STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alamance Health Care Center	1987 Hilton Road Burlington, NC 27217

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289 Based on record review and interviews with the staff, family member, physician, and nurse practitioners the facility failed to ensure effective communication occurred amongst staff and providers when a resident, who had chronic diarrhea, also began to have multiple episodes of nausea and vomiting in addition to the diarrhea. This was for one (Resident # 1) of one sampled resident reviewed for acute medical changes. The findings included: Record review revealed Resident # 1 was originally admitted to the facility on [DATE] and resided there until 3/18/24. Resident #1 had the following diagnoses which in part included a sacral pressure sore with chronic osteomyelitis (an infection of the bone which does not respond to treatment), history of both ovarian and breast cancer, history of ileus, chronic diarrhea, complete heart block with history of a pacemaker placement, congestive heart failure, coronary artery disease with history of coronary artery bypass surgery times two, chronic pain, atrial fibrillation, diabetes, peripheral vascular disease with a history of bilateral below knee amputations, chronic kidney disease, gastroesophageal reflux disease, hypomagnesemia, history of ischemic colitis, history of colitis (diagnosed during a hospitalization of 10/31/23 to 11/3/23), history of multiple intestinal infections originating from bacteria. Resident # 1's facility electronic record included information on the Medication Administration Record (MAR) that the resident had multiple drug allergies. One of the listed allergies was carbapenems. (Carbapenems are a group of antibiotics). The MAR did not include any specific reaction Resident # 1 had to carbapenems. On 6/16/23 Resident #1 had a palliative care consult. Notations on the consult indicated Resident # 1 would continue palliative care while at the facility. Resident # 1's significant change Minimum Data Set assessment, completed on 1/25/24, coded the resident as cognitively intact. She was assessed to need substantial to moderate assistance with her activities of daily living. She was also assessed to be incontinent of urine and stool, and as having a pressure sore. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 1's care plan, dated 1/25/24, noted Resident # 1 was at risk for gastrointestinal problems secondary to a history of colitis, gastroesophageal reflux disease, and a history of gastrointestinal bleeding. Staff were directed on the care plan to administer medications as ordered and to obtain labs as ordered. The care plan also noted the facility had identified Resident # 1 was at risk for dehydration. Staff were directed to observe the resident for fluid imbalances. Although not all inclusive, some of Resident # 1's medications on her facility order summary included the following. Two Creon Oral capsules delayed release 36000-114000 with meals as a digestive aid. This was a current med as of the time of Resident # 1's final discharge. (Creon is a pancreatic enzyme replacement medication which assists with digestion). Loperamide 2 mg (milligrams) as needed for diarrhea four times per day. This order originated on 11/3/23 and was a current medication as of Resident #1's discharge. Magnesium oxide 400 mg orally every day. This order originated on 11/3/23 and was a current order at the time of the resident's final discharge. (Magnesium oxide treats hypomagnesemia and can cause diarrhea as a side effect.) Doxycycline 100 mg twice daily. This antibiotic had been ordered from 1/15/24 to 3/13/24 for the treatment of Resident # 1's chronic osteomyelitis. Additionally Resident # 1 was receiving Acidophilus Lactobacillus capsule once a day for intestinal health. This had been ordered on 11/3/23 and continued until the resident's final discharge. (This is a probiotic supplement.) According to the record, Resident # 1 had both a chemistry (a type of blood test) and complete blood count completed on 1/30/24. Although not all inclusive some of the results showed the following: BUN (blood urea nitrogen) 56.3 (Normal range was listed as 6-20) BUN/Creatinine ratio 54.7 (Normal range was listed as 6-25) Creatinine 1.03 (.5 to 1.20) EGFT Cr PR-56 (This is an estimated glomerular filtration rate and helps determine kidney function and stages of kidney disease. The lab report noted Resident # 1's value of 56 equated to Stage 3 chronic kidney disease). Review of Resident # 1's bowel log sheet revealed between the date of 3/1/24 to 3/18/24 there were 35 entries made by Nurse Aides (NAs). Of the 35 entries, 29 noted Resident # 1's bowel movements were loose/diarrhea, 4 noted Resident # 1's bowel movements were normal/formed, one noted Resident # 1's bowel movements were putty like, and one noted not applicable. On 3/11/24 NP # 1 noted in a progress note that Resident # 1 was seen, was in no acute distress, and had no concerns at the time of the visit. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/24 Resident # 1 was seen by NP#1. NP # 1 noted in a progress note the resident had no acute concerns. On 3/13/24 Resident # 1 was seen by an infectious disease physician for an outside consultation regarding her chronic osteomyelitis. According to the consult report, the infectious disease physician recommended Resident # 1 to receive two new antibiotics. The first was Daptomycin 540 mg (milligrams) intravenously once a day for osteomyelitis of the sacrum and vertebrae for two weeks. The second antibiotic was Ertapenem 1 gram intramuscularly once every day for two weeks. (Ertapenem is an antibiotic which falls in the classification of carbapenem antibiotics.) Resident # 1's allergy to carbapenem was noted on the infectious disease consultation with a notation that the resident's reaction was unknown. On 3/13/24 at 3:41 PM Resident # 1's Unit Manager made a nursing entry documenting she called for a placement of a midline catheter for Resident # 1, and the company, which placed midlines, would be out on 3/14/24 to place the midline. (A midline catheter is a type of intravenous access which allows the intravenous catheter to stay in for longer periods of time for intravenous fluids and/or antibiotics to be administered). On 3/13/24 at 4:55 PM Resident #'1 s Unit Manger signed off on a note in the record that the system had identified a possible drug allergy for Ertapenem. On 3/13/24 at 5:29 PM there was a nursing notation that Resident # 1's facility physician had approved the infectious disease doctor's orders. The Unit Manager was interviewed on 4/18/24 at 9:20 AM and reported Resident # 1's physician had been present in the facility on 3/13/24 and had reviewed the infectious disease physician's recommendations and given his approval. The physician was interviewed on 4/18/24 at 4:00 PM and reported the following. In regards to the resident receiving Ertapenem while also having a flagged drug allergy to Carbapenems, the physician felt that the infectious disease physicians would have been diligent in reviewing the resident's history and saw that the medication had been tolerated in the past. If the resident had a true allergy to Ertapenem, then this would manifest itself within hours of the first administration of the medication. The physician reported at times, residents can report an allergy which in reality is more of a side effect to a medication. During an interview with the consultant pharmacist on 4/19/24 at 12:30 PM the pharmacist reported individuals can say they have a reaction but not recall what the reaction was and then the drug becomes part of an allergy list. If the infectious disease physician felt the benefit of Ertapenem was more advisable than the risk, then the pharmacist did not think the medication should have been avoided. If the resident was to have a reaction, then it would be expected to manifest soon after the initial administration. It would be hard to rule out whether medical changes that happened a few days after the initial dose were related to the antibiotic. Review of the Ertapenem's drug prescribing information located on the Federal Drug Administration's website revealed two of the most common adverse reactions were diarrhea and nausea. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to Resident # 1's March 2024 medication administration record both the Daptomycin and the Ertapenem antibiotics were begun on 3/14/24 and given daily from 3/14/24 through 3/18/24. Also, according to the March 2024 Medication Administration Record, no PRN Loperamide doses were given in the month of March and the resident continued to receive her daily scheduled doses of Magnesium Oxide from 3/1/24 to 3/18/24. On 3/15/24 NP # 1 noted in a progress note she saw Resident # 1 and the resident was noted to be in no acute distress and had no concerns. On 3/16/24 (Saturday) at 4:20 AM Nurse # 4 documented in a nursing entry that Resident # 1 was on antibiotics without any signs of adverse reactions. Nurse # 4 also documented Resident # 1 remained afebrile with a temperature reading of 97.8. On 3/16/24 (Saturday) at 2:58 PM Nurse # 2 documented a nursing entry noting Resident # 1 remained on antibiotics and had no adverse reactions. The resident's temperature was 97.5. Nurse # 2 was interviewed on 4/17/24 at 2:50 PM and 3:20 PM and reported the following. She had cared for Resident # 1 between the hours of 7 AM and 7 PM on 3/16/24 (Saturday). She did not recall that Resident # 1 had any problems on that day during her care. On 3/16/24 at 8 PM Nurse # 1 documented on Resident # 1's MAR that she administered Ondansetron 4 mg per the oral route. This was per an order that had originated on 11/3/23 for PRN (as needed) use for nausea. On 3/16/24 at 9:16 PM Nurse # 1 documented a nursing entry noting the following information. Resident # 1 was actively vomiting. She had administered oral PRN nausea medication and it had been ineffective. The NP was notified and ordered Resident # 1 receive Ondansetron by the IM (intramuscular) route and to follow up if not effective. On 3/16/24 Nurse # 1 documented on Resident # 1's March 2024 MAR that she administered Ondansetron 4 mg intramuscularly per a one- time order at 9:19 PM. Nurse # 1 was interviewed on 4/18/24 at 11:12 PM and reported the following information. She had cared for Resident # 1 on 3/16/24 beginning at 7 PM until 7 AM on 3/17/24. Her vital signs had been stable. She did not recall any problems in the nursing report about the resident having problems during the prior shift. At the beginning of the shift Resident # 1 had been nauseated and vomited. The oral medication was not helping and therefore she called the on- call provider who gave an order that the Ondansetron could be administered by an IM injection. She administered it by the IM route and that helped. The resident's vomiting ceased after that. Nurse # 1 was further interviewed about Resident # 1's bowel movements and reported the resident was alert and oriented. The resident had not said anything about bowel problems or diarrhea. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Aide (NA) # 5 had cared for Resident # 1 on 3/16/24 (Saturday) and 3/17/24 (Sunday) from 7 PM to 7 AM. NA # 5 was interviewed on 4/17/24 at 3:40 PM and reported the following information. She recalled that either on Saturday or Sunday night, (but not both) the resident had been very nauseated. It kept coming up and she was vomiting noodles she had eaten. During the first two times she vomited there was a lot of emesis but then it grew smaller in the amount as she continued to vomit. She (NA # 5) knew the nurse called and talked to the NP and gave Resident # 1 some medication. In the morning hours the vomiting stopped. NA # 5 was further interviewed about Resident # 1's bowel movements and reported Resident # 1's stools were runny all the time. That was her normal bowel pattern. While changing her, the stool would keep coming at times. This was not unusual for the resident. This pattern had been the same both nights she cared for Resident # 1 on 3/16/24 and 3/17/24. The NA reported Resident # 1 could have stools five to six times per shift. On 3/17/24 at 9:30 AM Nurse # 2 documented the following information in a nursing entry. Resident # 1 was nauseated and vomited undigested food one time. She administered Ondansetron at 9:12 AM. According to Resident # 1's March 2024, the Ondansetron was administered at 9:12 AM by Nurse # 2. A review of Resident # 1's vital sign logs revealed the following values for 3/17/24. Blood pressure 109/60; pulse 96; and temperature 98.1. Nurse # 2 was interviewed on 4/17/24 at 2:50 PM and 3:20 PM and reported the following information. On 3/17/24 (Sunday) she cared for Resident # 1 from 7 AM to 7 PM. She (Nurse # 2) could tell Resident # 1 did not feel her best but she was alert and talking. The night shift staff had reported Resident # 1 had vomited on their shift. Resident # 1 was able to take her morning medications. Breakfast arrived and she ate but then vomited undigested food. She (Nurse # 2) administered the Ondansetron orally and she also called to let the on-call NP know Resident # 1 had vomited on her shift after having vomited on the previous shift also. She (Nurse # 2) asked the NP if it could be the antibiotics, but the NP did not think so. She (Nurse # 2) obtained an order for some IM promethazine (another medication used to treat nausea and vomiting) as needed if the nausea continued. The resident did not throw up again after breakfast and she did not have to administer the promethazine. Nurse # 2 was interviewed about Resident # 2's bowel movements and reported she had one loose stool of which she was aware that day. The Nurse Aide had been at lunch, and she had provided incontinent care herself to Resident # 1. The NAs had not reported any further bowel movements and she did not think Resident # 1 was having diarrhea. Nurse Aide # 6 had cared for Resident # 1 from 7 AM to 7 PM on 3/16/24 (Saturday) and 3/17/24 (Sunday). NA # 6 was interviewed on 4/17/24 at 4:40 PM and reported the following information. She did not recall anything about the resident vomiting. She had routinely cared for the resident since the previous year. The resident routinely had loose stools. That was her normal pattern. She would often check on her because she knew the resident's stools were loose. She had a lot of watery stools on a regular basis. When turning Resident # 1 at times she had to jump back because the stool would start coming. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to Resident # 1's bowel log sheet, NA # 7 had also documented an entry on 3/17/24. NA # 7's entry noted on 3/17/24 Resident # 1 had a normal/formed stool. NA # 7 was interviewed on 4/23/24 at 2:57 PM and reported the following information. Although she was not assigned to Resident # 1 on 3/17/24 she at times helped NA # 6 turn Resident # 1 and provide incontinent care as they worked as a team. At times Resident # 1 could have a formed stool in the morning hours and as time went on throughout the day, it would become loose and watery. The resident had required frequent changing and at times the stool was so loose it would run out of her brief. NP # 2 was interviewed on 4/23/24 at 2:20 PM and reported the following information. She had taken the call when Nurse # 2 had called on 3/17/24. She was not the routine NP at the facility, but she was able to access the digital record if needed. During the interview, NP# 2 reviewed 3/17/24 on call notes which she could access from the call. The notes indicated the conversation had included that the Ondansetron had not been effective and promethazine was ordered. NP # 2 stated if the nurse had asked her if she thought the antibiotics were causing the nausea and vomiting, then she would have replied that she did not know rather than just saying that they were not. NP # 2 was interviewed regarding whether she recalled if she was told Resident # 1 was having diarrhea in addition to the nausea and vomiting, and NP # 2 replied she did not recall that being shared. The NP reported if this had been told to her, then she would have dug a little deeper into what was going on to see if an IV needed to be started to avoid dehydration. The NP was interviewed regarding whether it had been brought to her attention during the on- call phone call that one of Resident # 1's antibiotics which had been recently started also had a possible allergy alert. NP # 2 did not recall that being shared with her. On 3/18/24 at 4:27 AM Nurse # 4 documented the following information in a nursing entry. The resident had experienced two episodes of nausea and vomiting. The resident was given IM promethazine and it had been effective. There had been no continuation of her vomiting at the time of the nursing entry made at 4:27 AM. The resident continued on her antibiotics for osteomyelitis. Resident # 1's family member had visited and requested that labs be drawn for the resident. The nurse had called the on- call provider and obtained orders for a CBC (complete blood count) and a CMP (complete metabolic count) to be done. Nurse # 4 had cared for the resident beginning at 7 PM on 3/17/24 (Sunday) until 7 AM on 3/18/24 (Monday). Nurse # 4 was interviewed on 4/17/24 at 4:20 PM and reported the following information. At the first of the shift during report, the previous nurse had reported the resident had some vomiting. She had been told the Ondansetron had not been effective and therefore the previous nurse had called and gotten an order for the promethazine. During her (Nurse # 4's) shift, Resident # 1 vomited twice during one episode back- to -back. The first time it was a significant amount. The second time she vomited a few minutes later and it was clear emesis. Both amounts were less than an emesis basin. She administered promethazine and the resident had no further vomiting that shift. She knew the resident had a general GI diagnosis and she frequently had stool. They were not runny bowel movements, but they frequently came. The resident's family member visited and asked about lab work on Sunday (3/17/24) evening. She (Nurse # 4) looked and saw that no labs had been done since January. She called the provider and consulted about possible labs. She obtained orders for labs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 1's family member was interviewed on 4/17/24 at 11:51 AM and reported the following information. She visited Resident # 1 on the evening of 3/17/24. The resident had been vomiting and experiencing diarrhea. The family member stated she was aware dehydration could affect kidney function, and she was concerned about the resident's kidney function with the fluids she was losing in her stool and emesis. She talked to the nurse who said she would talk to the practitioner. NP # 3 was interviewed on 4/23/24 at 1:05 PM and reported the following information. She had taken the call on the evening of 3/17/24. She did not routinely provide services for the facility and did not have access to the resident records. Therefore, she relied on whatever the staff told her as she was making decisions. According to notes she could access from the 3/17/24 call, the facility had called and asked about getting lab work for Resident # 1 on 3/17/24. She did not recall specific details of the on-call conversation. Review of labs revealed a CBC and CMP were drawn on 3/18/24 at 8:10 AM. The reported time of the CBC results was at 4:23 PM. The reported time of the chemistry lab results was 8:58 PM. Although not all inclusive some of the results were. WBC 27.8 (Normal noted as 4.1-10.9.) (An elevated amount at times indicates possible infection. Creatinine-2.67 (Normal range .5 to 1.20) K- 4.2 (Normal range 3.3-5.1) BUN-64.5 (Normal range 6.0-20.0) eGFR Cr Pro-18 (Indicates Stage 4 chronic kidney disease) On 3/18/24 at 10:10 AM Nurse # 3 noted in a nursing entry that Resident # 1 was abnormal and weak. She had spoken to the NP (NP # 1) and asked for an assessment. Orders had been given to start an IV of Normal Saline at 100 ml (milliliters)/hour. Review of orders revealed an order for the normal saline at 100 ml/hour for 500 ml. According to the MAR, this began on 3/18/24 at 12:31 PM. Nurse # 3 was interviewed on 4/18/24 at 8:52 AM and reported the following information. The resident was alert but weak on 3/18/24. She did not have any vomiting. She was able to take her medications. As the day went along, she seemed to get weaker. She normally did not eat breakfast. She ate a few bites for lunch, and she did drink a little bit. She (Nurse # 3) did not see any signs of outward dehydration. She did not know about her bowel movements. The resident did not have a specific complaint. She (Nurse # 3) asked NP # 1 to look at the resident, and NP # 1 ordered the IV fluids which were started. On 3/18/24 at 7:07 PM the Unit Manger noted Resident # 1 was flushed. Her vitals registered temperature 97. 8, pulse 91 (normal range 60-100), respirations 22 (normal range 10 to 20), and blood pressure 105/46 (previous day's reading on 3/17/24 registered 109/60). She had cyanosis (bluish discoloration of the skin originating from a less oxygenated blood flow) to her oral mucosa (the lining of the mouth) and her speech was garbled. She appeared confused. The NP was contacted about the change and CBC results that had been returned. The NP ordered the resident be sent to the ER. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Unit Manger interviewed on 4/17/24 at 4:45 PM and reported the following information. On Monday, 3/18/24, the resident was alert and would say she felt alright when asked. The UM stated the resident looked weak, and the NP had seen her that AM (3/18/24). Later in the day on 3/18/24 Nurse # 3 had noticed a change in the resident. Her vital signs were stable, but her color had changed. They felt she was just not herself. She was talking but not in complete sentences. They called and got an order to send Resident # 1 to the hospital for evaluation. NP # 1 was interviewed on 4/18/24 at 10:00 AM and on 4/23/24 at 1:40 PM and reported the following. As NPs they are taught to intervene to try to stabilize residents until a resident can be seen in person. If a resident is vomiting and having diarrhea, then they can lose fluids rapidly and become dehydrated quickly. Antibiotics in general can cause diarrhea. She did see Resident # 1 on 3/18/24. At that time, the resident appeared to be a little dehydrated and was not herself but was not critically ill. The facility tried to keep residents in the facility when they could and provide care. She ordered fluids for the resident via IV route on 3/18/24. Labs were also pending. In regard to her chronic diarrhea, the resident had been on Xifaxan at one time and it would have helped slow down some of her loose stools because at times it is given to help irritable bowel syndrome. She had discontinued the Xifaxan because the resident had refused to take it. Regarding the resident's daily Magnesium Oxide, she had not considered that it might be contributing to the resident's loose stools. In assessing diarrhea, the NP thought it beneficial to clarify exactly how stool appeared. The NP reported at times residents can have stools that are not truly formed but not considered to be diarrhea because of chronic gastrointestinal problems and it is important to validate the consistency of stools. The NP stated in some clinical settings, there are classification scales used to classify the consistency so treatment can be better determined. Review of hospital ED (Emergency Department) notes, dated 3/18/24 revealed Resident # 1 vomited in the ED and had copious amounts of nonbloody yellow loose stool. She was alert to voice but would quickly fall asleep. IV fluids and diagnostic tests were done in the ED. The ED physician further noted, Her condition appears significantly improved after receiving IV fluids. Suspect a significant amount of dehydration but also underlying concern for acute intra-abdominal infection, sepsis, possible pneumonia. Bowel obstruction etc. are all strongly considered. One of the diagnostic tests was a CT (computerized topography) of the abdomen which showed a distal small bowel obstruction with single point transition within the right lower quadrant. adjacent to an ileocecal anastomotic staple line suggesting an underlying adhesion in this location. (Adhesions are bands of scar tissue in the abdomen that form between structures that are not typically together). According to the hospital record, supportive care was provided by giving IV fluids and antiemetics (medications for nausea) for the obstruction. No further intervention was needed for the obstruction. Further review of hospital records revealed the resident was found to have had a new stroke also. An infectious disease consult was also initiated regarding the resident's antibiotics due to osteomyelitis and suspected sepsis. The resident was hospitalized from 3/18/24 until her discharge on 4/4/24. According to the 4/4/24 hospital discharge summary her primary problem had been severe sepsis with lactic acidosis. (A condition in which lactic acid builds up in an individual's bloodstream due to a lack of oxygenated blood to an individual's tissues or an individual's inability to metabolize the lactate). According to the discharge summary it was not clear whether the resident's sepsis was due to her sacral osteomyelitis or an intra-abdominal infection. She was discharged to another care facility under palliative care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview with the consultant pharmacist on 4/19/24 at 12:30 PM the pharmacist reported the following. Magnesium can potentially contribute to diarrhea. Magnesium oxide is usually better tolerated than magnesium citrate, and there were no recommendations to routinely check magnesium levels for residents receiving supplementation. Resident # 1's dosage was an appropriate dosage. The physician was interviewed on 4/18/24 at 4:00 PM and reported the following. The resident had become septic regardless of multiple antibiotics and this led to her hospitalization on [DATE]. He felt the resident had multiple medical problems and the facility had done everything they could for her in a skilled nursing facility setting prior to her transfer to the hospital. The physician further reported that a large contributing factor to kidney problems are high potassium levels, and in both the January and March 2024 lab values Resident # 1's potassium levels were within normal range. Regarding the resident's diarrhea, the physician reported that given the resident's history of stercoral colitis, then constipation would need to be avoided as well while trying to manage her gastrointestinal problems.

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NAME OF PROVIDER OR SUPPLIER Alamance Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1987 Hilton Road Burlington, NC 27217	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 38077 Based on observations, record review, resident and staff interviews, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification/complaint investigation surveys dated 11/2/23 and 5/27/21; and for the complaint investigation surveys dated 7/6/23, 1/17/23, 3/31/22, and 12/13/21 in order to achieve and sustain compliance. These were for recited deficiencies on a recertification and compliant survey on 4/23/24. The deficiencies were in the following areas: Quality of Care, Bowel/Bladder Incontinence, Catheter, UTI, and label/ store drugs and biologicals. The continued failure during federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: 1. F684: Based on record review and interviews with the staff, family member, physician, and nurse practitioners the facility failed to ensure effective communication occurred amongst staff and providers when a resident, who had chronic diarrhea, also began to have multiple episodes of nausea and vomiting in addition to the diarrhea. This was for one (Resident # 1) of one sampled resident reviewed for acute medical changes. During a previous recertification and complaint investigation on 11/2/23, the facility failed to determine or assess the need to continue daily bedside blood sugar monitoring for an insulin dependent resident with numerous comorbidities for 1 of 3 residents reviewed for diabetic blood glucose monitoring. During a previous complaint investigation on 7/6/23, the facility failed to coordinate care for a resident with a seizure disorder. The resident's valproic acid medication dosage was decreased by a Psychiatric Nurse Practitioner who believed it only to be used for mood stabilization and who was unaware the medication was being using for seizure control. There was no communication with the medical provider before the change. The resident seized, was hospitalized , and intubated following the dosage decrease. Prior to transport to the hospital, the resident's seizure was documented to not respond to intramuscular Ativan medication and lasted approximately 28 minutes before emergency medical services arrived for care and transport. This was for one of three sampled residents reviewed for seizure medications. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a previous complaint investigation on 1/17/23, the facility failed to identify the seriousness of 3rd degree facial burns when staff did not provide continuous monitoring of Resident #1's vital signs or assess the resident to determine the need for nursing or medical interventions until EMS arrived. The resident sustained second- and third-degree flame burns to both sides of his face, both ears, left chest, left upper arm, left forearm, and back of left hand. Additionally, the low outdoor temperature on 01/07/23 was recorded as 29-degrees Fahrenheit, and the resident was only wearing thin pajama pants and a short sleeve shirt while outside. The resident was described by EMS records as being slouched/slumped over in his wheelchair when they arrived, and he was pulseless and not breathing. EMS personnel immediately began cardiopulmonary resuscitation (CPR) once inside the ambulance. The resident went into cardiac arrest twice, required intubation, and became comatose due to his injuries. The resident expired on 01/12/23. This deficient practice occurred for 1 of 3 residents reviewed for supervision to prevent accidents. During a previous complaint investigation on 3/31/22, the facility failed to complete full body skin assessments, including resident's genitalia, back and lower legs for 1 of 8 sampled residents. On 3/13/22, the resident was sent to the emergency department (ED) for evaluation and the ED records indicated the Resident had significant swelling of his scrotum and groin, multiple excoriations to his foreskin with active bleeding, two sacral pressure ulcers and multiple skin discolorations over the body. In addition, an identification band (ID) band was imbedded in his back and a toenail partially lifted when they removed his compression hose. During a previous complaint investigation on 12/13/21, the facility failed to change treatment orders after a podiatry visit, consistently provide wound care, and provide consistent wound care assessments for one of one resident reviewed for a non-pressure wound. 2. F690: Based on observations, resident and staff interviews, and record review, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 1 of 3 residents (Resident #129) reviewed with urinary catheters. During a previous complaint investigation on 3/31/22, the facility failed to manage the care for a condom catheter; the facility had knowledge the resident was applying a condom catheter independently without a physician's order and wrapping medical tape around the condom catheter; the facility failed to consider alternative interventions for the resident's urinary incontinence for 1 of 2 residents reviewed for urinary catheters. On 3/13/22 the resident arrived at the Emergency Department (ED) with significant swelling of his scrotum and groin and his condom catheter was extensively taped with medical tape. The condom catheter was removed immediately on arrival due to concerns for compromised circulation to the penis and scrotal area. Blood was observed coming from his penis when the catheter was removed. The skin assessment in ED described multiple excoriated lesions to his foreskin with active bleeding. Resident #7 was admitted due to suspected septic shock. During a previous complaint investigation on 12/13/21 the facility failed to obtain a physician's order and a diagnosis for the use of an indwelling urinary catheter for one of one resident reviewed for catheter use. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Alamance Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1987 Hilton Road Burlington, NC 27217	

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. F761 : Based on observations, staff interviews, and record reviews, the facility failed to: 1) Store medications in accordance with the manufacturer's storage instructions on 2 of 4 med carts (Teal South Med Cart and Mauve 2 South Med Cart); 2) Dispose of loose, unidentified tablets observed in the drawer of 1 of 4 medication carts (Teal South Med Cart); 3) Label a medication stored in 2 of 4 med carts with the minimum information required, including the resident's name (Teal South Med Cart and Mauve 2 South Med Cart); 4) Discard expired medication stored on 1 of 4 medication (med) carts (Teal South Med Cart); and 5) Date a vial of injectable medication as to when it was opened to allow for the determination of its shortened expiration date in 1 of 2 medication storage rooms observed (Teal Med Room). During a previous recertification and complaint investigation on 11/2/23 the facility failed to: 1) Accurately label medications (meds) to determine their shortened expiration date in accordance with the manufacturer's instructions on 3 of 4 med carts (Teal Middle Med Cart, Mauve 1 South Med Cart, and Mauve 2 North Med Cart) and 1 of 2 medication store rooms (Mauve 1 Med Room) observed; 2) Discard expired medications and/or meds without a legible expiration date on 1 of 4 medication carts (Teal Middle Med Cart) and 1 of 2 medication store rooms (Mauve 1 Med Room) observed; 3) Label medications with the minimum information required, including the name of the resident, on 1 of 4 medication carts (Mauve 2 North Med Cart) observed; 4) Store medications in accordance with the manufacturer's storage instructions on 1 of 4 medication carts (Mauve 1 South Med Cart) observed. During a previous recertification and complaint investigation on 5/27/21, the facility failed to provide the date medications were opened stored in 3 of 6 medication administration carts; failed to remove expired medications stored in 2 of 3 medication storage rooms (Mauve1, Teal North and Teal South halls). During an interview on 4/4/24 at 4:03 PM, the Administrator stated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits, and monitors that plan and 4) discusses the outcome. System changes and additional tasks would be put in place as needed to resolve the issue. Regarding the repeated deficiencies, the Administrator stated depending on the areas of the concerns the facility will determine the team members and a team lead. The Administrator would be part of the team. The Administrator stated the old plan of correction would be revisited and analyzed to see where the failures and breakdowns happened. This would help analyze the cause of repeat deficiency. The team leader will interview staff and residents (if applicable) to determine what changes need to be made. He indicated once the facility identified the changes that need to be made then a plan of correction was written. The policies and procedures would be reviewed. The plan would involve identifying staff or residents that may have been affected. The Administrator indicated once the plan was put in place, education, audits, and the monitoring phase would be completed. The plan of corrections, audit and monitoring tools would be discussed in QA meeting and the QA committee would see how the approach can be changed if needed. This could be education and training of staff or revision of the approach or new approach if needed. The Administrator was interviewed again on 4/23/24 at 3:50 PM. The Administrator stated their Quality Assurance program, looked at outliers, tracks, and trends regarding resident care. They then develop a plan of action. If their Quality Assurance program had missed something in the care for Resident # 1, then they could revisit her care and look at what they had missed doing for the resident.