview with a medication aide (MA) on 09/05/24 at 1:06pm revealed: -He had not noticed Resident #1's Advair Diskus inhaler in the medication cart was expired.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092131	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/06/2024
NAME OF PROVIDER OR SUPPLIER PHOENIX ASSISTED CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WEST HIGH STREET CARY, NC 27513		
(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 358	Continued From page 63 -He had administered the expired Advair Diskus inhaler to the resident without checking the expiration date. -The resident had a new Advair Diskus inhaler in the back up supply at the facility. Interview with the Special Care Coordinator (SCC) on 09/05/24 at 5:19pm revealed: -The MAs were trained to write the open date on inhalers and discard them when they expired. -The MAs should not have administered the expired Advair Diskus inhaler to Resident #1. -She had not observed Resident #1 having any issues with shortness of breath. Interview with the Administrator on 09/05/24 at 6:00pm revealed: -The MAs should check the expiration date on medications, including inhalers, prior to administering medications. -The MAs should order a new inhaler within 7 to 10 days prior to an inhaler expiring. -The MAs should not administer an expired inhaler to a resident. Telephone interview with Resident #1's primary care provider (PCP) on 09/06/24 at 12:18pm revealed: -The MAs needed to check the expiration date prior to administering the Advair inhaler to Resident #1. -She was not aware of any adverse effects to the resident because of receiving the expired inhaler but the MAs needed make sure it did not happen again. 2. Review of Resident #4's current FL-2 dated 12/21/23 revealed diagnoses included colostomy reversal, diverticulitis, dialysis, and end stage renal failure.	D 358			

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D 358	Continued From page 64 Review of Resident #4's physician's orders dated 05/02/24 revealed there was an order for Midodrine 10mg one tablet three times daily, hold if systolic blood pressure (Systolic blood pressure is the first number of a blood pressure reading) is greater than 120 (Midodrine is a medication used to treat low blood pressure). Review of Resident #4's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Midodrine 10mg one tablet three times daily, hold if systolic blood pressure is greater than 120. -There was an entry to check blood pressure three times a day, hold Midodrine if systolic blood pressure is greater than 120. -On 07/01/24 at 8:00am, Resident #4's blood pressure was documented as 122/64 and Midodrine 10mg was documented as administered. -On 07/06/24 at 8:00am, Resident #4's blood pressure was documented as 123/76 and Midodrine 10mg was documented as administered. -On 07/06/24 at 2:00pm, Resident #4's blood pressure was documented as 121/77 and Midodrine 10mg was documented as administered. -On 07/07/24 at 2:00pm, Resident #4's blood pressure was documented as 127/76 and Midodrine 10mg was documented as administered. -On 07/09/24 at 8:00pm, Resident #4's blood pressure was documented as 132/56 and Midodrine 10mg was documented as administered. -On 07/19/24 at 8:00am, Resident #4's blood pressure was documented as 128/68 and	D 358		

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D 358	Continued From page 65 Midodrine 10mg was documented as administered. -On 07/19/24 at 2:00pm, Resident #4's blood pressure was documented as 130/76 and Midodrine 10mg was documented as administered. -On 07/27/24 at 2:00pm, Resident #4's blood pressure was documented as 126/66 and Midodrine 10mg was documented as administered. -On 07/30/24 at 8:00pm, Resident #4's blood pressure was documented as 124/60 and Midodrine 10mg was documented as administered. Review of Resident #4's August 2024 eMAR revealed: -There was an entry for Midodrine 10mg one tablet three times daily, hold if systolic blood pressure is greater than 120. -There was an entry to check blood pressure three times a day, hold Midodrine if systolic blood pressure is greater than 120. -On 08/18/24 at 8:00am, Resident #4's blood pressure was documented as 123/54 and Midodrine 10mg was documented as administered. -On 08/25/24 at 8:00am, Resident #4's blood pressure was documented as 126/64 and Midodrine 10mg was documented as administered. Interview with Resident #4 on 09/04/24 at 1:18pm revealed: -He took medications a few times each day. -He knew he took a medication for his blood pressure, but he did not know the name of the medication. -The facility staff took his blood pressure a few times each day.	D 358		

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D 358	Continued From page 66 -Sometimes his blood pressure was low, especially on the days he had dialysis. -He did not recall having any recent high blood pressure readings. Interview with a medication aide (MA) on 09/05/24 at 10:50am revealed: -Resident #4 had an order for a blood pressure medication which required the MAs to take his blood pressure before giving the medication. -She was aware that Resident #4's Midodrine 10mg should be held if his systolic blood pressure was greater than 120. Interview with the Special Care Coordinator (SCC) on 09/05/24 at 11:44am revealed: -There was not currently a Resident Care Coordinator (RCC) at the facility, so she assisted with some of those duties. -MAs were supposed to check the eMAR and medication label to verify they were giving the right medication. -MAs should follow the instructions on the eMAR. -If Resident #4 had an order to hold a medication based on his blood pressure, the medication should have been held. -She was unsure why Resident #4 was administered Midodrine 10mg if his systolic blood pressure was greater than 120. Interview with the Executive Director (ED) on 09/05/24 at 3:33pm revealed: -MAs should follow the directions listed on the eMAR when administering medications to residents. -If a medication required MAs to take a blood pressure, the blood pressure should be taken before the medication was prepared. -If instructions on the eMAR included parameters, MAs should follow the parameters to determine if	D 358		

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D 358	Continued From page 67 a medication should be administered. -She was not aware Resident #4 had systolic blood pressures greater than 120 and received Midodrine 10mg. -She was unsure why Resident #4 received Midodrine 10mg if the medication should have been held. -If Resident #4 received this medication when it should have been held, receiving this medication could cause issues with his blood pressure. Interview with the Administrator on 09/05/24 at 5:08pm revealed: -MAs should compare the eMAR with the medication label when administering medications to residents. -If there were parameters, the MAs should follow the instructions listed on the eMAR. -MAs should hold medications if instructed to hold on the eMAR. -If Resident #4 had instructions to hold Midodrine 10mg, the medication should have been held. -She was unsure why Resident #4 received Midodrine 10mg if the medication should have been held. -MAs should ask the SCC, ED, or Administrator if they had questions about medications. Interview with a pharmacist from the facility's contracted pharmacy on 09/05/24 at 4:55pm revealed: -Midodrine was given to treat low blood pressure. -The effects of Midodrine usually lasted for a few hours, so blood pressure could become elevated as the medication was processed in the body. -If Midodrine was administered and Resident #4's blood pressure was already high, the medication could elevate the blood pressure significantly. Interview with Resident #4's primary care provider	D 358		

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D 358	Continued From page 68 (PCP) on 09/05/24 at 9:49pm revealed: -Resident #4 should not have received Midodrine if his blood pressure was greater than 120, because the MAs should have held the medication. -On the days Resident #4 had dialysis, receiving the medication was not as concerning because his blood pressure was often low. -If Resident #4 received Midodrine when his blood pressure was greater than 120 on days when he did not have dialysis, receiving this medication could cause hypertension..	D 358			