Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092161	A. BUILDING: _____ B. WING _____	R 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTONWOOD CARY PARKWAY	750 SE CARY PARKWAY CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 10/22/24 - 10/23/24.	D 000	This is the plan of correction for the alleged deficiency indicated in the summary statements of deficiencies. The plan of correction constitutes the community's plan for compliance such that the alleged deficiency cited has been or will be corrected by the dates indicated.	
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: Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 1 of 5 sampled residents (#5) who required staff assistance with nail care and had fingernails that were long and jagged with brown debris underneath the nails and who required assistance with bathing and had extremely dry, flaking skin on both feet. The findings are: 1. Review of Resident #5's current FL-2 dated 02/25/24 revealed: -Diagnoses included chronic atrial fibrillation, muscle weakness, cognitive impairment, chronic systolic heart failure, hypertension, hypothyroidism, anemia, history of deep vein thrombosis, chronic hyponatremia, chronic constipation, Vitamin D deficiency, Vitamin B12 deficiency, and bilateral hearing loss. -The resident was documented as intermittently disoriented. -The resident was documented as	D 269	Corrective actions for those affected. For the resident affected: • AL Wellness Coordinator cleaned and filed residents' nails. — 10/23/24 • AL Wellness Coordinator modified care plan to reflect accurate shower schedule. — 10/23/24 • Resident was bathed on the day in question. — 10/23/24 • Staff were made aware of the residents' needs. — 10/23/24	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 12/02/24

Reviewed and Acknowledged
WW 12/2/24

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D 269	Continued From page 1 non-ambulatory. -The resident was documented as needing assistance with bathing and dressing. -The resident was documented as incontinent of bladder and bowel. Review of Resident #5's Resident Register revealed: -The resident's date of admission was documented as 03/06/24. -The resident required assistance by staff with dressing, bathing, nail care, shaving, ambulation, correspondence, getting in/out of bed, toileting, hair/grooming, positioning/turning, and scheduling appointments. -The resident's memory was adequate but he was forgetful and needed reminders. -The resident had a wheelchair, eyeglasses, and hearing aids. Review of Resident #5's current assessment and care plan dated 4/11/24 revealed: -The resident had occasional difficulty remembering and was occasionally disoriented. -The resident was able to communicate effectively and make needs known. -The resident had severe hearing impairment and was legally blind. -Staff would push resident in a wheelchair for mobility. -The resident required extensive assistance by staff with toileting, ambulation, bathing, transferring, and dressing. -The resident required total assistance by staff with dressing. -The resident was dependent on staff to provide all grooming/personal hygiene needs. -Documentation in the care plan noted the resident did not resist care. -There was no documentation in the resident's	D 269	Corrective action for those potentially affected: • An audit was conducted of all residents to verify that showers were correct on their care plan. • Caregivers will complete the shower skin check form whenever a shower is given to a resident, and will document any abnormalities and will inform the Medication Tech and the Wellness Coordinator. • Resident Care Manager and/or designee will review the shower skin check forms on a weekly basis for compliance. • Random audits will be conducted to verify that the shower skin check forms are being completed.	10/25/24 11/19/24 and ongoing 11/19/24 and ongoing 11/22/24 and ongoing

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D 269	Continued From page 2 care plan to indicate he refused any assistance by staff with activities of daily living (ADLs). Review of Resident #5's licensed health professional support (LHPS) review dated 07/12/24 revealed: -The nurse documented that the resident was a non-insulin dependent diabetic. -The nurse recommended that diabetes mellitus be added as a diagnosis on the resident's electronic record. Observation of Resident #5 on 10/22/24 at 10:26am revealed: -Resident #5 was in his bedroom with covers pulled up to his neck. -Resident #5 was asleep. Interview with Resident #5's family member who resided in the room with Resident #5 on 10/22/24 at 10:26am revealed: -They moved into the facility in April 2024. -Resident #5 was in the bed and did not usually get out of bed. -Resident #5 needed assistance with personal care including bathing. -The facility staff "didn't really bathe" Resident #5. -The facility staff washed Resident #5's face and brought his razor to him. Observations of Resident #5 on 10/23/24 at 2:20pm and 2:40pm revealed: -The resident was in his bedroom lying in bed. -The resident's fingernails on both hands were ¼ to ½ inches long and jagged with uneven edges. -Some of the resident's fingernails had a brown substance underneath the nails. -The resident was wearing two pairs of socks on each foot. -When the PCA/MA removed the resident's socks	D 269	Systemic changes include: • Resident Care Manager and/or designee will verify that showers are actually being completed by randomly picking residents and observing the shower. This will be done twice a week for one month, once a week for two weeks and then as needed. • Resident Care manager and/or designee will audit electronic medical record to verify documentation of showers. This will be done for three (3) months. The Resident Care Manager and/or designee will conduct the following trainings with the Resident Care team: • Completing NGA (Needs, Goals, Action) for care plan in electronic medical record with the Resident Care Leadership team. • Training on "Completing the "Shower Skin Check form". • "Who performs and how to perform nail care." • "Basic Care- Showering and documentation."	11/18/24 and ongoing 12/2024 and ongoing until 2/2025 11/15/24 11/19/24 11/15/24, 11/19/24 11/19/24 11/15/24, 11/19/24

		• "Documenting Refusal of Showers."	11/15/24 and 11/19/24

see next page

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D 269	Continued From page 3 on each foot, a thick layer of pieces of flaking, dry skin fell out of the socks an onto the bed. -There were so many pieces of flaking skin, there was a pile heaped up on the mattress where the socks were removed from his feet. -The skin on the resident's feet was extremely dry with white, flaky skin peeling from the resident's feet including his toes. Interview with Resident #5 on 10/23/24 at 2:20pm revealed: -He was in bed most of the time. -Staff helped him with incontinence care. -He did not like his fingernails to be that long; he would like for his fingernails to be cut. -He did not want to take showers because he was in bed most of the time. -Staff helped him get cleaned up while in bed but he could not say how often or the last time he had a bed bath. -He denied any pain in his feet. Review of Resident #5's July 2024 monthly task log revealed: -There was a section for bathing indicating the resident required extensive assistance for this task. -The resident required hands on assistance with participation by the resident to complete the task. -The schedule for bathing was documented as 3 times per day with scheduled times of day shift, afternoon, and evening. -Bathing was initialed by staff as completed 3 times per day from 07/01/24 - 07/31/24. -There was no documentation of any refusals by the resident. -There were no other tasks listed on the monthly task log. -There was a section at the bottom of the task log that staff initialed as information only but no tasks	D 269		

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D 269	Continued From page 4 were specified. Review of Resident #5's August 2024 monthly task log dated revealed: -There was a section for bathing indicating the resident required extensive assistance for this task. -The resident required hands on assistance with participation by the resident to complete the task. -The schedule for bathing was documented as 3 times per day with scheduled times of day shift, afternoon, and evening. -Bathing was initialed by staff as completed 3 times per day from 08/01/24 - 08/31/24. -There was no documentation of any refusals by the resident. -There were no other tasks listed on the monthly task log. -There was a section at the bottom of the task log that staff initialed as information only but no tasks were specified. Review of Resident #5's September 2024 monthly task log dated revealed: -There was a section for bathing indicating the resident required extensive assistance for this task. -The resident required hands on assistance with participation by the resident to complete the task. -The schedule for bathing was documented as 3 times per day with scheduled times of day shift, afternoon, and evening. -Bathing was initialed by staff as completed 3 times per day from 09/01/24 - 09/30/24. -There was no documentation of any refusals by the resident. -There were no other tasks listed on the monthly task log. -There was a section at the bottom of the task log that staff initialed as information only, but no	D 269	This plan of correction completion date is 11/22/24 with ongoing monitoring.	

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D 269	Continued From page 5 tasks were specified. Review of Resident #5's October 2024 monthly task log dated 10/01/24 - 10/23/24 revealed: -There was a section for bathing indicating the resident required extensive assistance for this task. -The resident required hands on assistance with participation by the resident to complete the task. -The schedule for bathing was documented as 3 times per day with scheduled times of day shift, afternoon, and evening. -Bathing was initialed by staff as completed 3 times per day from 10/01/24 - 10/23/24 (day shift). -There was no documentation of any refusals by the resident. -There were no other tasks listed on the monthly task log. -There was a section at the bottom of the task log that staff initialed as information only but no tasks were specified. Interview with a medication aide (MA) / personal care aide (PCA) on 10/23/24 at 2:08pm revealed: -Resident #5 chose to stay in bed most of the time. -Resident #5 did not want to get in the shower and preferred a bed bath. -Resident #5 was scheduled for baths on Mondays and Saturdays. -The resident would swing at staff at times in the past when staff tried to provide care to the resident, but the resident did not usually do that now. -She did not recall when she was last assisted Resident #5 with bathing because she was usually administering medications. A second interview with the same MA/PCA on	D 269		

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D 269	Continued From page 6 10/23/24 at 2:40pm revealed she did not cut residents' fingernails because a resident could be diabetic. Interview with a PCA on 10/23/24 at 5:25pm revealed: -Resident #5 did not get in the shower but he did a bed bath twice a week. -She last helped Resident #5 get a bed bath one day last week when she was assigned to his care. -When she helped Resident #5 with a bed bath last week, the resident's skin was "good", and his feet looked "normal". -She did not recall seeing any dry, flaking skin. -Last week, she noticed the resident's fingernails were "a little long". -The PCAs were supposed to report things like long fingernails to the MA. -She did not remember if she reported Resident #5's long fingernails to the MA last week. -The PCAs could file residents' fingernails but the PCAs were not allowed to trim residents' fingernails. -Some residents had their fingernails done during actvities at the facility. Interview with the Assisted Living Coordinator (ALC) / Licensed Practical Nurse (LPN) on 10/23/24 at 5:10pm revealed: -If a PCA noticed a resident's fingernails were too long, the PCA could clip or file the resident's fingernails. -If the resident was diabetic, the PCAs should let her know and she could clip or file the diabetic residents' fingernails since she was a nurse. -Resident #5 was diabetic so the staff should have notified her about his long fingernails. -No staff had notified her about Resident #5's long fingernails or his dry feet prior to today. -Resident #5 would sometimes refuse care or	D 269		

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D 269	Continued From page 7 become combative during care. -Staff could go back later and the resident would comply. -For bed baths, the PCAs should wash the resident's entire body including his feet. -If a resident continued to refuse bathing, the staff should notify her. -She observed Resident #5's fingernails and feet today, once it was brought to her attention. -Resident #5's fingernails were too long, and the resident could accidentally scratch himself. -The condition of Resident #5's feet were "not good at all; unacceptable". -She entered information into the electronic monthly task log for Resident #5's bathing task incorrectly. -She reviewed monthly task logs daily but did not notice Resident #5's bathing task was entered as 3 times a day or that staff was documenting they were completing that task 3 times a day when they were not. Interview with the Administrator on 10/23/24 at 3:37pm revealed: -The top half of the monthly task log was for documenting bathing assistance. -Staff documented they were bathing Resident #5 three times a day. -She was unsure why staff was documenting the resident was being bathed 3 times a day. -Resident #5 was scheduled for bathing twice a week, not 3 times a day. -It appeared the information was entered incorrectly into the electronic system. -The bottom portion of the monthly task log was for documentation of the rest of the resident's care plan. -There was documentation for information only because they chart by exception. -The information should have been entered into	D 269		

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D 269	Continued From page 8 the system as show and chart. -The ALC was responsible for entering care plan tasks on the monthly task log. -The PCAs should let the ALC know if there was an entry error in the system. -For diabetic residents, one of the facility's nurses could soak and file a resident's fingernails. -If not diabetic, the PCAs could soak and file a resident's fingernails. -She was "shocked", and it was "upsetting" to see the condition of Resident #5's feet. -Resident #5 should be receiving a bed bath at least twice a week, to include washing and providing care for his feet. Interview with Resident #5's primary care provider (PCP) on 10/23/24 at 4:42pm revealed: -The resident had a profound decline over time and needed assistance with personal care. -The resident could not bathe or dress himself. -The resident was severely debilitated and was mostly in bed. -It could take anywhere from 1 to 4 people to assist the resident with getting up. -The resident had been very cooperative with him during visits. -He was not aware of the resident being non-compliant with personal care assistance except the resident did not usually want to get out of bed. -The facility staff should be assisting the resident with bed baths and with fingernail care. -When he saw the resident today, 10/23/24, he noticed the resident's fingernails were long. -He had not seen the resident's feet recently and was not aware of the resident's dry, flaking skin. -Not getting bathed and having dry skin could cause the resident to develop pressure ulcers.	D 269	This plan of correction will be implemented by the Resident Care Manager with oversight from the Executive Director.	