STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	C 08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4145 HAYWOOD ROAD MILLS RIVER, NC 28759

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D 000	Initial Comments The Adult Care Licensure Section and the Henderson County Department of Social Services completed a complaint survey on 08/06/19, 08/07/19 and 08/08/19.	D 000		
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: TYPE A2 VIOLATION Based on record reviews and interviews the facility failed to implement a physician's order related to keeping a dementia resident inside the facility for 1 of 5 residents (Resident #1) resulting with the resident being found outside for an undetermined amount of time and being sent to the hospital for dehydration and heat exhaustion. The findings are: Review of the current FL2 for Resident #1 dated	D 276		

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01/30/19 revealed:
Diagnoses included: dementia, developmental venous anomaly, chronic obstructive pulmonary disease, hypertension, vitamin D deficiency, hyperlipidemia.
-The resident was constantly disoriented and had wandering behaviors.
-The resident was ambulatory.
-The resident's current level of care was other assisted living facility.

Review of a physician's note for Resident #1 dated 10/18/18 revealed diagnosis of "skin cancers-type not specified".

Review of Resident #1's care plan dated 09/26/18 revealed:
-The resident had significant memory loss and had wandering behaviors.
-The resident was independent with ambulation.

Review of the physician's orders for Resident #1 revealed:
-Order dated 05/29/19 please limit outdoor sun exposure in elevated temperatures, please use sunscreen when outside.
-Order dated 06/18/19 please apply sunscreen when outside.

Review of physician's 6month order sheet for Resident #1 dated 06/09/19-07/09/19 revealed:
-The orders were signed by the physician on 07/10/19.
-An order to notify the physician if temperature was greater than 100 degrees Fahrenheit (F).
-An order to increase fluids as available, keep inside for now, every shift; 7:00am-3:00pm, 3:00pm-11:00pm, 11:00pm-7:00am.

Review of the July 2019 electronic medication

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administration record (eMAR) for Resident #1 revealed:
-Clobetasol ointment (used to treat a variety of skin conditions that respond to steroids) 0.05% apply to both arms twice daily.
-Eucerin Intensive Repair Cream (used to treat dry skin) apply to both feet twice daily.
-Hydrocortisone-aloe vera cream (used to treat a variety of skin conditions to treat the swelling itching and redness of the conditions) three times daily as needed to affected area (lesions/rash).
-Keppra (used to treat seizure disorders) 40mg twice daily.
-Triamcinolone acetonide cream (used to treat the swelling, itching and redness in some skin conditions) apply to trunk twice daily.

Review of the Incident Report for Resident #1 dated 07/29/19 revealed:
-Resident #1 was seen out in the courtyard and did not respond to staff at 5:15pm.
-The type of injury documented as redness and elevated temperature.
-The type of first aide provided was cool towels.
-Vitals documented by facility staff at 6:06pm were recorded as a temperature of 104.2F, a pulse of 97 and a blood pressure of 89/45.
- Emergency Medical Service (EMS) was notified and Resident #1 was transported to the local hospital.

Review of the call report from the local EMS dated 07/29/19 for Resident #1 revealed:
-The call for EMS assistance was received at 5:47pm for a resident with heat exhaustion.
-Resident #1 "was found sitting outside in the courtyard around 5:15pm, unconscious, unresponsive and extremely diaphoretic".
-Facility staff reported to EMS Resident #1 was outside for an "unknown" period.

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D 276	Continued From page 3 -Resident #1 was assessed by EMS at 5:57pm with a noted clinical impression of "heat exhaustion". -Resident #1 was transported to the local hospital at 6:23pm. Review of the local emergency department (ED) discharge record dated 07/29/19 for Resident #1 revealed: -The chief complaint for Resident #1 was he was found unresponsive outside for an unknown period. -Resident #1 was documented at 6:31pm upon assessment in the ED as in mild distress, warm, pale, skin was pink to bright red and his mouth had dry mucous membranes. -Resident #1 received a diagnosis of dehydration. -Resident #1 was discharged from the ED at 10:55pm on 07/29/19. Review of the facility policy for Medication Administration was not provided by exit. Interview with a first shift personal care aide (PCA) on 08/07/19 at 11:55am revealed: -After Resident #1 went to the hospital the doors to the inner courtyard were locked on hot days but Resident #1 was able to go outside in the inner courtyard at any time previously. -She was not aware Resident #1 had an order to stay inside. Telephone interview with a family member for Resident #1 on 08/07/19 at 2:36pm revealed: -Resident #1 had a history of dehydration and skin cancer and was limited to very short periods of time to be outside and if he went outside Resident #1 had to have sunscreen applied. -Resident #1 had orders for prescriptions of creams to be applied for his skin conditions.	D 276		

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D 276	Continued From page 4 Interview with the facility Nurse Practitioner (NP) for Resident #1 on 08/07/19 at 3:28pm revealed: -He was probably in the later stages of dementia. -Resident #1 had a history of dehydration and skin problems. -She was notified on 07/29/19 that Resident #1 had been found by staff outside in the inner courtyard unresponsive and was being sent to the ED for heat exhaustion. -She assessed Resident #1 on 07/30/19 after he had returned from the ED. -Resident #1 was "still red" and she wrote orders for hourly rounds and fluids. -She had spoken at length with the memory care Resident Care Coordinator (RCC) about her concerns for Resident #1's sun exposure related to his previous history of dehydration and his skin issues. -There had been "some lack of follow through" by the memory care RCC on orders she had written. Telephone interview with a second shift PCA on 08/07/19 at 6:27pm revealed she was not aware Resident #1 had an order stay inside. Telephone interview with a first shift PCA on 08/07/19 at 7:28pm revealed: -Resident #1 loved to go outside and went outside every day. -The Medication Aide (MA) would tell staff if there were new orders regarding the residents. -She was not aware Resident #1 had an order to stay inside. Telephone interview with a first shift PCA/MA, on 08/07/19 at 7:47pm revealed she was not aware Resident #1 had an order to stay inside. Interview with a first shift MA on 08/08/19 at	D 276		

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D 276	Continued From page 5 9:50am revealed she was not aware Resident #1 had an order to stay inside. Interview with the RCC on 08/08/19 at 10:32am revealed: -When the NP wrote orders copies are made, the RCC would get a copy and she and the NP would review the orders together. -The RCC would then fax the orders to the facility contracted pharmacy, the pharmacy would then enter the order into the system. -The RCC was responsible to verify the orders and when the orders were completed initial and date the bottom page of the orders. -The orders were placed in the resident's record. -The RCC would inform staff of the new orders. -The RCC would inform the MA and the MA would inform the PCA's. -When the physician's 6-month order sheet was needed the RCC would enter the dates needed, then the system pulls all the current physician orders. -The RCC would print these off for the NP or physician to sign. -Once the physician orders were signed, they would be placed in the resident's record. -Any orders on the 6-month physician order sheet were current orders once they were signed by the physician or NP. -She was not aware of the 07/10/19 order for Resident #1 to "stay inside for now" or that there were previous orders for limited sun exposure. -She was not aware there was an order for Resident #1 to "stay inside for now". Interview with the Administrator on 08/08/19 at 12:30pm revealed: -The RCC's would review the orders written by the physicians. -She was not aware Resident #1 had an order to	D 276		

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D 276	Continued From page 6 stay inside. Interview with the evening supervisor, on 08/08/19 at 2:06pm revealed she was not aware Resident #1 had an order to stay inside. Telephone interview with the NP on 08/08/19 at 2:35pm revealed: -She did remember writing the order for the resident to stay inside for now. -The memory care RCC was also aware of the order for Resident #1 to stay inside. -Resident had numerous skin issues and had also been taking a medication, Keppra 300 mg twice daily for seizures. -Resident #1 had had a seizure in December 2018 and had started him on Keppra. -Dehydration can affect the Keppra levels placing the resident taking it at an increased risk for seizures. -Resident #1 had a low Keppra level per Resident #1's lab results and the NP was attempting to get his level stabilized. Interview with the MA on 08/08/19 at 4:05pm revealed he was not aware Resident #1 had an order to stay inside. Attempted telephone interview with the previous memory care RCC on 08/07/19 at 6:20pm and 08/08/19 at 9:40am was unsuccessful. The facility failed to implement a physician's order to keep a resident inside the facility resulting in a resident with dementia being found outside for an undetermined amount of time and being sent to the local emergency department for treatment of dehydration and heat exhaustion. The facility's failure resulted in substantial risk of serious physical harm and neglect and constitutes a Type	D 276		

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D 276	Continued From page 7 A2 Violation. _____ The facility provided a plan of protection in accordance with GS 131D-34 on 08/08/19 for this violation. _____ THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 09/22/19.	D 276		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision and health care. The findings are: Based on record reviews and interviews the facility failed to implement a physician's order related to keeping a dementia resident inside the facility for 1 of 5 residents (Resident #1) resulting with the resident being found outside for an undetermined amount of time and being sent to	D912		

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D912	Continued From page 8 the hospital for dehydration and heat exhaustion. [Refer to Tag 0276 10A NCAC 13F .0902(c)(4) Health Care (Type A2 Violation)].	D912		