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

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077 Based on records review, and staff interviews, the facility failed to have Advance Directives (code status) in the residents' record for 1 of 1 resident reviewed for Advance Directives (Resident #44). Findings included: Resident #44 was readmitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #44 was assessed as cognitively intact. Resident #44' s care plan dated 3/25/24 indicated the resident was care planned as having an advance directive of Full Code. At the time of physician's orders review on 4/2/24, there was no active order for code status in Resident #44's Electronic Health Record (EHR). No Hard copy (paper charts) used in the facility. An interview was conducted with Nurse #2 on 4/3/24 at 10:15 AM. Nurse #2 stated the code status was usually displayed in EHR, next to the resident's picture, or in the physician's orders. Nurse #2 confirmed that there was no documentation to indicate the code status for Resident #44. During an interview on 4/3/24 at 10:32 AM, the Social Worker stated Resident #44 was readmitted to the facility on [DATE]. She indicated the Advance Directives were discussed with the resident during the jump start meeting (baseline care plan) at readmission. The resident was a Full Code and there was no change in resident's code status. The Social Worker stated she does not notify nursing if there was no change in resident's code status. The nurses were notified when there was a change in resident's code status. (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/3/24 at 12:40 PM, the Registered Nurse (RN) supervisor stated the residents Advance Directives were entered by the Nursing staff in the EHR. The RN supervisor further stated Nurses looked for a resident's code status under the resident profile, displayed next to the resident's picture in the EHR. In addition, the staff could look up the code status in the physician orders. The RN supervisor reviewed Resident #44's EHR and confirmed that there was no information regarding the resident's code status. The RN supervisor stated during any new admission or readmission, the admitting nurse would review the discharge orders and code status of the resident with the Provider. The Provider would review them and sign off or give verbal orders to be entered into the EHR. The RN supervisor indicated the admission nurse had missed the code status, resulting in no physician orders related to Resident #44's code status after her readmission to the facility. The RN supervisor stated the Social Worker (SW) and /or Social Worker Assistant would ensure the resident's code status was reviewed with the resident and /or resident's representative and if changes were made then the Nurse were notified for appropriate action. During an interview on 4/3/24 at 11:15 PM, Nurse Practitioner #1 stated that the admitting nurse would review the discharge medication and code status at the time of the admission / readmission from the discharge summary for any resident admitted to the facility. The admission nurse would then notify the Nurse Practitioner. The Nurse Practitioner stated the order was signed, and/or verbal approval given. The admission staff would then enter the information in the resident's EHR. She was unsure about the code status for Resident #44. During an interview on 4/4/24 at 3:50 PM, the Director of Nursing (DON) stated the resident's code status should be entered in the resident's electronic medical record at admission and/or readmission by the admitting nurse. The DON further stated Resident #44 should have a physician's order regarding the code status entered in their medical records. Resident #44' s code status may have been missed during the readmission by the admission nurse as it was not changed during the recent hospitalization .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 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. The findings included: Resident #129 was admitted to the facility on [DATE]. Her cumulative diagnoses included Stage 4 pressure ulcers of the right buttock and right thigh, and a history of urinary tract infections (UTIs). The resident's current care plan included an area of focus which indicated the resident required a urinary catheter related to wounds (Created on 10/15/23; Revised on 12/27/23). Resident #129 had a history of repeated UTIs requiring treatment with antibiotics on 11/29/23 to 12/6/23, 12/29/23 to 1/5/24, 1/29/24 to 2/5/24, and 2/14/24 to 2/21/24. A review of Resident #129's most recent Minimum Data Set (MDS) was a significant change MDS assessment dated [DATE]. The MDS reported Resident #129 was cognitively intact. She was independent for eating, required supervision or touching assistance for personal hygiene, and substantial / maximum assistance for dressing her lower body. The resident was dependent on staff for all her remaining Activities of Daily Living (ADLs). The MDS assessment indicated Resident #129 had an indwelling urinary catheter. Multiple observations were conducted of Resident #129's urinary catheter bag either touching or partially lying on the floor of the resident's room. The urinary catheter bag did not have a detachable cover. These observations were as follows: --On 4/1/24 at 1:20 PM, an observation was made of Resident #129 as she was lying in bed. Her urinary catheter bag was touching the floor as it hung from the bed frame. --On 4/1/24 at 3:50 PM, the resident's urinary catheter bag was observed with approximately one inch of the bag lying on the floor of the resident's room as she was lying in her bed. --On 4/2/24 at 10:47 PM, the resident's urinary catheter bag was again observed to be touching the floor of the resident's room as she was lying in her bed. --On 4/2/24 at 12:41 PM, an observation was made of Resident #129 as she was lying in her bed. Approximately 1/4 of her urinary catheter bag was observed to be lying on the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Accompanied by Nurse #5, an observation was made on 4/2/24 at 12:44 of the resident's urinary catheter bag partially lying on the floor beside her bed. Nurse #5 was the hall nurse assigned to care for Resident #129. Upon viewing the catheter bag, the nurse was asked to share her thoughts about the placement of his catheter bag. The nurse reported the catheter bag should not be on the floor. She stated that sometimes the resident lowered the bed, resulting in the urinary catheter bag touching the floor. Resident #129 had an electric bed with a control pad, which enabled her to raise and lower the bed independently. An interview was conducted on 4/3/24 at 1:00 PM with Resident #129. At the time of the interview, the resident's urinary catheter bag was appropriately positioned below the level of the resident's bladder and off the floor. When the resident was asked about the placement of her urinary catheter bag, the resident reported she had not been previously aware that her catheter bag was lying on the floor if she lowered her bed to the lowest level. The resident stated now that she was aware of the concern, she did not lower the bed down to its lowest position. An interview was conducted on 4/4/24 at 1:53 PM with the facility's Registered Nurse (RN) Supervisor. During the interview, the RN Supervisor was asked what education was typically provided to nursing staff about the positioning of a urinary catheter bag. She reported staff were educated to ensure a urinary catheter bag was not on the floor and if the bag was hung on the bed frame, the bed should be raised to a level where the bag was off the floor.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 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). The findings included: 1. An observation was conducted on [DATE] at 3:15 PM of the Teal South Medication (Med) Cart in the presence of Nurse #6. The observation revealed the following medications were stored on the med cart: a. The manufacturer's storage instructions for neomycin, polymyxin B, and 0.1% dexamethasone ophthalmic suspension (a combination antibiotic and steroid eye drop medication) indicated the eye drop bottle should be stored in an upright position. An unopened bottle of neomycin, polymyxin B, and 0.1% dexamethasone ophthalmic suspension eye drops dispensed from the pharmacy for Resident #25 on [DATE] was stored lying on its side in the medication cart. The manufacturer's storage instructions were observed to be printed on the label of the eye drops. An interview was conducted with Nurse #6 on [DATE] at 3:20 PM. When asked about the storage of the ophthalmic suspension eye medication, Nurse #6 reported she was not aware that these eye drops should be stored in an upright position. b. Five (5) loose, unidentified tablets were observed to be lying on the bottom of a medication cart drawer. An interview was conducted with Nurse #6 on [DATE] at 3:20 PM. At that time, Nurse #6 reported the loose, unidentified tablets needed to be discarded. An interview was conducted with the facility's Registered Nurse (RN) Supervisor on [DATE] at 2:44 PM. During the interview, the Nurse Supervisor reported the manufacturer's storage instructions for the suspension eye drops were probably new to the facility's staff. She indicated the nursing staff would need to be educated on these instructions. When asked, the RN Supervisor also reported the medication carts should be cleaned after each shift and any loose tablets or capsules discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Accompanied by Nurse #7, a second observation was conducted of the Teal South Med Cart on [DATE] at 10:32 AM. The observation revealed two opened manufacturer bottles of 145 micrograms (mcg) Linzess capsules (a prescription gastrointestinal agent used to treat constipation and irritable bowel syndrome) were stored in the top drawer of the med cart along with the facility's over-the-counter stock medication bottles. Neither of the medication bottles were labeled with the minimum required information, including the name of the resident the medication was dispensed for. The first bottle contained 6 capsules and had a manufacturer expiration date of [DATE] (indicative of an expired medication). The second bottle of Linzess capsules (observed to be almost full) was not expired. An interview was conducted with Nurse #7 on [DATE] at 10:40 AM. When asked, the nurse confirmed one bottle of Linzess capsules was expired and needed to be removed from the med cart. During a follow-up interview conducted on [DATE] at 12:37 PM with Nurse #7, the nurse reported she had removed the expired bottle of Linzess. However, the second opened bottle of Linzess capsules remained on the medication cart. Nurse #7 stated both bottles of Linzess were likely dispensed from the pharmacy in a labeled, plastic bag that had been inadvertently discarded. The nurse reported she understood the medication bottle needed to be labeled with the minimum required information (including the resident's name) and that she would share this concern with a supervisor. An interview was conducted with the facility's Registered Nurse (RN) Supervisor on [DATE] at 2:44 PM. During the interview, the Nurse Supervisor reported, We always tell them [nurses] to ensure the meds are labeled with the correct resident's name. 3. An observation was conducted on [DATE] at 11:06 AM of the Mauve 2 South Medication (Med) Cart in the presence of Nurse #2. The observation revealed the following medications were stored on the med cart: a. The manufacturer's storage instructions for 1% prednisone acetate ophthalmic suspension (a steroid eye drop medication) indicated the eye drop bottle should be stored in an upright position. Two bottles of 1% prednisone acetate ophthalmic suspension eye drops dispensed for Resident #106 were observed to be stored lying on their side in a drawer of the medication cart. An interview was conducted with Nurse #2 on [DATE] at 11:10 AM. During the interview, the nurse reported she was not previously aware of the need to store suspension eye drops in an upright position. Nurse #2 stated she could place the eye drop bottle in a disposable cup to hold it upright. b. One vial of 0.5 milligrams (mg) / 3 mg per 3 milliliters (ml) of ipratropium bromide / albuterol inhalation solution (a prescription medication administered via nebulization for the treatment of asthma or chronic obstructive pulmonary disease) was stored in an individual foil package on the med cart. The vial was not labeled with the minimum information required, including the name of the resident the medication had been dispensed for. An interview was conducted with Nurse #2 on [DATE] at 11:10 AM. When asked who the vial of ipratropium bromide / albuterol inhalation solution belonged to, Nurse #2 stated, I have no idea. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the facility's Registered Nurse (RN) Supervisor on [DATE] at 2:44 PM. During the interview, the Nurse Supervisor reported the manufacturer's storage instructions for the suspension eye drops were probably new to the facility's staff. She indicated the nursing staff would need to be educated on these instructions. When asked, the RN Supervisor also stated, We always tell them [nurses] to ensure the meds are labeled with the correct resident's name. 4. The manufacturer's storage instructions for a multi-dose vial of Tuberculin PPD injectable medication indicated that once opened the product should be discarded after 30 days. An observation was conducted on [DATE] at 3:23 PM of the Teal Med Room in the presence of the Unit Manager for the Teal halls. The observation revealed one opened multi-dose vial of Tuberculin PPD injectable medication (used for skin testing in the diagnosis of tuberculosis) was stored in the med room refrigerator. Neither the vial nor the manufacturer box it was stored in were labeled as to when the vial had been opened. The labeling on the manufacturer's box indicated a vial of PPD solution in use for more than 30 days should be discarded. Upon request, the Unit Manager examined the vial and manufacturer box. She confirmed no date was written on the vial or box to indicate when it had been opened. The Unit Manager reported the vial should have been dated when opened, noting it was not supposed to be kept more than 30 days after opening. She reported she would discard this vial. An interview was conducted with the facility's Registered Nurse (RN) Supervisor on [DATE] at 2:44 PM. During the interview, the Nurse Supervisor reported the vial of Tuberculin PPD injectable medication should have been dated when opened.

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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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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.