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 |
|---|---|---|---|
| | HAL033005 | A. BUILDING: ______ B. WING ______ | 10/02/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE CARE OF ROCKY MOUNT | 1650 COKEY ROAD ROCKY MOUNT, NC 27801 |

| (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 |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual and complaint investigation survey on 9/29/15 - 10/2/15. | D 000 | | |
| D 067 | 10A NCAC 13F .0305(h)(4) Physical Environment<br><br>10A NCAC 13F .0305 Physical Environment<br>(h) The requirements for outside entrances and exits are:<br>(4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observation, interview, and record review, the facility failed to assure 2 of 6 exit door alarms were activated with sufficient volume to alert staff which resulted in 1 of 7 sampled residents (#6) who was disoriented eloping from the facility.<br><br>The findings are:<br><br>Observation upon entrance to the facility on 9/29/15 at 9:45 a.m. revealed the front entrance door did not alarm. | D 067 | | |

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Observation on 9/29/15 at 10:15 a.m. of the B Hall revealed:
- A door alarm was attached to the exit door.
- Attempt to open the door was not successful.

Interview on 9/29/15 at 11:15 a.m. with a Personal Care Aide (PCA) revealed:
- The B Hall exit door was difficult to open and required a strong push.
- As she pushed on the door it did not open but she said the alarm sounds and the location of which door was alarming was able to be detected at the entrance area nurse station.

Observation of the side door on C hall on 9/29/15 at 11:10 a.m. revealed a surveyor opened the door, the door alarmed and staff immediately checked the outside of the door for residents.

Observation on 9/30/15 at 10:36 a.m. revealed:
-Residents were constantly going in and out of the back door, which was located between C and D halls, to the smoking area on the back porch.
-The door did not alarm.

Interview with a Nurse Aide (NA) on 10/2/15 at 12:10 p.m. revealed:
-The alarms are on at all times on all of the doors except the front entrance door and the door leading to the back porch.
-The front door and back porch alarms are off during the day.
-She was unsure the times the front porch and back porch door alarms were turned on.

Interview with a second NA on 10/2/15 at 12:15 p.m. revealed:
-The alarms are on at all times on all of the door except the front entrance door and the door

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leading to the back porch.
-The front door and back door alarms are turned on and the doors are locked at 10:00 p.m.
-When residents go out the back door to smoke at night staff watch the residents.
-The alarms are turned off and the front and back doors are unlocked at 6:00 a.m.

Interview with Maintenance on 10/2/15 at 12:23 p.m. revealed:
-The side doors are alarmed all day.
-The front and back doors are alarmed and locked during third shift, possibly around 11:00 p.m. and unlocked and unalarmed at 6:00 a.m.

Review of Resident #6's current FL-2 dated 2/6/15 revealed:
-The resident's diagnoses included uncontrolled Type II Diabetes Mellitus, insomnia and schizoaffective disorder.
-The resident was constantly disoriented and ambulatory.

Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 8/29/14.

Review of Resident #6's Care Plan dated 2/6/15 revealed:
-The resident was sometimes disoriented.
-The resident had "no problems" with the upper extremities and ambulation.

Interview with Resident #6 on 9/30/15 at 5:50 p.m. revealed she had never gotten out of the facility or went anywhere with any of her roommates.

Interview with a third NA on 10/1/15 at 9:21 a.m. revealed Resident #6 had never wandered away

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from the facility.

Interview with a fourth NA on 10/1/15 at 9:46 a.m. revealed:
-One day around lunch time (12 p.m.) during the middle of the week between July 5-18, 2015, Resident #6 was about twenty feet from the front porch. Staff saw the resident and paged the NA to go and get the resident.
-Resident #6 saw staff and started running from the porch. The resident was on the left side of the breezeway.
-When the NA had gone to get the resident, the resident had gotten ten feet further from the original location.
-He talked to Resident #6 and the resident revealed "I am going to go and get my babies."
-He gave Resident #6 a cigarette. The resident smoked the cigarette and he talked the her into coming back inside of the facility.
-He had never known Resident #6 to try to leave the facility before. He remembers the incident well, because it was a very hot day. He could not remember who was on shift during the time.
-Staff constantly monitored Resident #6 to see where the resident was located or if the resident needed anything.

Interview with a Medication Aide (MA) on 10/1/15 at 10:19 a.m. revealed:
-Resident #6 had never wandered away from the facility.
-Resident #6 walked around inside of the building.
-Resident #6 walked into the parking lot and staff got the resident to come back into the facility. She could not remember when the incident happened.
-Staff monitored Resident #6 every two hours.

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Interview with a second MA on 10/1/15 at 10:36 a.m. revealed:
-Sometime between July 2015 and August 2015 before second shift (3:00 p.m.), staff had to go up the street and get Resident #6. Staff went and got the resident.
-She was not here when Resident #6 eloped from the facility.
-Resident #6 was not allowed to leave the facility unsupervised.
-Staff checked on Resident #6 every two hours.

Review of Resident #6's progress notes an entry dated 7/11/15 (no time) by a third MA revealed:
-Resident #6 had gone down the highway with the roommate.
-The resident went into a neighbor's yard and begin throwing items in the yard.
-The owner of the yard said if the resident came back into the yard she would press charges.

Telephone interview with the MA, who documented the entry in the progress notes on 7/11/15, on 10/1/15 at 12:21 p.m. revealed:
-One day around lunch time (12:00 p.m.) someone called the facility and informed them Resident #6 went up the street with another resident who no longer lived at the facility. She could not remember who called the facility. The MA immediately locked her medication cart and walked to the site where both residents were located. The transporter person drove to the site to pick up both residents. It took her less than five minutes to get to the site where the residents were located. Resident #6 was in the neighbor's yard sale upset and throwing items. Both residents rode with the transporter person back to the facility.
-Resident #6 went out the front door, made a left at the end of the drive way and was at the second

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house to the right past the cornfield.
-It would have taken Resident #6 five minutes to walk to the neighbor's yard.
-Resident #6 did not tell staff she was leaving the facility.
-She did not know who was assigned to Resident #6 on 7/11/15 when she eloped from the facility.
-She had never known Resident #6 to leave the facility.
-Resident #6 was never allowed to leave the facility unsupervised by staff.

Interview with the Transporter person on 10/2/15 at 3:40 p.m. revealed:
-One day before July 4, 2015 during the day possibly around lunch time, Resident #6 had walked out of the front door at the facility and was walking toward the end of the driveway.
-He had just returned from bringing another resident from a doctor's appointment. He was looking at the appointment book in the front Supervisor's office, he looked out the window and observed Resident #6 halfway in the parking lot heading towards the entrance of the driveway (located on the right side of the facility). He walked outside and called the resident, but she kept walking fast and did not turn around to respond to the call.
-Resident #6 walked across the street across into another driveway, which was across from the facility.
-He got in the van and picked up the resident.
-The resident admitted to trying to go home.
-Three minutes prior he had just seen Resident #6 in the hall standing near the nurses' station on A and B hall.
-He could not remember the date nor the time of the incident.

Observation on 10/2/15 at 7:00 p.m. revealed:

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-The entrance of the parking lot was on the right side of the facility.
-The entrance of the driveway to the front of the facility was between 100 to 150 feet.
-The street in front of the facility was a two way street with a speed limit of 35 miles per hour.
-There was a ditch on both sides of the street.
-Across from the facility were houses.
-To the right of the houses were a corn field, which was estimated to be 100 feet wide
-To the right of the corn field were more houses.
-The distance between the facility and the white house was one tenth of a mile.
-Beside the facility was a grassy area, a side street and apartment complexes.

Telephone interview with Resident #6's primary care physician nurse on 10/2/15 at 11:46 a.m. revealed:
-The primary care physician was not available for interview.
-The resident had dementia, but she did not know the level of dementia.
-The resident had a history of seizure disorders.
-She did not know if Resident #6 could leave the facility unsupervised.

Interview with the Resident Care Coordinator on 10/2/15 at 1:15 p.m. revealed:
-One weekend between 10:00 a.m. and 10:30 a.m., staff had to go and get Resident #6 and another resident from a neighbor's yard.
-Someone who worked at the facility told them the residents were up the street.
-The resident had gone out the front door. The door did not alarm. The resident did not want to leave the neighbor's yard. After staff had bought the resident back to the facility, the resident calmed down and said the resident "would not do it again."

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-Earlier during the day, the resident had gotten agitated because the resident wanted to go with a family member.
-When Resident #6 wanted to go with a family member, staff called the family member.
-Resident #6 would have taken 10 to 20 minutes to walk to the neighbor's yard.
It took staff 20 minutes to convince the resident to get inside of the van and return back to the facility.
-During the day, she was told Resident #6 had been crying.
-The RCC was off on the day of the incident.
-Two MAs were Supervisor's during the shift.
-She does not know when was the last time staff had seen Resident #6 before the resident eloped from the facility.
-She is always concerned about Resident #6 leaving the facility, because sometimes the resident may just try to "take off."
-Before the incident she had never known Resident #6 to elope or attempt to elope from the facility.
-The doors on the end of the hallways and the dining room are always alarmed.
-The front door was locked and alarmed when second shift left (11:00 p.m.) and unlocked and unalarmed at 5:45 a.m.
-The alarm at the back door was never turned on.
-During the day, the front and back door are not locked and alarmed, because the residents are constantly in and out of both doors.
-If residents are disoriented or a wanderer the residents are placed on 15 minute checks.
-Resident #6 was disoriented at times, but was not on 15 minute checks.

Interview with the Administrator on 10/2/15 at 4:16 p.m. revealed:
-The front and back door are not locked and

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alarmed during the day.
-All of the other doors where residents have access are locked and alarmed at all times.
-At 10:15 p.m., the front door was locked and alarmed, the back door was not locked and not alarmed so the smokers can go outside and smoke.
-The Supervisors turn off the alarm to the front door at 6:00 a.m.
-There were 6 residents on A and B halls and 3 residents on C and D halls who were disoriented or were wanderers.
-Resident #6 was not on the list for 15 minute checks.
-She was aware door alarms had to be on for disoriented residents, but she was not aware door alarms had to be on at all times for disoriented residents.
-She thought the alarms could be off during certain times of the day.

Resident #6's Responsible Party could not be reached by the end of the survey.

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Review of the facility's Plan of Protection dated 10/02/15 revealed:
- All door alarms will be activated immediately.
- Assess all residents' charts for disorientation and wanderers.
- Have door alarms on at all times and monitor residents.
- Monitor doors when alarms are activated.
- Supervisors and Administrator will ensure alarms are on at all times.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2015.

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| D 074 | 10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings<br><br>10A NCAC 13F .0306 Housekeeping And Furnishings<br>(a) Adult care homes shall:<br>(1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;<br><br>This Rule is not met as evidenced by:<br>Based on observations and interview, the facility failed to assure walls, ceilings, and floors were kept clean and in good repair for the 4 of 4 common resident bathrooms (A, B, C, D halls) in the facility, one shared resident bathroom (rooms 300/302) and one single bathroom in a resident room (room 303) and resident room (room 118) with a black substance around the air conditioner unit on the wall. The findings are:<br><br>1. Observation of the common bathroom on C hall on 09/29/15 at 11:28 a.m. revealed:<br>- The blue tile floor around the toilet had brown stains on the tile and in the grout of the tile.<br>- There was brown stains where the floor and wall meet behind the toilet.<br>- The white caulking around the bottom of the toilet had brown stains and was pulling away from the floor.<br>- A round metal ring in the middle of the grab bar beside the toilet was loose and dangling from the wall.<br>- The caulking in the crack between the back of the sink and the wall was cracked and the sink was pulling away from the wall.<br>- There was a buildup of white plaster on the wall around the sink where it appeared the area had been patched. | D 074 | | |

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- The half wall in the first shower stall had 9 tiles on the left side and 2 tiles on the right side with brown rust colored stains built up in the grout.
- The inside shower walls had a buildup of yellow stains all around the walls of both shower stalls.
- The floor of the second shower stall had uneven cement in the floor of the shower that appeared to be from repair of the shower floor.
- Three ceiling vents had a buildup of dust with strings of dust hanging down.

Interview with Maintenance Staff on 09/29/15 at 3:08 p.m. revealed:
- Housekeeping staff was responsible for cleaning the bathrooms daily.
- The building was old and he usually worked on repairs each day.
- He did not know how long the bathroom had been in need of repairs.
- He sometimes gets a list from staff of things that need repair.
- He did not currently have a repair list.
- He did not recall if any of the issues in the C hall bathroom had been on any lists he had received in the past.

Interview with the Resident Care Coordinator (RCC) on 09/29/15 at 3:35 p.m. revealed:
- They have two housekeepers on duty 7 days a week.
- The housekeepers were responsible for cleaning everything in the bathrooms daily.
- Staff should make a list of for the maintenance person if they see issues that need repair.
- She would check to see if there was a current list.
- She would get housekeeping and maintenance to work on the bathroom.

Recheck of the common bathroom on C hall on

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09/30/15 at 4:35 p.m. revealed:
- Some of the brown stains in the grout around the tile in the first shower stall had been removed.
- The metal ring on the hand bar beside the toilet had been attached to the wall.
- White caulking had been put around the bottom of the toilet.
- The blue tile around the toilet had been cleaned but some brown stains remained.
- The ceiling vents had been cleaned.

2. Observation of the common bathroom on A hall on 09/29/15 at 2:47 p.m. revealed:
- The blue tile floor around the toilet had brown stains on the tile and in the grout of the tile.
- One piece of tile flooring was pulling up away from the floor behind the toilet.
- There was brown stains where the floor and wall meet behind the toilet.
- The white caulking around the bottom of the toilet had brown stains and was pulling away from the floor.
- The caulking in the crack between the back of the sink and the wall was cracked and the sink was pulling away from the wall.
- There was a buildup of white plaster on the wall around the sink where it appeared the area had been patched.
- There was a crack on the wall with peeling paint running across the width of the wall from the sink to the door approximately 5 feet long.
- The bottom of the wall dividing the two shower stalls had a broken off area about 8 inches high and 4 inches wide exposing rusted metal that was jagged and stuck out from the wall.
- The bottom of the sheetrock wall connected to the first shower stall had broken off and peeling paint exposing rusted metal underneath.
- The baseboard around the wall under the window was pulling away from the wall.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| D 074 | Continued From page 12<br>- The inside shower walls had a buildup of yellow stains all around the walls of both shower stalls.<br>- The floor of the second shower stall had uneven cement in the floor of the shower that appeared to be from repair of the shower floor.<br>- Three ceiling vents had a buildup of dust with strings of dust hanging down.<br><br>Interview with a housekeeper on 09/28/15 at 2:55 p.m. revealed:<br>- This was the first time he had noticed any issues with the bathroom.<br>- Residents use the shower and the tub for bathing.<br><br>Interview with maintenance staff on 09/29/15 at 3:08 p.m. revealed:<br>- Housekeeping staff was responsible for cleaning the bathrooms daily.<br>- The building was old and he usually worked on repairs each day.<br>- The toilet was just replaced about two months ago because it was leaking on the floor.<br>- The stains and damage to the floor tiles were from that previous leak.<br>- The wall between the showers became cracked about two months ago and he planned to repair it.<br>- He did not recall if any of the issues in the A hall bathroom had been on any lists he had received in the past.<br><br>Interview with the Resident Care Coordinator (RCC) on 09/29/15 at 3:30 p.m. revealed:<br>- They have two housekeepers on duty 7 days a week.<br>- The housekeepers were responsible for cleaning everything in the bathrooms daily.<br>- The floor of the shower had a hole in it and it was repaired with the cement but she could not recall when this was done. | D 074 | | |

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- The ceiling vents in the bathroom should be cleaned at least once a week.
- The building is old and they plan to make repairs.
- Staff should make a list of for the maintenance person if they see issues that need repair.
- She would get housekeeping and maintenance to work on the bathroom.

Recheck of the common bathroom on A hall on 09/30/15 at 4:45 p.m. revealed:
- White caulking had been put around the bottom of the toilet.
- The blue tile around the toilet had been cleaned but some brown stains remained.
- The ceiling vents had been cleaned.

3. Observation of the common bathroom on D hall on 09/29/15 at 3:10 p.m. revealed:
- The blue tile floor around the toilet had brown stains on the tile and in the grout of the tile.
- There was brown stains where the floor and wall meet behind the toilet.
- The white caulking around the bottom of the toilet had brown stains and was pulling away from the floor.
- The caulking in the crack between the back of the sink and the wall was cracked and the sink was pulling away from the wall.
- There was a buildup of white plaster on the wall around the sink where it appeared the area had been patched.
- There was a hole in the wall about 1 inch in diameter under the right edge of the sink.
- The blue floor tile around the metal drain in the floor near the heating/cooling unit was sunken in and uneven and had yellow and brown stains on the tile.
- The ceramic tile floor in front of the second shower stall had a crack about 6 inches long

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| D 074 | Continued From page 14<br>across the tiles with a 2 by 2 inch area broken off and missing.<br>- The blue and white tile in front of the shower stalls had about ½ inch gaps between some of the tiles exposing the subflooring.<br>- The inside shower walls with tile had a buildup of yellow stains all around the walls of both shower stalls.<br>- The ceramic tile in both shower stalls had brown stains between the grout.<br>- The floor of the first shower stall had an uneven stained cement patched area that covered 3/4ths of the floor of the shower that appeared to be from repair of the shower floor.<br>- Three ceiling vents had a buildup of dust with strings of dust hanging down.<br><br>Interview with maintenance staff on 09/29/15 at 3:15 p.m. revealed:<br>- Housekeeping staff was responsible for cleaning the bathrooms daily.<br>- The building was old and he usually worked on repairs each day.<br>- A while back (no time frame given), they had to repair a hole in the bottom of the shower with the cement patch.<br>- He did not recall the bathroom on D hall being on any repair lists.<br><br>Interview with the Resident Care Coordinator (RCC) on 09/29/15 at 3:35 p.m. revealed:<br>- They have two housekeepers on duty 7 days a week.<br>- The housekeepers were responsible for cleaning everything in the bathrooms daily.<br>- The sink had been loose for "a while" (did not specify timeframe).<br><br>Interview with a medication aide on D hall on 09/29/15 revealed: | D 074 | | |

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| D 074 | Continued From page 15<br>- The bathroom on D hall had been that way "a while" (did not specify timeframe).<br>- They were working on the repairs.<br><br>Recheck of the common bathroom on D hall on 09/30/15 at 4:40 p.m. revealed:<br>- Some of the brown stains in the grout around the tile in the first shower stall had been removed.<br>- White caulking had been put around the bottom of the toilet.<br>- The blue tile around the toilet had been cleaned but some brown stains remained.<br>- The ceiling vents had been cleaned.<br><br>4. Observation on 9/29/15 at 10:55 a.m. of the B hall common bathroom revealed:<br>- The single toilet stall's metal walls and door were white in color with multiple areas of brown rusted spots.<br>- The pale blue floor in front of the commode was discolored with white and brownish stained areas,<br>- The white caulking on the floor around the base of the commode was discolored with brown and black stains.<br>- The commode caulking had pulled away from around the base of the commode attached to the floor and was broken away in places.<br>- The previously repaired wall behind the commode had paint and wall board substance peeling away.<br>- The tiled shower stall # 1 had wall tiles that were dulled from soap residue.<br>- The shower stall wall tile grout, from about chest height down and onto the floor was discolored with brown/black stains.<br>- The paint on the wall next to the tiled shower stall was peeling off.<br>- The floor of the shower stall # 1 was dirty appearing with black smears.<br>- The three ceiling exhaust fan vent covers in the | D 074 | | |

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bathroom were covered with gray fuzzy dust.

Interview on 9/29/15 at 11:10 a.m with the housekeeper on B hall revealed:
- He did routine daily cleaning of the bathrooms.
- Deep cleaning included using a scouring powder and a brush to get rid of the mildew on the grout.

Interview on 9/29/15 at 11:25 a.m. with the Resident Care Coordinator (RCC) revealed:
- The RCC was not aware of the condition of the bathroom.
- Housekeepers worked in the facility every day of the week according to the schedule provided.
- Housekeeping staff were to wipe the showers down and the commode area daily as well as the floors and the vents were to be cleaned frequently.
The tile grout and tiles were to be scrubbed and kept clean.
- Staff were to notify maintenance and housekeeping of cleaning and repair needs.
- She completed periodic monitoring of the bathrooms but was not aware of the condition of all of the common bathrooms shown to to her today.
- She called a housekeeping staff into the bathroom and told them to clean these areas.
- She would have to consider a another cleaning agent to get the floors and wall tiles clean.

Recheck of the B Hall bathroom on 9/29/15 at 3:45 p.m. revealed the commode metal walls had been painted over the rust with white paint.
- The tiled shower wall grout appeared to be somewhat cleaner but continued to need a deeper clean.
- The commode floor area was minimally cleaner but would need further cleaning.

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| D 074 | Continued From page 17<br><br>5. Observation of resident room #300, which was located on the C Hall, on 09/29/15 at 11:15 a.m. revealed:<br>-Three of four walls had multiple, brown dried stains.<br>-One fourth of the wall in the shared bathroom between room #300 and #302 had brown dried stains.<br>6. Observation of room #303, which was located on C hall, on 9/29/15 at 11:19 a.m. revealed twenty tiles throughout the room had streaks of dried grey stains.<br><br>7. Observation on 09/29/15 at 10:25 a.m. revealed the air conditioner in resident room # 118 was noted to have a black fuzzy substance around the seal.<br><br>Interview with Maintenance Staff on 09/30/15 revealed:<br>-He was unaware of the black fuzzy substance.<br>-He would clean it now with some bleach. | D 074 | | |
| D 079 | 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings<br><br>10A NCAC 13F .0306 Housekeeping and Furnishings<br>(a) Adult care homes shall<br>(5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by: | D 079 | | |

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Based on observation, interview and record review, the facility failed to assure hazardous automatic metered insecticide spray units were not used inside of the facility and 3 of 4 common bathrooms (A, C, D halls) and one resident room (room 410) on the D hall were maintained in an orderly manner and were free of all hazards. The findings are:

1. Observation of the facility throughout the survey revealed automatic metered spray insecticide units on the walls as follows:

Observation on 09/29/15 at 5:05 p.m. revealed there was a automatic metered pesticide sprayer on the wall near the dining room.

Observation on 09/30/15 at 4:05 p.m. revealed:
-An automatic metered pesticide sprayer was at the front door of the facility.
-The sprayer sprayed 1 foot out of the sprayer into the hallway.
-The facility transporter staff was closing the sprayer lid after opening to make sure the sprayer was working.

Interview with Maintenance staff on 09/30/2015 at 4:20 p.m. revealed:
-He was taking the sprayers to clean them off.
-When asked about the sprayer can's he stated they do not change the cans they have a contracted pesticide man come in and so they do not keep the cans on hand at the facility.

Observation on 9/30/15 at 4:35 p.m. revealed in the C hall common bathroom:
- An automatic metered insecticide sprayer was attached on the wall of the approximately 10 foot by 12 foot bathroom used by residents.
- Residents were observed to be walking by the

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| D 079 | Continued From page 19<br>bathroom.<br><br>Observation on 10/01/15 at 3:30 p.m. revealed the middle hall had an automatic metered insect spray unit on the wall near where residents were walking by.<br><br>Interview of a resident walking by a spray unit on the middle hall on 10/01/15 at 3:30 p.m. revealed the resident thought it was to kill the flies in the facility.<br><br>Observation on 10/01/15 at 3:40 p.m. of the back hall exit door revealed:<br>- An automatic metered insecticide spray unit on the wall near the exit door.<br>- Multiple residents were going in and out of the door near the spray unit.<br><br>Observation on 10/01/15 at 3:45 p.m. revealed:<br>- An automatic metered insecticide spray unit on the wall near the front exit door.<br>- Multiple residents were going in and out of the door near the spray unit.<br><br>Interview on 10/01/15 at 3:45 p.m. with the Administrator revealed:<br>- The spray units on the walls in the halls were for the flies.<br>- They had used them for years in the facility.<br>- The had been using them during the fly season.<br>- The units spray about every 30 minutes out into the hall area to get to the flies.<br>- The fly population in the facility was better since the use of the spray units.<br>- The exterminator had brought them to be used and said they were safe.<br>- The exterminator came to the facility to change out the empty cans as necessary.<br>- She was not aware of the label warnings on the | D 079 | | |

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metered insecticide spray cans.
- She did not know the label indicated not to use it in a confined place and not to be used where children and elderly lived.
- The Administrator was not aware of any effects on residents from the insecticide spray.
- The Administrator would call the exterminator for further information.
- She immediately had staff remove the cans from the units.

Review of the pesticide spray can revealed the back of the can said not for use in enclosed places or in residential places where children or elderly adult's live.

Review of the automatic metered spray insecticide product website revealed:
- The insecticide spray product was hazardous if swallowed, inhaled, got on the skin and if it got in the eyes.
- When using the product, do not allow others to enter the area until vapors, mists and aerosols have dispersed and the area was thoroughly ventilated.
- Do not apply this product in a way that will contact persons either directly or through drift.
- Do not remain in the treated area. Exit immediately and remain outside the treated area until aerosols, vapors and or mists have dispersed.

2. Observation of Resident Room #410 on the D Hall on 10/1/15 at 4:45 p.m. revealed:
- The sink top vanity was broken on the right side edge of the top.
- The edge was broken off in pieces and had some sharp edges.
- The sink was sitting at an angle in the vanity top so that the hole for the sink was open and the

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floor was visible.
- The sink was sitting in the vanity top at an angle and wobbled side to side when touched.

Interview on 10/1/15 at 4:45 p.m. with a resident in the room revealed:
- The resident could not recall how long it had been that way.
- The resident said no one had been hurt on the sink and broken vanity.
- The resident wanted to have the sink and vanity fixed.

Interview on 10/1/15 at 5 p.m. with the Administrator revealed:
- She was not aware of the condition of the sinks and bathrooms in the facility.
- She would monitor the areas and have them repaired.

3. Observation of the common bathroom on C hall on 09/29/15 at 11:28 a.m. revealed:
- The white wooden cabinet under the sink did not have a front cover, exposing six nail heads sticking out from the front sides of the two cabinet walls.
- There was yellow stains in the sink around the metal drain.
- The bath tub had yellow stains in the bottom of the tub at the end and dirt and debris scattered in the bottom of the tub.
- Half of the metal drain in the tub was broken off leaving sharp edges around the drain.
- The plastic privacy curtain hanging from the ceiling beside the sink was faded and worn with light brown stains scattered at the bottom edge of the curtain.
- A second plastic privacy curtain hanging from the ceiling beside the first shower stall was faded and worn with light brown stains scattered at the

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bottom edge of the curtain.
- The light beige plastic shower curtain on the second shower stall had a buildup of brown stains on the bottom half of the curtain that spanned the entire width of the curtain.
- A blue transparent plastic mat in the floor of the first shower stall had buildup of brown and black slimy substance on the back side of the mat that was seeping around the edges of the mat into the shower floor.

Interview with maintenance staff on 09/29/15 at 3:08 p.m. revealed:
- Housekeeping staff was responsible for cleaning the bathrooms daily.
- The building was old and he usually worked on repairs each day.
- He did not know how long the bathroom had been in need of repairs.
- He sometimes gets a list from staff of things that need repair.
- He did not currently have a repair list.
- He did not recall if any of the issues in the bathroom had been on any lists he had received in the past.

Interview with the Resident Care Coordinator (RCC) on 09/29/15 at 3:35 p.m. revealed:
- They have two housekeepers on duty 7 days a week.
- The housekeepers were responsible for cleaning everything in the bathrooms daily.
- She did not know what happened to the front cover of the sink cabinet.
- The nails should not be sticking out from the cabinet.
- Staff should make a list for maintenance if they see issues that need repair.
- She would check to see if there was a current list.

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- She would get housekeeping and maintenance to work on the bathroom.

Recheck of the common bathroom on C hall on 09/30/15 at 4:35 p.m. revealed:
- All 3 shower/privacy curtains had been replaced with new ones.
- The dirt and debris had been cleaned from the tub but yellow stains remained.
- A new white rubber mat was on the floor of the second shower covering the cement floor.
- The blue transparent mat in the first shower had been cleaned but some brown stains remained in three areas on the underside of the mat.

4. Observation of the common bathroom on A hall on 09/29/15 at 2:47 p.m. revealed:
- The white wooden cabinet under the sink had a front cover with a piece of wood approximately 12 inches by 4 inches with jagged edges around the hole.
- There was yellow stains in the sink around the metal drain.
- The bath tub had yellow stains in the bottom of the tub at the end with dirt and debris scattered in the bottom of the tub.
- The plastic privacy curtain hanging from the ceiling beside the sink was faded and worn with light brown stains scattered at the bottom edge of the curtain.
- The plastic privacy curtain hanging from the ceiling beside the first shower stall was faded and worn with light brown stains scattered at the bottom edge of the curtain.
- The white plastic shower curtain on the second shower stall had a buildup of brown stains on the bottom half of the curtain that spanned the entire width of the curtain.
- Blue transparent plastic mat in the floor of the

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first shower stall had buildup of brown and black slimy substance on the back side of the mat that was seeping around the edges of the mat into the shower floor.

Interview with a housekeeper on 09/28/15 at 2:55 p.m. revealed:
- This was the first time he had noticed any issues with the bathroom.
- They usually replace the shower curtains when they get dirty.
- They usually wash the rubber mats in the showers about twice a week.
- Residents use the shower and the tub for bathing.

Interview with maintenance staff on 09/29/15 at 3:08 p.m. revealed:
- Housekeeping staff was responsible for cleaning the bathrooms daily.
- The building was old and he usually worked on repairs each day.
- They had just replaced the sink cabinet about two months ago.
- The cabinet had just gotten this way about 2 weeks ago and he planned to repair it.
- Housekeeping would be responsible for replacing shower curtains when needed.
- He sometimes gets a list from staff of things that need repair.
- He did not recall if any of the issues in the bathroom had been on any lists he had received in the past.
- He did not cuurently have a list.

Interview with the Resident Care Coordinator (RCC) on 09/29/15 at 3:30 p.m. revealed:
- They have two housekeepers on duty 7 days a week.
- The housekeepers were responsible for

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cleaning everything in the bathrooms daily.
- The housekeepers were supposed to check the condition of the shower curtains daily.
- If the curtains can be washed they should wash them and put them back up.
- If the curtains cannot be washed, they should replace them.
- She did not know how the sink cabinet was broken or how long it had been broken.
- The building is old and they plan to make repairs.
- Staff should make a list of for maintenance if they see issues that need repair.
- She would get housekeeping and maintenance to work on the bathroom.

Recheck of the common bathroom on A hall on 09/30/15 at 4:45 p.m. revealed:
- The shower/privacy curtains had been replaced with new ones.
- The front of the sink cabinet had been removed.
- The dirt and debris had been cleaned from the tub but yellow stains remained.
- Two new rubber mats were on the floor in each of the shower stalls.

5. Observation of the common bathroom on D hall on 09/29/15 at 3:10 p.m. revealed:
- There was yellow stains in the sink around the metal drain.
- The bath tub had yellow stains in the bottom of the tub at the end with dirt and debris scattered in the bottom of the tub.
- The underside of the toilet seat had one seat bumper broken off that made the toilet seat sit unevenly on the rim of the toilet.
- The light beige plastic shower curtain for both shower stalls had a buildup of brown stains on the bottom half of the curtain that spanned the

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entire width of the curtains.
- A blue transparent plastic mat in the floor of the second shower stall had buildup of brown and black slimy substance on the back side of the mat that was seeping around the edges of the mat into the shower floor.

Interview with maintenance staff on 09/29/15 at 3:15 p.m. revealed:
- Housekeeping staff was responsible for cleaning the bathrooms daily.
- The building was old and he usually worked on repairs each day.
- He did not recall the bathroom on D hall being on any repair lists.

Interview with the Resident Care Coordinator (RCC) on 09/29/15 at 3:35 p.m. revealed:
- They have two housekeepers on duty 7 days a week.
- The housekeepers were responsible for cleaning everything in the bathrooms daily.
- Housekeeping staff were supposed to clean the plastic mats every week.
- She did not know the toilet seat was broken but she would get the maintenance person to replace it.

Interview with a medication aide on D hall on 09/29/15 revealed:
- The bathroom on D hall had been that way "a while" (did not specify timeframe).
- They were working on the repairs.

Recheck of the common bathroom on D hall on 09/30/15 at 4:40 p.m. revealed:
- Both shower curtains had been replaced with new ones.
- The dirt and debris had been cleaned from the tub but yellow stains remained.

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| D 079 | Continued From page 27<br>- The blue transparent mat in the second shower had been removed. | D 079 | | |
| D 163 | 10A NCAC 13F .0504(c) Competency Validation For LHPS Tasks<br><br>10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task<br>(c) Competency validation of staff, according to Paragraph (a) of this Rule, for the licensed health professional support tasks specified in Paragraph (a) of Rule .0903 of this Subchapter and the performance of these tasks is limited exclusively to these tasks except in those cases in which a physician acting under the authority of G.S. 131D-2(a1) certifies that non-licensed personnel can be competency validated to perform other tasks on a temporary basis to meet the resident's needs and prevent unnecessary relocation.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record review, the facility failed to ensure staff were competency validated to perform wound packing to a resident's scrotum (#3). The findings are:<br><br>Review of Resident #3's current FL-2 dated 6/20/15 revealed:<br>-Diagnoses included dementia, cardiovascular accident, hypertension, seizure disorder, atrial fibrillation, congestive heart failure, mentally challenged and history of dysphasia.<br><br>Review of Resident #3's facility record revealed:<br>-Resident #3 was admitted to the hospital on 7/3/15 and discharged on 7/10/15 for scrotal | D 163 | | |

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edema/cellulitis.
-The resident was ordered Home Health services for wound care.

Review of physician order sheet dated 9/25/15 revealed:
-"Change order due to SNF(skilled nursing facility) not able to purchase Dakin's Left Scrotum".
-Normal Saline wet to dry pack daily.

Review of physician orders dated 9/30/15 revealed:
-Pack scrotal ulcer wet to dry normal saline daily and as needed when soiled. Return to wound clinic in 3 weeks. Call if any changes.

Observation on 9/30/15 at 11:55am revealed:
Personal Care Aide(PCA) providing incontinent care to Resident #3.
Scrotum dressing was not on resident. The PCA informed the Medication aide (MA)the resident needed the dressing replaced.
Medication aide cleaned the area with normal saline with a white gauze that she had in her hand.
The Medication aide put normal saline on another gauze, then pushed the gauze into the open wound of the Resident's left scrotum.
The Medication aide placed gauze on the resident bed. Medication aide took the gauze and placed it over the packing. MA did not use paper tape, the resident began hitting at the MA. The MA removed the gauze and tape.
The MA retrieved new gauze and paper tape and placed it on the resident.

Review of the treatment medication record revealed:
Wound care packing scrotal wound was provided

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| D 163 | Continued From page 29<br>by facility staff on 9/26/15-9/30/15.<br><br>Interview with a medication aide on 9/30/15 at 11:55 am revealed:<br>-Physician orders staff are supposed to pack and redress the wound daily.<br>-No one instructed staff on how to pack the wound<br>-If wound dressing comes off staff will pack and redress the wound.<br>-Staff have to redress it several times a day because of the resident incontinent episodes.<br><br>Telephone interview with the Home Health Intake Nurse on 10/1/15 at 4:00pm revealed:<br>-There were no orders received for Resident #3 for wound care.<br>-Last note in the resident record was on 8/31/15 "problems with wound care waiting on call back from the physician".<br>Telephone interview with Home Health Nurse on 10/1/15 at 4:30 pm revealed:<br>-Resident #3 was discharged from home health services on 9/27/15.<br>-Staff were supposed to continue wet to dry dressing to scrotum to include packing the area.<br>-Home Health does not do daily dressing changes.<br>-Home Health nurse stated that the facility staff informed her that the staff could perform wet to dry dressings with packing.<br>-The Home Health Nurse did not know who informed her that the facility staff could perform wet to dry dressings that included packing of the wound.<br>-The dressing was never in place when Home Health visited.<br>-If the wound is not packed it will not heal properly and possibly cause infection.<br>-The Home Health Nurse requested information | D 163 | | |

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| D 163 | Continued From page 30<br>from facility staff on what kind of wound care they could provide to residents. The Home Health Nurse stated the facility did not provided any information regarding what they could and could not do regarding wound care.<br>-The facility had not provided any information to the home health nurse.<br><br>Interview with the wound care Registered Nurse on 10/2/15 at 10:25 am revealed:<br>Facility staff had not contacted the wound clinic until today 10/2/15 stating they could not provide packing of a wound.<br><br>______________________________<br><br>Review of the facility's Plan of Protection dated 10/02/15 revealed:<br>- Immediately, staff were stopped from packing the wound due to not having competency validation.<br>A home health agency nurse had been contacted to competency validate staff for the packing of the wound task.<br>- A home health nurse would complete the wound care until staff were competency validated.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2015. | D 163 | | |
| D 270 | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. | D 270 | | |

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This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observation, interview and record review, the facility failed to provided supervision for 1 of 1 sampled residents (#6) known to be disoriented and to eloped from the facility.

The findings are:

Review of Resident #6's current FL-2 dated 2/6/15 revealed:
-The resident's diagnoses included uncontrolled Type II Diabetes Mellitus, insomnia and schizoaffective disorder.
-The resident was constantly disoriented, ambulatory and injurious to self and others.

Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 8/29/14.

Review of Resident #6's Care Plan dated 2/6/15 revealed:
-The resident was sometimes disoriented.
-The resident had "no problems" with the upper extremities and ambulation.
-There was no documentation on supervision needs.

Interview with Resident #6 on 9/30/15 at 5:50 p.m. revealed the resident had never gotten out of the facility or went anywhere with the resident's roommate.

Interview with a Nurse Aide (NA) on 10/1/15 at 9:21 a.m. revealed Resident #6 had never

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wandered away from the facility.

Interview with a second NA on 10/1/15 at 9:46 a.m. revealed:
-One day around lunch time (12 p.m.) during the middle of the week between July 5-18, 2015, Resident #6 was about twenty feet from the front porch. Staff saw the resident and paged the NA to go and get the resident.
-Resident #6 saw staff and started running from the porch. The resident was on the left side of the porch.
-When the NA had gone to get the resident, the resident had gotten ten feet further from the original location.
-He talked to Resident #6 and the resident revealed "I am going to go and get my babies."
-He gave Resident #6 a cigarette. The resident smoked the cigarette and he talked the resident into coming back inside of the facility.
-He had never known Resident #6 to try to leave the facility before. He remembers the incident well, because it was a very hot day. He could not remember who was on shift during the time.
-Staff constantly monitored Resident #6 to see where the resident was located or if the resident needed anything.

Interview with a Medication Aide (MA) on 10/1/15 at 10:19 a.m. revealed:
-Resident #6 had never wandered away from the facility.
-Resident #6 walked around inside of the building.
-Resident #6 walked into the parking lot and staff got the resident to come back into the facility. She could not remember when the incident happened.
-Staff monitored Resident #6 every two hours.

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| D 270 | Continued From page 33<br><br>Interview with a second MA on 10/1/15 at 10:36 a.m. revealed:<br>-One day between July 2015 and August 2015 before second shift (3:00 p.m.), staff had to go up the street and get Resident #6. Staff went and got the resident.<br>-She was not here when Resident #6 eloped from the facility.<br>-Resident #6 was not allowed to leave the facility unsupervised.<br>-Staff checked on Resident #6 every two hours.<br><br>Review of Resident #6's progress notes revealed an entry dated 7/11/15 (no time) by a third MA revealed:<br>-Resident #6 had gone down the highway with her roommate.<br>-The resident went into a neighbor's yard and begin throwing items in the yard.<br>-The owner of the yard said if the resident came back into the yard charges would be pressed against the resident..<br><br>Telephone interview with the MA, who documented the entry in the progress notes on 7/11/15, on 10/1/15 at 12:21 p.m. revealed:<br>-One day around lunch time (12:00 p.m.) someone called the facility and informed them Resident #6 went up the street with another resident, who no longer lived at the facility. She could not remember who called the facility. The MA immediately locked her medication cart and walked to the site where both residents were located. The transporter person drove to the site to pick up both residents. It took MA less than five minutes to get to the site where the residents were located. Resident #6 was in the neighbor's yard. The resident was upset and throwing items. Both residents rode with the transporter person back to the facility. | D 270 | | |

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-Resident #6 went out the front door, made a left at the end of the drive way and was at the second house (white) to the right past the corn field.
-It would have taken Resident #6 five minutes to walk to the neighbor's yard.
-Resident #6 did not tell staff she was leaving the facility.
-She did not know who was assigned to Resident #6 on 7/11/15 when the resident eloped from the facility.
-She had never known Resident #6 to leave the facility.
-Resident #6 was never allowed to leave the facility unsupervised by staff.
-Staff monitored and had always monitored Resident #6 every two hours for incontinent care and to see if the resident needed anything.

Observation on 10/2/15 at 7:00 p.m. revealed:
-The entrance of the parking lot was on the right side of the facility.
-The entrance of the driveway to the front of the facility was between 100 to 150 feet.
-The street in front of the facility was a two way street with a speed limit of 35 miles per hour.
-There was a ditch on both sides of the street.
-Across from the facility were houses.
-To the right of the houses were a corn field, which was estimated to be 100 feet wide
-To the right of the corn field were more houses.
-The distance between the facility and the white house was one tenth of a mile.
-Beside the facility was a grassy area, a side street and apartment complexes.

Interview with a third NA on 10/1/15 at 4:30 p.m. revealed:
-She had been working at the facility for the past three months.
-She had never known Resident #6 to wander

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away from the facility.
-She checked on Resident #6 every 15 to 30 minutes to make sure the resident was fine and to check on the resident's behaviors.
-She had been checking on the resident every 15 to 30 minutes since she had been working at the facility, which is what she was told to do by staff when she first started working at the facility.

Interview with a fourth NA on 10/2/15 at 10:36 a.m. revealed:
-One day in August 2015 between 12:30 p.m. and 1:00 p.m., someone told her to go and get Resident #6 from the parking lot before the resident had reached the end of the driveway.
-When the NA had gone outside to get Resident #6, the resident was halfway in the parking lot. The resident was agitated.
-She bought Resident #6 back inside of the facility. The resident calmed down. She offered her something to drink. The resident laid down in the bed.
-Resident #6 did not show any signs of agitation during the day.
-Later she was told by a Supervisor, Resident #6 had been upset during the day.
-She was not assigned to Resident #6 and she does not know who was assigned to the resident when she tried to leave out of the parking lot.
-When things do not go as the resident wants, the resident starts cursing. Staff try to calm the resident down.
-She constantly monitored Resident #6 every 10 to 15 minutes to see where the resident was located.

Interview with a Transporter person on 10/2/15 at 3:40 p.m. revealed:
-One day before July 4, 2015 during the day possibly around lunch time (12:00 p.m.), Resident

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#6 had walked out of the front door at the facility and was walking toward the end of the driveway.
-He had just returned from bringing another resident from a doctor's appointment. He was looking at the appointment book in the front Supervisor's office, he looked out the window and observed Resident #6 halfway in the parking lot heading towards the entrance of the driveway. He walked outside and called Resident #6 by name, but she kept walking fast and did not turn around to respond to the call.
-Resident #6 walked across the street across into another driveway, which was across from the facility.
-He got in the van and picked up the resident.
-The resident admitted to trying to go home.
-Three minutes prior he had just seen Resident #6 in the hall standing near the nurses' station on A and B hall.
-He could not remember the date nor the time of the incident.

Telephone interview with Resident #6's primary care physician's nurse on 10/2/15 at 11:46 a.m. revealed:
-The primary care physician was not available for interview.
-The resident had dementia, but she did not know the level of dementia.
-The resident had a history of seizure disorders.
-She did not know if Resident #6 could leave the facility unsupervised.
-She was sure the resident's primary care physician would like to have known if the resident had eloped from the facility.
-She did not see any documentation of the resident eloping from the facility in the resident's file.

Interview with the Resident Care Coordinator

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| HERITAGE CARE OF ROCKY MOUNT | 1650 COKEY ROAD ROCKY MOUNT, NC 27801 |

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(RCC) on 10/2/15 at 1:15 p.m. revealed:
-One weekend between 10:00 a.m. and 10:30 a.m., staff had to go and get Resident #6 and another resident, who no longer lived at the facility, from a neighbor's yard.
-Someone who worked at the facility told them the residents were up the street.
-The resident had gone out the front door. The door did not alarm. The resident did not want to leave the neighbor's yard. After staff had bought the resident back to the facility, she calmed down and the resident said "I would not do it again."
-Earlier during the day, the resident had gotten agitated because she wanted to go with a family member.
-When Resident #6 wanted to go with a family member, staff called the family member.
-Resident #6 would have taken 10 to 20 minutes to walk to the neighbor's yard.
It took staff 20 minutes to convince the resident to get in the van and get her back to the facility.
-During the day, she was told Resident #6 had been crying.
-The RCC was off on the day of the incident.
-She did not know the last time staff had seen Resident #6 before the resident eloped from the facility.
-She is always concerned about Resident #6 leaving the facility, because sometimes the resident may just try to "take off."
-Before the incident she had never known Resident #6 to elope or attempt to elope from the facility.
-Her expectation was for staff to inform her if Resident #6 had eloped from the facility or attempted to elope from the facility.
-She was not aware Resident #6 had attempted to elope from the facility.
-If residents are disoriented or a wanderer the residents are placed on 15 minute checks.

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-Resident #6 was disoriented at times, but was not on 15 minute checks.
-She expected staff to monitor Resident #6 every 15 minutes to two hours. Staff should know where the resident was located.

Interview with the RCC on 10/2/15 at 3:56 p.m. revealed anytime a resident eloped from the facility, the resident's mental health provider was contacted.

Telephone interview with Resident #6's mental health provider on 10/2/15 at 1:58 p.m. revealed:
-Resident #6 had the early stages of dementia.
-Resident #6 could not leave the facility without staff supervision.
-He did not know how often Resident #6 needed to be monitored.
-He was not aware Resident #6 had eloped from the facility.

Interview with the Administrator on 10/2/15 at 4:16 p.m. revealed:
-She had only known of one incident where Resident #6 had left the facility with another resident (7/11/15).
-The incident was reported to her by staff. She did not know too much about the incident.
-Resident #6 should not leave the property without being supervised by staff.
-If the resident tried to go towards the parking lot, staff should get the resident.
-She was not aware Resident #6 had attempted to elope from the facility.
-There were 6 residents on A and B halls and 3 residents on C and D halls who were disoriented or were wanderers. Staff monitored the residents every 15 minutes and documented the checks on a log.
-Resident #6 was not on the list to do 15 minute

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| D 270 | Continued From page 39<br>checks.<br><br>Resident #6's Responsible Party could not be reached by the end of the survey.<br>______________________________<br><br>Review of the facility's Plan of Protection dated 10/02/15 revealed:<br>- Reassess and check all charts for residents classified as disoriented, fall precautions and behaviors.<br>- Put in place - 15 min checks on disoriented residents.<br>- Supervisor will monitor the dcoumentation on the check off sheets and then the Resident Care Coordinator will randomly check behind the supervisor.<br><br>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2015 | D 270 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observation, record review, and interview, the facility failed to assure referral and follow-up to meet the acute health care needs of 5 of 8 residents (#1, #3, #5, #6, #8) sampled as | D 273 | | |

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related to not obtaining a swallowing study for a resident with swallowing problems and not notifying the physician of hospitalization related to swallowing problems (#1), not obtaining home health services for packing a scrotal wound for a resident (#3), not notifying the physician of a resident's multiple falls (#6), not obtaining a psychiatric consult for a resident suspected to have depression (#5), and not coordinating with podiatrist for instructions and orders from appointment to remove toenail (#8). The findings are:

1. Review of Resident #1's current FL-2 dated 06/25/15 revealed:
- Diagnoses included seizure disorder, hypertension, traumatic brain injury, schizophrenia, paranoid, psychoses, chronic pain, coronary artery disease, dyslipidemia, alcohol use disorder in remission, and cannabis use disorder in remission.
- The resident was intermittently disoriented.
- The resident was semi-ambulatory with wheelchair.
- The resident required assistance with bathing, feeding, and dressing.
- The resident was incontinent bowel and bladder.

Review of the Resident Register revealed Resident #1 was admitted to the facility on 06/25/15.

Review of progress notes for Resident #1 revealed:
- 06/25/15: Resident was admitted to the facility and put in wheel chair because unsteady when walking.
- 06/30/15: Resident is having trouble swallowing. Resident Care Coordinator notified.

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- 06/30/15: Resident ate 10% of dinner. Great shake given.

Review of a primary care physician (PCP) visit form dated 07/01/15 revealed:
- The PCP noted the resident needed fall precautions.
- The resident needed to follow-up with ophthalmology to evaluate eye sight.
- The resident needed to follow-up with psych as advised.
- The PCP noted labwork was done today.
- There was no documentation to indicate the PCP was notified of the resident's swallowing problems noted by staff on 06/30/15.

Review of progress notes for Resident #1 revealed:
- 07/08/15: Resident is having a hard time swallowing puree food. She ate about 30% of breakfast. She had chicken noodle soup for lunch. The Supervisor was notified about resident holding her throat while eating. Supervisor stated they would have to get a referral from the PCP.

Review of progress notes for Resident #1 revealed:
- 07/18/15: Resident did not eat much for dinner. She was doing some jerking/shaking during shift. Medications were given.

Review of a primary care physician (PCP) visit form dated 08/05/15 revealed:
- PCP noted to push oral fluids and keep hydrated.
- PCP noted aspiration precaution.
- PCP noted to refer for swallow test and the PCP underlined it.

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Review of Resident #1's record revealed no documentation a swallow study had been done as ordered on 08/05/15.

Review of progress notes for Resident #1 revealed:
- 08/18/15: Resident ate half of supper, drank a great shake.
- 08/29/15: Resident sent out to ER. She as doing a lot of shaking and could not tell us what was wrong.

Review of hospital emergency room (ER) form dated 08/30/15 (6:33 a.m.) revealed:
- The reason for visit was seizures, tremors.
- The resident was diagnosed with generalized tremors; seizure.

Review of a primary care physician (PCP) visit form dated 09/02/15 revealed:
- The resident's blood pressure was 121/91 and pulse was 99.
- PCP noted to keep the resident well hydrated.
- PCP wrote swallow test as ordered on 08/05/15 and if normal may try regular diabetic diet.
- PCP ordered Megace, an appetite stimulant.
- PCP wrote again, "barium swallow test as ordered previously" due to complaint of dysphagia and debility.

Review of progress notes for Resident #1 revealed:
- 09/05/15: Resident has been moving around a lot today. She ate only 3 spoonsful of sausage this morning. She drank her orange juice and a glass of water and she took her meds with applesauce.
- 09/11/15: Resident was not acting herself. She was shaking a lot and not responding like she normally does. She was holding food in her

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mouth and holding her throat as if it was hurting and unable to tell staff. She was sent to the hospital.

Review of hospital emergency room (ER) form dated 09/11/15 revealed:
- The resident went to the ER for altered mental status, shaking, and not eating.
- The resident was diagnosed with altered mental status, generalized weakness, and grand mal seizure.

Review of progress notes for Resident #1 revealed:
- 09/11/15: Resident came back from hospital with no new orders. She took meds with no problems.
- 09/13/15: Resident has been rolling around in her wheel chair. She is not eating. She is holding food and meds in her mouth. She is not swallowing anything. She will not drink great shakes. She holds it in her mouth and lets it run out.
- 09/13/15: Resident ate 20% of supper. Medication aide got her to drink great shake.

Review of a lab report form for outpatient at local hospital dated 09/14/15 revealed:
- A barium swallow procedure was ordered for Resident #1 by the primary care physician on 09/02/15.
- A barium swallow procedure was done on 09/14/15 due to an indication of dysphagia.
- The results noted limited visualization of the cervical esophagus due to patient positioning and clinical status.
- No gross aspiration was noted.
- Physiologic motility was noted.
- No hiatal hernia reflux was identified.
- There was no gross obstruction in the

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visualized of the esophagus noted.
- There was no hiatal hernia seen.

Review of progress notes for Resident #1 revealed:
- 09/15/15: Resident did not eat much for breakfast or lunch. She was given ½ of great shake.
- 09/15/15: Resident would not take meds this evening. She was just holding them in her mouth.
- 09/16/15: Resident drank great shake. She took all liquid medications and eye drops. She took a couple of spoons of pudding then started to spit it out.

Review of a primary care physician (PCP) visit form dated 09/16/15 revealed:
- PCP noted to refer to gastroenterology for dysphagia.
- PCP noted to refer to neurologist for seizure disorder.

Review of progress notes for Resident #1 revealed:
- 09/17/15: Resident ate a very small amount at meal time. She was holding food in her mouth. Shake was given.
- 09/17-18/15: Resident was sent to ER doing a lot of shaking, slobbering, and wasn't looking right. The resident had a knot on her right hip that was sticking out and reddish around the area and it was tender to the touch.
- 09/18/15: Resident was admitted to the hospital.

Review of a hospital discharge note for Resident #1 dated 09/27/15 revealed:
- The resident was admitted to the hospital on 09/18/15.

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- The resident had dehydration with hypernatremia, acute kidney injury, and hyperchloremia due to poor oral intake secondary to advanced dementia and psych issues.
- The resident also had encephalopathy with worsening dementia due to infection (cellulitis of the right hip).
- There was a discharge order dated 09/27/15 for dysphagia puree diet with nectar thick liquids and 1:1 assist and medications in puree.

Review of progress notes for Resident #1 revealed:
- 09/27/15: Resident returned back to the facility at 1:30 p.m. She is on nectar thickener. She came back to the facility with food in her mouth.
- 09/28/15: Resident did not eat or drink. Nectar thickener today. Her meds were crushed up and put in pudding but she will not take. She just held it in her mouth.
- 09/28-29/15: Resident has been in bed. We're trying to give her some thickener but would not take.
- 09/29/15: Resident had a soda and meds were given. She did not eat much at meals.
- 09/30/15: Resident is still not eating. She continues to hold food in her mouth. She is not drinking. PCP was called and he stated to call the psych doctor and see what he thinks. Psych doctor was called and a letter was written to him. He did not respond. Resident was sent out to the hospital.
- 10/01-02/15: Resident still in the hospital.

Interview with a medication aide on 09/30/15 at 1:30 p.m. revealed:
- Prior to recent hospitalization, Resident #1's hands and arms would shake "real bad".
- She did not think the shaking was from a seizure.

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- The resident was holding food in her mouth and would let it run out of the side of her mouth.
- The resident just returned from the hospital on Sunday, 09/27/15.
- The resident was still holding food and medications in her mouth and not swallowing.
- They tried crushing the medications and putting it in applesauce.
- They tried to give the resident a house supplement.
- The resident does not cough or choke but just holds everything in her mouth and does not swallow.
- She called the primary physician today about the resident not eating or taking her medications
- The primary physician instructed the facility to contact the psychiatrist.
- They left a message for the psychiatrist but had not heard back.

Interview with a medication aide on 09/29/15 at 11:08 a.m. revealed:
- The resident just returned from the hospital on Sunday, 09/27/15.
- The resident was not eating and was sent out to the hospital.
- She was blind but sees some shadows.
- Since resident has returned from the hospital, staff now has to feed her.
- She was now getting nectar thick liquids.

Interview with the Resident Care Coordinator (RCC) on 10/01/15 at 5:00 p.m. revealed:
- The Supervisor was responsible for making appointments.
- The RCC participates in the on-site visits with the PCP when he comes to the facility.
- She gives any orders for referrals or follow-up appointments to the Supervisor to schedule.
- She gave the supervisor a copy of the orders

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| D 273 | Continued From page 47<br>from Resident #1's visit on 08/05/15.<br>- The supervisor should have scheduled the swallowing test on 08/05/15 when she received the order.<br>- The RCC did not follow-up to see if the supervisor had made the appointment.<br>- When the PCP came back for the next visit on 09/02/15, the PCP asked if the swallowing test ordered on 08/05/15 had been done.<br>- The RCC asked the supervisor about the swallowing test on 09/2/15 while the PCP was at the facility.<br>- The supervisor told the RCC that she did not think she had the order.<br>- The supervisor could not find the order dated 08/05/15.<br>- The PCP reordered the swallow test on 09/02/15 because the resident was still have problems swallowing.<br>- The referrals ordered on 09/16/15 for gastroenterology and neurology had not been made yet because the resident was hospitalized on 09/18/15 and just returned to the facility on Sunday, 09/27/15.<br><br>Interview with the supervisor on 10/02/15 at 9:25 a.m. revealed:<br>- She would have called a local gastroenterology clinic to set up the appointment for the swallow test on either 08/05/15 when she received the order or the next day.<br>- She thought when she called they told her there was no appointments available until October or November 2015.<br>- She did not set up the appointment because it was so far out.<br>- She did not remember if she called back to reschedule the appointment after that.<br>- There was no other clinics that she would have called to set up the appointment. | D 273 | | |

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| D 273 | Continued From page 48<br>- She did not document any conversations with the gastroenterology office.<br>- When the PCP came to the facility on 09/02/15, the supervisor called the gastroenterology office to see if there had been a cancellation appointment that she could get for the resident.<br>- She was unsure where the swallow test dated 09/14/15 had been done.<br><br>Telephone interview with a representative from the local gastroenterology clinic on 10/02/15 at 9:45 a.m. revealed:<br>- No one had called their office in August 2015 to set up a swallow test for Resident #1.<br>- There was nothing showing in their records that any swallow test had been scheduled for Resident #1.<br>- It usually took about 1 to 2 weeks to get an appointment for tests/procedures depending on insurance.<br><br>Telephone interview with the nurse at Resident #1's primary care physician's (PCP) office on 10/02/15 at 11:23 a.m. revealed:<br>- The PCP was out of the office and unavailable for interview.<br>- The PCP usually went to the facility for on-site visits with the residents.<br>- Resident #1 was seen by the PCP on 08/05/15 and a swallow test was ordered.<br>- She thought the PCP ordered the barium swallow because the resident was holding food and medications in her mouth.<br>- The PCP had to reorder the swallow test during the visit on 09/02/15.<br>- She was unsure why the swallowing test ordered on 08/05/15 had not been done.<br>- The facility was responsible for setting up appointments for tests.<br>- The PCP last saw the resident on 09/16/15 | D 273 | | |

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when he ordered a gastroenterology referral for dysphagia and a neurology referral for seizure disorder.
- She did not see anything in the resident's chart to indicate the resident had been hospitalized on 09/18/15.
- They did not have anything in their records regarding the resident's new diet order from the hospital for puree with nectar thick liquids.
- The facility did not usually send hospital records to the PCP's office.
- They did not usually receive information from the local hospital either.
- They last heard from the facility on 09/30/15 when the facility called about the resident not eating and drinking and not taking medications.

Interview with the Administrator on 10/02/15 at 1:22 p.m. revealed:
- The RCC usually lets the Supervisor know when an appointment or test needs to be scheduled.
- The Supervisor was responsible for scheduling appointments.
- They usually let a resident's family know when they go to the ER but not the PCP because the PCP may not be available.
- The RCC would usually let the PCP know about any ER visits or hospitalizations when the PCP came for on-site visits.

2. Review of Resident #3's current FL-2 dated 6/20/15 revealed:
-Diagnoses included dementia, cardiovascular accident, hypertension, seizure disorder, atrial fibrillation, congestive heart failure, mentally challenged and history of dysphasia.

Review of Resident #3's facility record revealed:
-Resident #3 was admitted to the hospital on

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7/3/15 and discharged on 7/10/15 for scrotal edema/cellulitis.
-The resident was ordered Home Health services for wound care.

Review of physician order sheet dated 9/25/15 revealed:
-"Change order due to SNF not able to purchase Dakin's Left Scrotum".
- Normal Saline wet to dry pack daily.

Review of physician orders dated 9/30/15 revealed:
-Pack scrotal ulcer wet to dry normal saline daily and as needed when soiled. Return to wound clinic in 3 weeks. Call if any changes.

Observation on 9/30/15 at 11:55am revealed:
-Personal Care Aide(PCA) providing incontinent care to Resident #3.
-Scrotum dressing was not on resident. The PCA informed the Medication aide (MA)the resident needed the dressing replaced.
-The Medication aide cleaned the area with normal saline with a white gauze that she had in her hand.
-The Medication aide put normal saline on another gauze, then pushed the gauze into the open wound of the Resident's left scrotum.
-The Medication aide placed gauze on the resident bed. Medication aide took the gauze and placed it over the packing. MA did not use paper tape, the resident began hitting at the MA. The MA removed the gauze and tape.
-The MA retrieved new gauze and paper tape and placed it on the resident.

Interview with Medication Aide on 9/30/15 at 11:55 am revealed:
-Per Physician orders staff were supposed to

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pack and redress the wound daily.
-No one instructed staff on how to pack the wound.
-If wound dressing comes off staff will pack and redress the wound.
-Staff have to redress it several times a day because of the Resident's incontinent episodes.

Telephone interview with Home Health Intake Nurse on 10/1/15 at 4:00pm revealed:
-There were no orders received for Resident #3 for wound care.
-Last note in the resident record was on 8/31/15 "problems with wound care waiting on call back from the physician".

Telephone interview with Home Health Nurse on 10/1/15 at 4:30 pm revealed:
-Resident #3 was discharged from home health services on 9/27/15.
-Staff were supposed to continue wet to dry dressing to scrotum to include packing the area.
-Home health does not do daily dressing changes.
-Home health nurse stated that the facility staff informed her that the staff could no wet to dry dressings with packing.
-The home health nurse did not whom informed her or what staff told her.
-The dressing was never in place when home health visited.
-If the wound is not packed it will not heal properly and possibly cause infection.
-The home health nurse requested information from facility staff on what kind of wound care they could provide to residents.
-The facility had not provided any information to the home health nurse.

Interview with the wound care Registered Nurse

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on 10/2/15 at 10:25 am revealed:
Facility staff had not contacted the wound clinic until today 10/2/15 stating they could not provide packing of a wound.

3. Review of Resident #6's current FL-2 dated 2/6/15 revealed:
-The resident's diagnoses included uncontrolled Type II Diabetes Mellitus, insomnia and schizoaffective disorder.
-The resident was constantly disoriented, ambulatory and injurious to self and others.
-Klonopin 0.5 milligrams (mg) 1 tablet by mouth twice daily (used to help control seizures and panic attacks).
-Lorazepam 0.5 m 1 tablet by mouth three times daily (used to help control agitation).

Review of Resident #6's record revealed a subsequent order dated 10/1/15 to discontinue Klonopin and increase Ativan to 1 mg three times daily.

Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 8/29/14.

Review of Resident #6's Care Plan dated 2/6/15 revealed the resident had "no problems" with the upper extremities and ambulation.

Review of Resident #6's record revealed there were ten documented times where the resident had fallen and one documented time when the resident had thrown self to the floor.

Review of Resident #6's Licensed Health Professional Support (LHPS) task dated 6/8/15 revealed:
-The resident fell the night of 6/7/15, but did not

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report the fall to staff.
-The resident fell on 3/11/15 and had a head injury.

Review of Resident #6's progress notes revealed:
-An entry dated 3/10/15 (no time) by a Medication Aide (MA) revealed the resident had fallen outside.
-An entry dated 6/29/15 (no time) by a MA revealed during the lunch meal, the resident was in the dining room and had thrown herself on the floor. The resident did not have any injuries.
-An entry dated 7/22/15 (no time) by a MA revealed the resident had fallen in the room going to the bathroom. The resident complained of her chest and back hurting. The resident was sent to a local emergency room and was admitted in the local hospital.

Review of Resident #6's incident report dated 6/9/15 (no time) completed by a MA revealed:
-The resident "was coming in the building from the front porch." The resident slipped and fell on the floor. The resident was transported to the local hospital. The resident's family member was called. The resident returned back to the facility with stitches.

Review of Resident #6's progress notes dated 6/9/15 (no time) completed by a MA revealed:
-The resident had fallen near the front door.
-The resident had a gash near the right eye brow.
-The resident was sent out to the local hospital.

Review of Resident #6's incident report dated 7/1/15 (no time) completed by a MA revealed:
-Resident #6 stated "I got up to use the bathroom. I fell."
-The resident complained of the back and neck hurting.

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-The resident was sent to the local emergency room (ER). The resident was admitted to the local hospital.

Review of Resident #6's LHPS task dated 9/7/15 revealed:
-The resident was seen at the local ER on 7/3/15 due to altered mental status.
-The resident was on falls precautions.

Review of Resident #6's incident report dated 8/5/15 (no time) completed by a MA revealed:
-The resident had fallen outside in the smoking area.
-"Resident fell face first-noted nose bleeding and swelling."
-The resident had a "moderate amount of bleeding."
-The resident had a small laceration on the bottom lip.
-The resident complained of pain to the left wrist.
-"The resident stated I stumbled on the mat outside and fell."
-"The contact person was called-message left."
-The resident returned to the facility.

Review of primary diagnoses on Resident #6's hospital discharge summary from the local hospital dated 8/5/15 revealed the resident had a nose bleed due to a fall.

Review of Resident #6's incident report dated 8/24/15 (no time) completed by a MA revealed:
-The resident was in her roommate's bed.
-Resident #6 had gotten out of the roommate's bed fell and hit the head. The resident was breathing, but was not responding.
-The Emergency Medical Services (EMS) was called.
-The resident was sent to the local ER to be

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evaluated.
-The resident's responsible party was called and revealed the resident was on the way back to the facility.

Interview with Resident #6 on 9/30/15 at 5:50 p.m. revealed:
-She had falls.
-She fell in the hallway. She could not remember when the fall occurred. The fall hurt her.
-"I fell sometime last week (September 20-26, 2015.") She could not remember the date of the fall.
- She did not hit her head.

Interview with a Nurse Aide (NA) on 10/1/15 at 9:21 a.m. revealed:
-She had not seen Resident #6 fall.
-Resident #6 told her she had fallen once a while back.
-The resident did not say when the fall occurred. The resident did not go to the hospital.
-The resident the resident told the NA she admitted to laying down on the floor and pretending to fall to get a cigarette.
-Staff are always checking on Resident #6.
-She checks on Resident #6 every thirty minutes to make sure the resident was ok.

Interview with a second NA on 10/1/15 at 9:32 a.m. revealed:
-She checked on Resident #6 every hour.
-She had never known or heard of Resident #6 having a fall.

Interview with a third NA on 10/1/15 at 9:46 a.m. revealed:
-He did not provide personal care to Resident #6.
-He had not known Resident #6 to have falls.
-At least since July 2015, staff had been

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constantly monitoring Resident #6.

Observation of Resident #6 on 10/1/15 at 10:11 a.m. revealed the resident was lying in bed.

Interview with a MA on 10/1/15 at 10:19 a.m. revealed:
-Resident #6 may have a "temper tantrum" and intentionally fall on the floor.
-Resident #6 had not had any nose bleeds from the falls.
-Staff checked on Resident #6 every two hours for incontinent care and to make sure the resident was doing fine.

Observation of Resident #6 on 10/1/15 at 10:36 a.m. revealed:
-The resident had walked quickly from the hall to the nurse's station without using assistive devices.
-The resident requested for a MA to call another staff.
-The MA told the resident she could not call the other staff and offered to call the resident's family member.

Interview with a second MA on 10/1/15 at 10:36 a.m. revealed:
-Resident #6 may have an outburst and quickly fall in the middle of the floor. The resident does not fall.
-Resident #6 tripped over a rug at the entrance to the front door. The resident hit her head, had a nose bleed and went to the hospital.
-The MA was unsure if the incident was one incident or two separate incidents.
-Sometime in August 2015 (afternoon), Resident #6 had fallen on the back porch. The resident could have hit her head, but the MA was unsure.
-Currently, staff monitored Resident #6 every two

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hours. Staff had always monitored the resident every two hours.

Observation inside of the facility in front of the entrance door on 9/29/15 at 9:45 a.m. revealed a large black plastic mat.

Observation of Resident #6 on 10/1/15 at 1:00 p.m. revealed:
-The resident had fallen on the floor at the front entrance hall and was laying on her back.
-Staff assessed the resident, got the resident off the floor, put the resident in the wheelchair and rolled the resident to her room.

Interview with the Resident Care Coordinator (RCC) on 10/1/15 at 2:55 p.m. revealed:
-After Resident #6 had the fall on 10/1/15 at 1:00 p.m. the resident did not have any injuries from the fall and was not taken to the hospital.
-She could not remember if the resident's primary care physician was contacted after the fall.

Interview with Resident #6 on 10/1/15 at 3:02 p.m. revealed:
-She fell all the time and thought it was probably due to the blood sugar or smoking cigarettes.
-She was not in pain.
-She walked all of the time. She could not "stay balanced" and may feel dizzy and fall.

Interview with a fourth NA on 10/1/15 at 4:46 p.m. revealed:
-Resident #6 fell outside on the back porch three to four months ago between 6:00 p.m. and 7:00 p.m. The resident was walking and stumbled. The resident went to the hospital.
-The NA was working at the facility on the day of the fall, but she was not assigned to work with Resident #6.

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-She had not known of Resident #6 to have any other falls.
-She had been checking on Resident #6 every 15 to 30 minutes since she had been working at the facility (3 months).

Telephone interview with Resident #6's primary care physicians nurse on 10/2/15 at 11:46 a.m. revealed:
-The resident had dementia, but she did not know the level of dementia.
-The resident had a history of seizure disorders.
-Resident #6 was last seen by the primary care physician August 2015 and there was nothing documented about falls.
-The primary care physician would have wanted to have known if Resident #6 had fallen especially if the resident had injury from the falls.

Telephone interview with Resident #6's mental health provider on 10/2/15 at 1:58 p.m. revealed:
-He does not monitor Resident #6's falls.
-The facility should contact the resident's primary care physician to see how often the resident should be monitored.

Interview with the RCC on 10/2/15 at 3:56 p.m. revealed:
-Resident #6 may be walking and just falls intentionally.
-Resident #6's primary care physician was aware of the falls. The physician's office just tells them to keep monitoring the falls.
-Staff does not contact the resident's primary care physician every time the resident falls. They only contact the physician if the resident had a major injury.
-Staff should have completed an incident report on 10/1/15 when Resident #6 had fallen. She sent a note to the resident's primary care

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| D 273 | Continued From page 59<br>physician on 10/1/15, because of the fall. The physician increased Lorazepam 1 mg by mouth to three times daily and discontinued Klonopin.<br>-The only documentation for contacting Resident #6 primary care physician would be in the progress notes.<br>-When Resident #6 had the falls, the family and the physician were notified. Staff did not always keep documentation of contacting the resident's primary care physician.<br>-Staff monitored Resident #6 every 30 minutes to two hours.<br><br>Interview with the Supervisor on 10/2/15 at 4:09 p.m. revealed:<br>-Two months ago, Resident #6 fell on the porch and had a nose bleed. The resident went to the ER.<br>-She had known Resident #6 to fall two to three times since the resident had been at the facility.<br>-She could not remember if the falls had been reported or documented.<br><br>Interview with the Administrator on 10/2/15 at 4:16 p.m. revealed:<br>-Resident #6 had fallen a couple of times.<br>-Staff encouraged Resident #6 to slow down when walking. They try to get the resident to sit and calm down when walking.<br>-It seems when Resident #6 gets excited, she falls.<br>-Sometimes Resident #6 just sits on the floor.<br>-One time Resident #6 had tripped over her shoes and the facility got her new shoes.<br>-Sometimes Resident #6 does not have on shoes and staff had to remind her to put on shoes.<br>-When Resident #6 falls, staff assessed the resident called the family member and the rescue squad if needed.<br>-If the RCC had a concern, she would contact the | D 273 | | |

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resident's primary care physician.
-The facility does not always contact the resident's primary care physician if the resident had a fall.
-If the fall was severe, the resident was sent to the local ER.
-Resident #6 had a fall and she had 2 to 4 stitches on the eyebrow on one side of the head. The Administrator could not remember when the fall occurred.
-When Resident #6 fell on 10/1/15, she was evaluated for bruises and her primary care physician was not notified.
-Staff checked on Resident #6 all of the time to see her location and to see what she was doing.

Resident #6's Responsible Party could not be reached by the end of the survey.

4. Review of Resident #5's FL-2 dated 4/1/15 revealed diagnosis of:
-Hypertension, Hyperlipidemia, Respiratory Insufficiency, Chronic Obstructive Pulmonary Disease (COPD), Smoker, Osteoporosis, Urinary Incontinence and Cerebral Vascular Accident (CVA) with right sided weakness.

Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 9/12/11.

Review of Resident #5's physician's order dated 6/3/15 revealed a referral was ordered for a Psychiatrist (Psych) consult.

Review of Resident #5's physician's order dated 8/5/15 revealed resident was to continue to follow up with psych.

Observation of Resident #5 on 9/30/15 at 4:05pm

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revealed the resident was unable to use the right side of body and propelled wheelchair with left foot and left hand.

Interview with Resident #5 on 9/30/15 at 4:05pm revealed:
-She smoked whenever she had money to buy cigarettes.
-She had lived independently until she had a stroke "a few years ago".
-Resident could no longer walk and had to start using a wheelchair.

Interview with Personal Care Aide (PCA) on 9/30/2015 at 4:25 pm revealed:
-Resident #5 required total assistance with all daily activities except feeding.
-Resident #5 smoked throughout the day.
-Resident #5 got along well with other residents and had shown no behaviors.

Interview with Supervisor/Medication Aide (MA) on 9/30/15 at 5:30pm revealed:
-Physician orders which contain appointments were given to the RCC.
-MA only faxed orders for medicines or treatments.
-There was no notation made on the order to indicate if order was faxed.

Interview with Resident Care Coordinator (RCC) on 10/1/15 at 11:10am revealed:
-Physician orders were faxed by RCC when they are received.
-A copy of the physician's order were placed into pharmacy tote for pharmacy pickup.
-The original physician's orders were then placed into the chart.
-There was no notation made on the original order.

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| D 273 | Continued From page 62<br>-Resident #5 had never been seen by the psychiatrist in this facility because she had no mental problems.<br>-Facility did not carry out the psych referral because "I did not think the primary physician meant to order a psych consult because the resident was not only any psych medications".<br>-The primary physician was not contacted to clarify the psych consult order.<br>-Resident #5 was not on any psych medications or had any documented behaviors.<br><br>Review of Resident #5's progress notes dated 10/1/15 (no time indicated) revealed:<br>-The RCC had written the primary care physician and had ask to have psych referral order written on 8/5/15 discontinued.<br>-Primary physician wanted to continue with referral to evaluate for any underlying problems.<br><br>Telephone interview with Resident #5's primary care physician on 10/1/15 at 4:25pm revealed:<br>-He was not aware that the psych referral had not been done.<br>-He ordered it due to Resident #5's frequent emergency room visits with no underlying discharge diagnosis, resident's continued smoking and questionable depression related to stroke leaving resident unable to walk.<br>-He had not been contacted by facility to clarify the psych referral order until today (10/1/15).<br><br>5. Review of Resident #8's current diagnosis on FL-2 revealed hyperlipidemia, hypertension, osteoporosis, paranoid schizophrenia, sleep apnea, gastroesophageal reflux disease, irritable bowel syndrome, and cerebral palsy.<br><br>Interview with Resident #8 on 10/02/15 at 8:50 a.m. revealed: | D 273 | | |

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-It took them a long time to get him an appointment tothe podiatrist and he had to approach the Administrator to get it scheduled.
-When he went to the podiatrist, they removed what was left of his toenail.
- When he returned to the facility he gave the paperwork to the Resident Care Coordinator (RCC), and they have yet to provide him with the basin and baking soda to soak his foot with as the podiatrist had ordered.

Review of the Resident #8's record revealed:
- Resident #8 had a prescription from the podiatrist for pain medication dated 09/08/15 for acute pain.
- The prescription was written by the resident's podiatrist but there was no other paperwork noted in the resident's record at this time regarding the visit to the podiatrist.

Interview with the Resident Care Coordinator (RCC) on 10/02/15 at 9:00 a.m. revealed:
-She was aware that the resident had gone to the podiatrist on 09/08/15.
-She was not sure that any paperwork had been received by the facility.
-She would call the podiatrist's office and speak with them about faxing over the paperwork to the facility.

Interview with the resident on 10/02/15 at 9:50 a.m. revealed:
-He had spoken with the supervisor (that schedules appointments) around July 10th or 11th of 2015 and told her that he wanted to go to the podiatrist.
-He went to the podiatrist but he was not sure of the date that he had gone.

Review of faxed documents (from podiatrist's

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office) on 10/02/15 at 10:10 a.m. revealed:
-The resident was to start with foot care following an Incision and Debridement of abscess to toe and was to follow abscess instruction sheet on soaking and applying antibiotic ointment to area as directed.

Interview with Resident #8 on 10/02/15 at 10:18 AM revealed:
-The resident was transferred by a transport company to his appointments.
-He did not remember if the paperwork was given to him or the transport company
-The paperwork was given to RCC when he returned to the facility.
-He was told by podiatrist that his foot needed to be soaked and he was sent back with a new prescription for pain meds.
-He thought there was a follow-up appointment with the podiatrist sometime around the 8th or 9th of October.

Observation of Resident #8's toe on 10/02/15 at 10:20 a.m. revealed resident's toe was noted to be pink and dry with no drainage and a small scab with no signs or symptoms of infection.

Interview with the Supervisor on 10/02/15 at 10:23 a.m.revealed:
-The resident made a lot of his own appointments and she just wrote them down in the appointment book.
-Resident #8 has an appointment with the podiatrist on October the 6th and she had already arranged transportation for him.

Telephone interview with a nurse at the podiatrist's office on 10/02/15 at 1:56 a.m. revealed:
-All of the paperwork that had been faxed to the

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facility this morning was sent with the resident when he left the office on 09/08/15.
-She was going to fax a copy of the abscess instructions to the facility; this was also sent home with the resident when he was sent home from his last visit.

Review of the document on 10/02/15 at 2:25 a.m. revealed:
-The resident was to wait 24 hours to remove the initial bandage, then soak his toe for 10 minutes twice per day in warm/ baking soda mixture for 1 week.
-After soaking, the resident was to remove any drainage that has accumulated around the nail with a clean dry Q-tip and apply wound dressing ointment and apply a Band-Aid.

Review of the September 2015 Treatment Administration Record (TAR) revealed:
-The treatment ordered on 09/08/15 was not included on the TAR.
-There was no documentation of the treatment ever being done.

Interview with RCC on 10/02/15 at 3:29 p.m. revealed:
-When a resident gets new orders from a Medical Doctor (MD), they fax them to the pharmacy to be put on the Medication Administration Record (MAR) or the TAR.
-She does not follow up with the MD if there is no paperwork sent back with the resident.
-The policy was if they send a resident via the facility's in house transport then the driver was responsible for getting the paperwork from the MD.
-If a resident goes via other transport then the resident is responsible for getting the paperwork and bringing it back.

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-She did not feel that Resident #8 could remember to bring the paperwork to them with his current cognitive functioning.

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Review of the facility's plan of protection dated 10/02/15 revealed:
- The facility will check residents' records immediately and will ensure the physician is notified with any changes.
- When an order is received it will be checked by the Resident Care Coordinator, Supervisor, and then the Administrator.
- The facility will document when they contact the physician for referral or appointment.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2015.

D 282 10A NCAC 13F .0904(a)(1) Nutrition and Food Service

10A NCAC 13F .0904 Nutrition and Food Service
(a) Food Procurement and Safety in Adult Care Homes:
(1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to assure the reach in-cooler, shelves in pantry, ice machine and the floors and walls in the kitchen and dining room were cleaned, in good repair and free of contamination.

The findings are:

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Observation of the dining room on 9/29/15 at 10:00 am revealed:
-The wallpaper had peeled in multiple areas on all four walls of the small and large dining rooms.
-There were multiple areas where the rubber base boards were loose and peeling away from the walls of small and large dining rooms.
-Paint had chipped off the lower left and right side of the door frame of the door on B Hall.
-The center wall facing B Hall dining room door contained multiple, dried brown drip stains and dried brown splattered dots.

Observation of the ice machine on 9/29/15 at 10:30 am revealed:
-The outside of the metal ice machine was covered in dry smudges with dried spots of crusty, brown food particles.
-Underneath the lid there were dried white crumbs in the hinge when opened.
-When opened the plastic blue lining contained black scratches on left side which continued until ice level.
-The blue lining had a large dry yellow/white circular stain on right side and was not touching ice.
-Inside the ice machine at top was a silver metal bar that extended across the width of the machine. The right side of the metal bar contained an approximately 4 inch raised, brown stain which was not touching ice.

Observation of the stainless steel reach in freezer on 9/29/15 at 10:45am revealed:
-The outside had cloudy, grease smudges on the doors and were sticky to touch.
-Both sides of freezer had rust, primarily at the bottom and extending up approximately 2 feet from the bottom of the freezer.
-All three doors had dried white and brown food

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particles in handles.
-The bottom on the freezer contained a white flaky substance. A bag which contained raw chicken was sitting on top of the white flakes.
-The ice cream container, which was in a separate compartment, was not completely covered.

Observation of the pantry on 9/29/15 at 3:50pm revealed:
-The floor under 5 metal wire racks with shelves had dried brown stains.
-The wall behind the door had dried brown powder splattered.
-All 26 metal shelves were sticky to touch.

Observation of kitchen floor and walls on 9/29/15 at 3:55pm revealed:
-The vent cover on the back wall between the pantry and walk in cooler was dusty and rusted.
-The outside of the metal fire alarm which was located on wall beside the back exit door and three compartment sinks, was rusted and covered with brown sticky substance.
-The ceiling in front of the walk-in cooler had peeled paint, approximately 7 x 5 inches with water dripping onto the floor.
-The two visible tiles under the cooking stove were cracked.

Observation of the water fountain in large dining room on 9/29/15 at 5pm revealed the vents on both sides had brown rust and dust.

Interview with Dietary Supervisor on 9/29/15 at 4:00 pm revealed:
-The freezer was cleaned as needed and there was not a cleaning schedule.
-Kitchen staff are supposed to mop floors and walls after each meal.

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-Maintenance was responsible for cleaning the ice machine.
-Floors were mopped after meals and each night.
-Surface areas were wiped down as needed.
-Pantry shelves are cleaned as needed and do not have a cleaning schedule.
-Dining room walls were cleaned by kitchen staff, housekeeping and maintenance.
-Dining room walls were cleaned one week ago.
-Staff had just noticed the leak in the ceiling this morning (9/29/15).

Interview with second Dietary Supervisor on 9/30/15 at 11:00 am revealed:
-There are two kitchen staff teams which have a rotating schedule.
-The kitchen staff cleaned between cooking meals.
-Maintenance was responsible for cleaning all the walls in the dining room.
-Kitchen staff wiped down walls in kitchen nightly.
-Kitchen staff mopped the kitchen floor three times a day.
-Maintenance mopped dining room floor after each meal.
-Maintenance was responsible for cleaning ice machine.

Interview with Maintenance on 10/1/15 at 10:00 am revealed:
-He worked Monday through Friday and as needed on Saturdays.
-There was another employee who helped as needed.
-If a big repair job was needed a separate staff came from another facility.
-There was no daily log of schedule duties.
-A daily written documentation was given to the Administrator of duties performed.
-Repairs are done as needed by observation, by

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staff written request or personally if after hours.
-The kitchen and dining room walls were cleaned by kitchen staff, housekeeping and maintenance.
-The kitchen floors were cleaned by the kitchen staff.
-The ice machine was cleaned every Friday by Maintenance.
-When the ice machine was cleaned it was emptied of ice, a bleach mixture was prepared and the inside was scrubbed.
-The ice machine was serviced last week.
-Inside the right side of the ice machine, the yellow stain had been there for some time and will not come off.
-The dark marks on the left inside are cuts in the lining.
-"I will scrub the metal flap at top inside to remove brown, raised buildup". He was unsure of how long it had been there.
-The kitchen staff and maintenance were responsible for wiping down the outside of the ice machine.
-Maintenance was not responsible for cleaning the water fountain in dining room. Dietary staff wiped out the top of the water fountain where water was dispensed.
-Kitchen staff was responsible for wiping down all cooler doors and food prep surfaces.
-Wallpaper in the dining room had been torn for more than six months (unsure of exact time). It cannot be covered up and must be replaced when administration decides.
-The floor molding in the dining room had been coming lose (unsure of time frame) but a team was sent to repair large areas today (10/1/15).

Review of service record from outside company on 9/28/15 revealed:
-Checked ice machine and found no water to be running across evaporator.

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-There was no cleaning of the ice machine noted.

Interview with Administrator on 10/1/15 at 10:20am revealed:
-Maintenance and housekeeping are responsible for repairs and cleaning of walls and floors.
-A team had been sent to repair the base boards today (10/1/15).
-Dining room was a team effort by kitchen staff, maintenance and housekeeping and should be cleaned.
-Maintenance changed the ice machine water filters every 3 months.
-Water fountain was old (unsure of how old) and the top is cleaned by kitchen staff. Not aware of any other service required to maintain water fountain.

Observation of kitchen on 10/2/15 at 11:00am revealed:
-The metal bar that extended across the inside of the ice machine had been cleaned and was free of stains.
-The stainless steel reach in freezer had been wiped down on the outside and was free of smudges. The handles had been cleaned and the sides of the freezer were no longer sticky to touch.
-The inside of the reach in freezer floor had been cleaned out and was free of food particles. All foods were covered.

Interview with a Cook on 9/29/15 at 3:30 p.m. revealed:
-The walls and shelves in the pantry are cleaned as needed.
-The reach-in freezer is cleaned twice monthly and on Sundays as needed.
-She cleaned the dining room walls and the kitchen walls the week of September 20-26,

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| D 282 | Continued From page 72<br>2015. She could not remember the day.<br><br>Interview with a Dietary Supervisor on 9/29/15 from 3:30 p.m. to 4:15 p.m. revealed:<br>-The shelves in the pantry were cleaned a couple of weeks ago.<br>-Maintenance cleaned the vent covers and the fire alarm.<br>-The outside of the ice machine was cleaned twice weekly by dietary staff.<br>-Dietary tried to keep the kitchen cleaned.<br>-She was aware the racks in the pantry needed to be cleaned.<br><br>Interview with a second Dietary Supervisor on 9/30/15 at 11:30 a.m. revealed:<br>-The floor in the kitchen was cleaned three times daily.<br>-The filter on the ice machine was cleaned the week of September 20-26, 2015.<br>-The ice machine should be cleaned twice weekly. The ice was moved from the ice machine when it is cleaned.<br>-The ice machine was last cleaned the night of 9/29/15.<br>-She was not aware of the stains inside of the ice machine.<br>-The metal racks in the pantry were just purchased "not too long ago."<br>-The racks are wiped and cleaned as needed.<br>-She was aware the racks needed to be cleaned. | D 282 | | |
| D 310 | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be | D 310 | | |

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served as ordered by the resident's physician.

This Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to assure thickened liquids for 2 of 2 sampled residents (#1,#9) were prepared and served as ordered by the physician.
The findings are:

1. Review of Resident #1's current FL-2 dated 06/25/15 revealed:
- Diagnoses included seizure disorder, hypertension, traumatic brain injury, schizophrenia, paranoid, psychoses, chronic pain, coronary artery disease, dyslipidemia, alcohol use disorder in remission, and cannabis use disorder in remission.
- The resident was intermittently disoriented.
- There was an order on the FL-2 dated 09/28/15 for a No Added Salt diet.

Review of progress notes for Resident #1 revealed staff documented the resident was having trouble swallowing, holding food and/or meds in her mouth, and/or holding her throat as if it was hurting on 06/30/15, 07/08/15, 09/11/15, 09/13/15, 09/15/15, 09/16/15 and 09/17/15.

Review of a hospital discharge note for Resident #1 dated 09/27/15 revealed:
- The resident was admitted to the hospital on 09/18/15.
- The resident had dehydration with hypernatremia, acute kidney injury, and hyperchloremia due to poor oral intake secondary to advanced dementia and psych issues.
- There was a discharge order dated 09/27/15 for

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dysphagia puree diet with nectar thick liquids and 1:1 assist and medications in puree.

Review of a subsequent physician's order dated 09/28/15 revealed an order for No Added Salt, puree diet with nectar thick liquids.

Interview with a medication aide on 09/30/15 at 1:30 p.m. revealed:
- Prior to recent hospitalization, Resident #1 was holding food in her mouth and would let it run out of the side of her mouth.
- The resident just returned from the hospital on Sunday, 09/27/15.
- The resident was still holding food and medications in her mouth and not swallowing.
- The resident does not cough or choke but just holds everything in her mouth and does not swallow.

Review of facility diet list dated 8/2015 revealed Resident #1 was on a pureed, no added salt diet with nectar thick liquids.

Review of the manufacturer's instructions for preparing thickened liquids on 9/29/15 at 5:00pm revealed one packet of nectar thick was added for every 4 ounces (oz) of liquid.

Observation of Resident #1 on 9/29/15 at 4:50pm during dinner meal revealed:
-Staff was feeding the resident.
-The resident was served a 6oz cup of water without ice, a 4oz cup of coffee and a 12oz cup of tea without ice.
-The amount of liquid in each cup was unmeasurable and was below the top line on cup.
-The 6oz cup of water appeared less than nectar thickened consistency when staff picked up cup and the liquid in the cup moved.

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-The 4oz cup of coffee appeared to be of honey thick consistency as it moved slowly when staff tilted cup for resident to drink.
-The 12oz cup of tea appeared of honey thickened consistency when staff picked up glass and put towards residents mouth.
-Resident did not cough or exhibit any signs of difficulty when swallowing.

Interview with the Personal Care Aide (PCA), who prepared the thickened liquids for Resident #1's dinner meal, on 9/29/15 at 5:15 pm revealed:
-Resident #1 was on honey thickened liquids.
-She did not pour the beverages in the cups. She just added the thickener.
-She added two packs of the pre-measured nectar thickened packages to the 12oz cup (tea) without ice, she added 1 pack of the pre-measured nectar thickened package to the 6oz cup (water) without ice and she added two packs of the pre-measured nectar thickened packs to the 6 oz cup (coffee) and stirred the liquids.

Observation and Interview with a second PCA, who prepared thickened liquids for Resident #1's lunch meal, on 9/30/15 at 12:00 pm revealed:
-Resident #1 was to receive nectar thickened liquids.
-Staff obtained nectar thick packets from kitchen drawer.
-Staff obtained an 8oz cup (tea) without ice and added 2 packs of pre-measured nectar thick packets, she added 2 packs of pre-measured nectar thickened packages to the 6oz cup (water) without ice and she added 2 packs of pre-measured nectar thickened packages to the 6oz cup (coffee).
-The beverages were prepared nectar thickened consistency for Resident #1.

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Observation on 9/30/15 at 12:10 pm revealed Resident #1 received nectar thickened liquids.

Observation on 9/30/15 at 12:20 pm revealed staff attempted to serve thickened liquids but Resident #1 would not drink.

Interview with Dietary Supervisor on 10/1/15 at 10:45am revealed:
-Thickener for liquids was in drawer for PCA's to mix prior to serving liquids.
-It was the PCA's responsibility to prepare thickened liquids.
-The kitchen staff was all trained to prepare thickened liquids.
-There are 3 sizes of cups used, 12oz, 6oz and 4oz.
-Each cup has a line at top, just under rim that provides exact measurement of ounces of liquid poured into cup.
-There is a measuring cup available.
-Each cup of liquid was not measured.

Interview with a third PCA on 10/2/15 at 10:20am revealed that honey thickened was supposed to be thicker than nectar thick.

2. Review of Resident #9's current FL-2 dated 3/9/15 revealed:
-Diagnoses of seizure disorder, hypertension, mild anemia, dementia, chest pain, pulmonary embolism, pneumonia and constipation.
-A diet order of no concentrated sweets with honey thickened liquids.

Review of Resident #9's Resident Register revealed the resident was admitted to the facility on 12/20/12.

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| D 310 | Continued From page 77<br>Review of Resident #9's Discharge Summary from Hospital dated 3/9/15 revealed:<br>-Liquids to be of nectar consistency.<br>-Upper Endoscopy was performed while in hospital and esophageal dilatation was performed.<br><br>Review of Resident #9's record revealed a subsequent diet order for honey thickened liquids dated 3/14/15.<br><br>Review of Resident #9's progress note dated 3/15/15 (Time Unknown) written by a Medication Aide (MA) revealed:<br>- " Resident did better with honey thickened than with nectar thickened " .<br>-No other progress notes regarding thickened liquids found.<br><br>Review of Resident #9's Assessment and Care Plan dated 3/10/15 revealed a diet order of no concentrated sweets with honey thickened liquids.<br><br>Review of Resident #9's Licensed Health Professional Support (LHPS) dated 7/13/15 revealed resident should be given honey thickened liquids.<br><br>Review of facility diet list dated 8/2015 revealed Resident #9's diet was pureed with no concentrated sweets and honey thickened liquids.<br><br>Review of Resident #9's six month physicians order signed 8/27/15 revealed the resident had a diagnosis of dysphagia, and was to receive a pureed, no concentrated sweets diet with honey thickened liquids.<br><br>Observation of Resident #9 on 9/29/15 at 4:50pm | D 310 | | |

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during dinner meal revealed:
-The resident was independent with eating.
-The resident was served a 6 ounce (oz) cup of water without ice, 12oz cup of tea without ice and a 6oz cup of coffee.
-The amount of liquid in each cup was unmeasurable and was below the top line on cup.
-The 6oz cup of water appeared honey thickened consistency when resident picked up the cup and the liquid in cup moved.
-The 6oz cup of coffee appeared honey thickened consistency when resident picked up the cup and the liquid in cup moved.
-The 12oz cup of tea appeared of consistency less than honey thickened but slightly more than nectar thick as the tea moved easily when resident picked up glass and put towards his mouth.
-Resident did not cough or exhibit any signs of difficulty when swallowing.

Observation of thickened liquid packets on 9/29/15 at 5:00pm revealed there were packets for honey thick and nectar thick located in the kitchen drawer.

Review of the manufacturer's instructions for preparing thickened liquids on 9/29/15 at 5:00pm revealed:
-One packet of honey thick for every 4oz of liquid.
-Honey/spoon thick consistency may be obtained by substituting 2 nectar thick packets for every 4oz of liquid.

Interview with the PCA, who prepared the thickened liquids for Residents #9's dinner meal, on 9/29/15 at 5:15 p.m. revealed:
-Resident #9 was on honey thickened liquids.
-She did not pour the beverages in the cups. She just added the thickener.

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-She added two packs of the pre-measured nectar thickened packages to the 12oz cup (tea) without ice, she added 1 pack of the pre-measured nectar thickened package to the 6oz cup (water) without ice and she added two packs of the pre-measured nectar thickened packs to the 6oz cup (coffee) and stirred the liquids.

Observation and interview with a second PCA, who prepared thickened liquids for Resident #9's lunch meal, on 9/30/15 at 12:00 pm revealed:
-Resident #9 was to receive honey thickened liquids.
-Staff obtained honey thick packets from kitchen drawer.
-Staff obtained a 12oz cup (tea) without ice and added 3 packs of pre-measured honey thick packets, she added 2 packs of pre-measured honey thickened packages to the 6oz cup (water) without ice and she added 2 packs of pre-measured honey thickened packages to the 6oz cup (coffee).

Observation on 9/30/15 at 12:15 pm revealed Resident #9 received honey thickened liquids.

Observation on 9/30/15 at 12:30 pm revealed Resident #9 had no difficulty when consuming honey thickened liquids.

Interview with Dietary Supervisor on 10/1/15 at 10:45am revealed:
-Thickener for liquids was in drawer for PCA's to mix prior to serving liquids.
-It was the PCA's responsibility to prepare thickened liquids.
-All PCA's were trained to prepare thickened liquids.
-The kitchen staff was all trained to prepare

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thickened liquids.
-There are 3 sizes of cups used, 12oz, 6oz and 4oz.
-Each cup has a line at top, just under rim that provides exact measurement of ounces of liquid poured into cup.
-There is a measuring cup available.
-Each cup of liquid was not measured.

Interview with Resident #9 on 10/2/15 at 10:15am revealed:
-The resident coughed at times when the resident drinks and when he does not drinking.
-He sometimes had to use a spoon to drink liquids, because the liquid would not come out of the cup.
-He was unsure of why he was on thickened liquids.

Interview with a third PCA on 10/2/15 at 10:20am revealed:
-Resident #9 was supposed to get honey thick liquids.
-She had not noticed Resident #9 having any trouble coughing or choking.
-All PCA's were trained on how to make thickened liquids.
-The PCA was taught by the Supervisor to mix thickened liquids.
-She was taught to use premeasured packets for honey or nectar thick liquids, depending on order.
-Staff was supposed to add the honey thickened packet when preparing Resident #9's thickened liquids.
-Use 1 packet for "tiny glass", 2 packets for "medium glass" and 3 packets for "big glass".
-Honey thick was supposed to be thicker than nectar thick.

Interview with Resident Care Coordinator (RCC)

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on 10/2/15 at 10:30am revealed:
-Training for thickened liquids was provided by the Supervisor.
-Dietary staff and PCA are monitored daily to ensure liquids are prepared correctly.
-Resident #9 was supposed to receive honey thickened liquids and she had not noticed the resident having any coughing or choking.
-She was not aware the PCA's had not prepared thickened liquids for Resident #9 correctly.
-Staff will need to be retrained.
-The Nurse Consultant and Supervisor had to retrain and check off.

Interview and observation with the Supervisor on 10/2/15 at 1:15pm revealed:
-The Administrator trained her "a long time ago" on how to teach and prepare thickened liquids.
-She was responsible to teaching all staff.
-Honey and Nectar thick packets are used to prepare thickened liquids
-She taught staff to add 1 packet to unknown about of liquid (held her hand up to paper cup to indicate where liquid would stop). Did not verbalize directions based on ounce of liquid per one packet.
-Unaware staff had not prepared thickened liquids correctly.

Interview with Administrator on 10/2/15 at 1:20pm revealed:
-She checked off the Supervisor on correct preparation of thickened liquids. (No documentation of date)
-She instructed Supervisor on how to teach other staff to prepare thickened liquids.
-The RCC and the Supervisor along with evening shift Supervisor monitored the dining room at meals to ensure thickened liquids were prepared correctly.

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| D 310 | Continued From page 82<br>-There was no written documentation of when thickened liquids were monitoring in the dining room.<br>-Each staff was taught how to prepare thickened liquids yearly.<br>-She was not aware staff had not prepared thickening liquids correctly. | D 310 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.<br><br>This Rule is not met as evidenced by:<br>Based on interviews, the facility failed to assure residents were treated with respect, consideration, and dignity as related to the tone and manner in which staff members speak to residents. (Staff D, E and G).<br>The findings are:<br><br>Confidential interview with a resident revealed:<br>-Staff E treats the resident badly and with disrespect.<br>-Staff E is rough with the resident as she slams the resident around when taking the resident in and out of the bed or wheel chair.<br>-Sometimes Staff E refuses to bathe the resident but will document the resident received a bath.<br><br>Confidential interview with a second resident revealed:<br>-The resident felt the resident was being neglected and verbally abused by Staff E at the facility. | D 338 | | |

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-Staff E will holler at the resident when they have to come in and change or bathe the resident.

Confidential interview with a staff person revealed:
-The staff person overheard Staff E have an attitude with the residents.
-She heard Staff E use choice words (would not repeat the choice words but insinuated they were ugly language) with some of the resident's when they need a bath or need to be changed.

Observation on 10/1/15 at 10:13 a.m. revealed:
-A resident was sitting halfway in the wheelchair leaning to the right side of the chair asleep.
- Staff G, Nursing Assistant (NA), called the resident by her name and yelled "Slide your behind back in the chair."

Confidential interview with a third resident revealed:
- Staff D talks "bad" and "mean" to the resident.
- The resident went to the medication station about two days ago and Staff D talked mean and told the resident to come back later for medications in a loud, angry voice.
- The resident knocked on the door to the kitchen and Staff D told the resident to get the "hell out of there".

Confidential interview with a fourth resident revealed:
- A Supervisor, Staff D did not speak to residents in a nice way.
- The Staff D had talked to (the resident) in a hateful way.
- The resident had heard Staff D cuss at residents.
- The resident said Staff D made [the resident] afraid.

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- The resident said the way Staff D spoke to the resident was very concerning.
- The resident had told the Administrator about these incidents many times.

Confidential interview with a fifth resident revealed:
- "If residents do not do as told, staff would cuss us out, quick!"
- Unnamed staff members would cuss at residents and had "attitudes" by the way they spoke to residents.
- The resident did not report to anyone in the facility because they would not do anything about it.
- There had not been any physical abuse observed.
- No staff member was identified.

A confidential interview with a sixth resident revealed:
- Some staff members had attitude problems.
- Staff sometimes did not want to help residents and showed it by the way they spoke.

Confidential interview with a seventh resident revealed:
- Staff F spoke disrespectfully to residents.
- Staff F was short and rude to residents.
- The resident had notified a medication aide or the Administrator about Staff F treatment before.

A confidential interview with a Personal Care Aide (PCA) revealed:
- The PCA had never seen nor heard staff verbally or physically abuse a resident.
- Staff had to be restrained and tolerant when working with some of the residents and their behaviors.
- Residents should be treated well and with

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| D 338 | Continued From page 85<br>respect.<br><br>Confidential interview with staff revealed:<br>- The staff member was not aware of any residents being disrespected by staff.<br>- There had been no reports by residents or staff about lack of respect to residents by staff.<br>- The staff member had not heard or seen any abuse, either physical or verbal to residents.<br>- Staff had been trained frequently and reminded to work with the residents and to treat them with respect and dignity.<br><br>Interview with the Administrator on 10/01/15 at 9:45 a.m. revealed:<br>- Residents had told her about the way staff talked to them before.<br>- When complaints come to her from residents about how staff speak and treat residents, the Administrator talks with staff about how to treat residents with respect and dignity.<br>- She gets the residents and the staff involved by talking the situation out together.<br>- She said there had not been any verbal abuse reported. but the manner in which staff may have interacted with residents was discussed.<br>- No Health Care Personnel Registry investigations had been completed.<br>- The Administrator said there were several Resident Rights courses have been completed by staff already this year as she showed the surveyor the notebook with the training on resident rights.<br>- The ombudsman is going to give a Resident Rights talk when it can be scheduled. | D 338 | | |
| D 344 | 10A NCAC 13F .1002(a) Medication Orders<br><br>10A NCAC 13F .1002 Medication Orders | D 344 | | |

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NAME OF PROVIDER OR SUPPLIER: **HERITAGE CARE OF ROCKY MOUNT**

STREET ADDRESS, CITY, STATE, ZIP CODE: **1650 COKEY ROAD, ROCKY MOUNT, NC 27801**

| (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 |
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(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:
(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure physician's orders were clarified for 2 of 7 sampled residents (#3, #5) resulting in incorrect medication dosage administered and discontinuation of medication that the primary physician wanted to continue.

The findings are:

1. Review of Resident #5's FL-2 dated 4/1/15 revealed:
-Diagnosis of Hypertension, Hyperlipidemia, Respiratory Insufficiency, Chronic Obstructive Pulmonary Disease (COPD), Smoker, Osteoporosis, Urinary Incontinence and Cerebrovascular Accident (CVA) with right sided weakness.
-Medication orders for Coreg 12.5 mg by mouth twice a day with meals. (Coreg is a medication used to treat the heart and high blood pressure), and Metformin 500 mg by mouth twice a day with meals. (Metformin is a medication used to treat diabetes).

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Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 9/12/11.

Review of physician's visit note for Resident #5 dated 6/3/15 revealed a blood pressure of 144/93.

Review of Resident #5's Hospital Discharge Summary dated 6/25/15 revealed:
-Order for Coreg 12.5 mg twice a day with meals.
-Order for Metformin 250 mg twice a day with meals.

Review of Resident #5's subsequent physician 6 month orders dated 7/1/15 revealed:
-Original document was received by the pharmacy on 7/1/15 at 2:22 pm.
-Coreg 25 mg twice a day with meals.
-Metformin 500 mg twice a day with meals.

Review of physician's visit note for Resident #5 dated 8/5/15 revealed a blood pressure of 146/92.

Review of Resident #5's August 2015 Medication Administration Record (MAR) revealed:
-Metformin 500 mg take one half tablet two times a day with meals was transcribed on the MAR.
-Resident was documented as receiving Metformin 250 mg twice a day from 8/1/15 through 8/31/15 with no documentation on 8/23/15.
-Coreg 12.5 mg take one table two times a day with meals was transcribed on the MAR.
-Resident was documented as receiving Coreg 12.5 mg twice a day from 8/1/15 through 8/31/15 with no documentation on 8/23/15.
-Finger stick blood sugars were taken twice a day

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at 7:30 am and 4:00 pm.
-Blood sugar results were recorded from 8/1/15 through 8/31/15 with documented refusal on 8/4/15 at 4:00 pm and 8/23/15 7:00 am and 4:00 pm had no documentation.
-Blood sugars ranges recorded were between 113 and 238.

Review of Resident #5's September 2015 MAR revealed:
-Metformin 500 mg take one half tablet by mouth two times a day with meals was transcribed on the MAR.
-Resident was documented as receiving Metformin 250mg twice a day from 9/1/15 through 9/29/15.
-Coreg 12.5 mg take one tablet by mouth two times a day with meals was transcribed on the MAR.
-Resident was documented as receiving Coreg 12.5 mg twice a day from 9/1/15 through 9/29/15.
-Blood sugar results were recorded from 9/1/15 through 9/30/15 at 7:00 am and 4:00 pm with a documented refusal on 9/29/15 at 4:00 pm.
-Blood sugars ranges recorded were between 110 and 239.

Interview with Supervisor/Medication Aide (MA) on 9/30/15 at 5:30 pm revealed:
-Physician orders were faxed to the pharmacy.
-The order was copied and copy was placed in the pharmacy tote for pharmacy pick up.
-There was no notation on orders to indicate if they were faxed to the pharmacy.
-The pharmacy was supposed to put medication and treatment orders into the MAR.
-The MA was responsible for checking the order to ensure it was correct in the MAR.
- The MA had to accept or reject new order on the MAR before it can be administered.

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| D 344 | Continued From page 89<br>-New MAR orders are supposed to be compared to original physician's order.<br><br>Interview with the RCC on 10/1/15 at 9:25am revealed the pharmacy was called and asked to send fax of six month physician's order from 7/1/15.<br><br>Telephone interview with a Pharmacist from the local pharmacy on 10/1/15 at 9:35 revealed:<br>-They received a copy of Resident #5's FL-2 dated 4/1/15.<br>-Pharmacy received orders on Resident #5's Hospital Discharge summary on 6/25/15.<br><br>Interview with Resident Care Coordinator (RCC) on 10/1/15 at 11:10 am revealed:<br>-Physician orders were faxed to pharmacy by RCC when they are received from the physician.<br>-A copy of the physician's order was placed into pharmacy tote for pharmacy pickup.<br>-The original physicians order was then placed into the record.<br>-There was no notation made on the original order to indicate if orders had been faxed to the pharmacy.<br>-Fax receipts were kept but are not available because they are "in the shed", which is where paperwork that is not important is kept.<br>-There was not enough room in the building for all the past fax receipts.<br>-Resident #5's 6 month signed physician orders dated 7/1/2015 was faxed to the pharmacy (date unknown).<br>-"I do not know why the pharmacy didn't change the order".<br><br>Interview with a second MA on 10/1/15 at 3:40 pm revealed:<br>-New labeled medications were compared to the | D 344 | | |

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order in computer and order in the record .
-Monthly MAR's were to be acknowledged in the MAR before medications can be administered.

Telephone interview with Resident #5's Primary Care Physician on 10/1/15 at 4:25 pm revealed the physician had not been contacted to clarify any orders written until 10/1/15.

By the end of the survey on 10/2/15, the orders for Coreg and Metformin had not been clarified.

2. Review of Resident #3's current FL-2 dated 6/20/15 revealed:
-Diagnoses included dementia, cardiovascular accident, hypertension, seizure disorder, atrial fibrillation, congestive heart failure, mentally challenged and history of dysphasia.
- Medication orders for Cardizem 30mg three times a day (Cardizem is used to treat high blood pressure and chest pain) and Aricept 10mg at bedtime (Aricept is used to treat dementia).

Review of the Hospital patient discharge instructions /clinical summary dated 7/10/15 revealed:
-Discontinue Diltiazem 30 mg three times a day.
-Discontinue Aricept 10 mg at bedtime.

Interview with the Resident Care Coordinator (RCC) on 10/1/15 at 10:00 am revealed:
-Staff that accept the resident back from the hospital is responsible for checking the discharge summary for any changes in medications.
-Staff are supposed to check the physician orders from the discharge summary with the current physician orders on the Medication Administration Record (MAR) and orders that were on the current FL-2.

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| D 344 | Continued From page 91<br>-If there were changes on the discharge instructions the physician should be notified for clarification of orders.<br>-The RCC notified the physician on 10/1/15, the physician stated to discontinue Cardizem and start Aricept 10 mg at bedtime.<br><br>Interview with the Administrator on 10/2/15 at 11:00 am revealed:<br>-The RCC or supervisor is supposed to check for physician order changes when the resident returned from the hospital or a physician appointment.<br>-The assistance RCC is supposed to check behind the RCC and the medication aide supervisors to make sure medications are clarified.<br>-The orders for Aricept and Cardizem should have been clarified by staff when the resident returned to the facility. | D 344 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observation, interview, and record review, the facility failed to assure medications | D 358 | | |

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were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 5 residents (#9 #10 #11) observed during the medication passes, including errors with medication for diabetes, mood disorder, constipation, prevention of heart disease and prevention of side effects from antipsychotics and 1 of 7 residents (#1) sampled for review related to medications for seizures, anxiety, psychosis, and side effects from antipsychotics. The findings are:

1. The medication error rate was 17% as evidence by observation of 5 errors out of 29 opportunities during the 4:00 PM medication pass on 09/29/15 and the 7:00 AM / 8:00 AM med pass on 09/30/15.

A. Review of Resident #9's current FL-2 dated 03/09/15 revealed diagnoses of seizure disorder, mild anemia, dementia, hypertension, chest pain, pulmonary embolism, pneumonia, and constipation.

Review of Resident #9's current FL-2 dated 03/09/15 revealed a physician's order for Humalog injection 4 units subcutaneous 3 times per day. (Humalog is a rapid acting insulin that lowers blood sugar. The manufacturer recommends Humalog be taken 15 minutes before eating a meal.)

Review of the September 2015 Medication Administration Record (MAR) revealed:
-An entry to administer Humalog Insulin 4 units subcutaneous 3 times per day.
-Humalog was scheduled to be administered at 7:30 AM, 11:30 AM, and 4:30 PM before meals.

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Observation of the medication pass on 09/29/15 at 3:53 PM revealed:
-The Medication Aide drew up insulin with the top of the plunger between the lines marking 4 and 5 units.
-The Medication Aide drew up the insulin in an area of the hallway which had poor lighting.
-He tilted the syringe towards him and did not hold it straight up when he was looking at the measurement.
-The Medication Aide went into the resident's room to administer the insulin.
-Surveyor intervened and asked the Medication Aide to step in the hall to the medication cart.
-When asked how much insulin was in the syringe he stated 4 units.
-He then looked at the syringe under a light in the hallway and held the syringe at eye level.
-He then adjusted the dose to 4 units of Humalog Insulin.
-The Medication Aide then walked back into the room and administered the insulin to the resident at 3:56 PM.

Observation on 09/29/15 at 4:43 PM revealed:
-Resident #9 received his meal tray and started to eat which was 47 minutes after he received his Humalog Insulin.

Interview with the Medication Aide on 09/29/15 at 5:40 PM revealed:
-The Medication Aide had been working at the facility for about 7 years and he had always been a Medication Aide.
-He received his diabetes training when he got there from the facility's Registered Nurse.
-Training included how to draw up insulin and administer insulin.
-He usually gave insulin about 30 minutes before a meal and then takes them down to get their

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meal.
-The supper meal was usually served at 4:30 PM.

Interview with Resident Care Coordinator (RCC) on 09/29/15 at 5:59 PM revealed:
-The residents were to get their insulin right before they receive their meal tray.
-All of the Medication Aides were aware of the facility's policy of when to administer insulin.

B. Review of Resident #10's FL-2 dated 07/09/15 revealed diagnoses of dementia, hypertension, schizoaffective disorder, diabetes mellitus, and constipation.

Review of Resident #10's current FL-2 dated 07/09/15 revealed a physician's order for Depakote Sprinkles 125 milligrams to take 4 capsules with food 2 times per day. (Depakote may be used to treat mood disorders.)

Review of the September 2015 Medication Administration Record (MAR) revealed an entry to administer Depakote Sprinkles 125 milligrams take 4 capsules with food twice a day.

Observation on 09/30/15 at 8:50 AM revealed:
-Resident #10 was lying in bed.
- The Medication Aide administered 4 Depakote Sprinkles 125 mg capsules to the resident.
-The Medication Aide did not offer any food to the resident when she administered his medications.

Interview with the Medication Aide on 09/30/15 at 8:51 AM revealed the resident had not eaten breakfast or any food at this time.

Observation on 09/30/15 at 8:52 AM revealed the Medication Aide went to get assistance for Resident #10 to get to the dining room.

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Observation on 09/30/15 at 9:04 AM revealed a Personal Care Aide came down to the resident's room and took him to the dining room via wheel chair.

Observation on 09/30/15 at 9:08 AM revealed the resident received his meal tray and began to eat his breakfast 18 minutes after he received his Depakote.

Interview with the resident on 09/30/15 at 10:41 AM revealed the resident was confused and unable to answer questions.

Interview with Medication Aide on 09/30/15 at 10:55 AM revealed:
-This was not the resident's normal routine.
- The resident normally came down to the dining room and she gave his medications while he was in the dining room.
-The resident usually got food with his medications but he did not come down to the dining room today.
-If the resident refused food they would hold his dose and offer him a snack so that he could get his medications.

Interview with Resident Care Coordinator (RCC) on 09/30/15 at 11:13 AM revealed the policy for medications ordered to be given with food or meals was to give it with the first bite of food or offer a snack to the resident.

C. Review of Resident #10's FL-2 dated 07/09/15 revealed diagnoses of dementia, hypertension, schizoaffective disorder, diabetes mellitus, and constipation.

Review of a signed hospital discharge order

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sheet dated 07/09/15 revealed:
-An order for Pericolace 2 tablets twice per day. (Pericolace is used for constipation.)
-No order for Aspirin was on the signed discharge order sheet.

Review of a hospital discharge note dated on 07/09/15 revealed:
-List of medications included Aspirin EC 81 milligrams 1 tablet daily. (Aspirin may be used for the prevention of heart disease.
-The hospital discharge included Pericolace on the list of medications.
-The list was not signed by a physician.

Review of the September 2015 Medication Administration Record (MAR) revealed:
-Pericolace and Aspirin were not listed on the MAR.
-There was no documentation that Pericolace or Aspirin were being administered to the resident.

Observation of the medication pass on 09/30/15 revealed the resident did not receive the Pericolace or the Aspirin with his morning med pass at 8:50 AM.

Interview with Medication Aide on 09/30/15 at 10:55 AM revealed:
-The resident goes to a local veteran's hospital to get his medications.
-She remembered him being on the Pericolace and the Aspirin in the past.
-These two medications were no longer on the MAR and so she was not aware of him taking them any longer.

Review of medication on hand on 09/30/15 revealed:
-A supply of 120 Pericolace tablets were

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dispensed on 07/08/15.
-A supply of 120 Aspirin EC 81mg tablets were dispensed on 08/06/15.
-The bottle of Aspirin was sealed and had not been opened.

Interview with Resident Care Coordinator (RCC) on 09/30/15 at 11:13 AM revealed that she would send a clarification form to the MD to ask about the Pericolace and the Aspirin.

Review of order that was provided by RCC on 09/30/15 at 4:45 PM revealed:
-The Medical Doctor wanted the facility to follow the discharge orders from the VA.
-The resident was supposed to be on the Pericolace and the Aspirin.

D. Review of Resident #11's current FL-2 dated 08/12/15 revealed diagnoses of altered mental status, diabetes mellitus, seizure, sleep apnea, bipolar disorder, and schizophrenia.

Review of Resident #11's record revealed:
-A physician's order on the current FL-2 dated 08/12/15 for Cogentin 2mg 3 times per day. (Cogentin is used to treat side effects of anti-psychotics.)
-A subsequent order dated 09/25/15 to change to Cogentin 1mg twice a day.
-A subsequent order dated 09/29/15 to change to Cogentin 2mg 3 times per day.

Review of Resident #11's September 2015 Medication Administration Record (MAR) revealed:
-An entry for Cogentin 2mg 3 times per day.
-Cogentin was scheduled to be administered at 8:00 AM, 2:00 PM, and 8:00 PM.

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Observation on 09/30/15 at 9:03 AM revealed the Medication Aide administered Cogentin 1mg tablet to Resident #11 instead of the 2 mg that was ordered on 09/29/15.

Interview with the Medication Aide on 09/30/15 at 10:30 AM revealed:
-She gave the 1mg Cogentin tablet on hand in the medication cart because she did not see on the MAR that 2mg should have been administered.
-The Cogentin had been changed on 09/25/15 to 1mg and they had sent back the 2mg tablets they had on hand previously.
-They only had 1mg tablets on hand currently in the medication cart.
-The resident had just seen her Medical Doctor on 09/29/15 and the order had changed.
-No one had pulled the old dosage from the cart.

2. Review of Resident #1's current FL-2 dated 06/25/15 revealed:
- Diagnoses included seizure disorder, hypertension, traumatic brain injury, schizophrenia, paranoid, psychoses, chronic pain, coronary artery disease, dyslipidemia, alcohol use disorder in remission, and cannabis use disorder in remission.
- The resident was intermittently disoriented.

Review of the Resident Register revealed Resident #1 was admitted to the facility on 06/25/15.

A. Review of Resident #1's current FL-2 dated 06/25/15 revealed an order for Lamictal 25mg twice daily. (Lamictal is for seizures.)

Review of progress notes for Resident #1 revealed:
- 07/18/15: resident did not eat much for dinner.

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She was doing some jerking/shaking during shift. Medications were given.
- 08/29/15: resident sent out to ER. She was doing a lot of shaking and could not tell us what was wrong.

Review of hospital emergency room (ER) form dated 08/30/15 (6:33 a.m.) revealed:
- The reason for visit was seizures, tremors.
- The resident was diagnosed with generalized tremors; seizure.

Review of progress notes for Resident #1 revealed:
- 09/11/15: resident was not acting herself. She was shaking a lot and not responding like she normally does. She was holding food in her mouth and holding her throat as if it was hurting and unable to tell me. She was sent to the hospital.

Review of hospital emergency room (ER) form dated 09/11/15 revealed:
- The resident went to the ER for altered mental status, shaking, and not eating.
- The resident was diagnosed with altered mental status, generalized weakness, and grand mal seizure.

Review of the June 2015 medication administration record (MAR) revealed:
- Lamictal 25mg was documented as administered twice daily at 8:00 a.m. and 8:00 p.m. from 06/27/15 - 06/30/15.
- A total of 8 doses were documented as administered.

Review of the July 2015 MAR revealed:
- Lamictal 25mg was documented as administered twice daily at 8:00 a.m. and 8:00

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p.m. from 07/01/15 - 07/31/15.
- One dose was not administered due to resident being out of the facility
- One dose was not administered due to resident let it dissolve and run out of her mouth.
- A total of 60 doses were documented as administered.

Review of the August 2015 MAR revealed:
- Lamictal 25mg was documented as administered twice daily at 8:00 a.m. and 8:00 p.m. from 08/01/15 - 08//31/15.
- One dose was not administered due to resident was "NPO" (nothing by mouth) due to eye procedure.
- One dose was not administered due to resident being out of the facility.
- A total of 60 doses were documented as administered.

Review of the September 2015 MAR revealed:
- Lamictal 25mg was documented as administered twice daily at 8:00 a.m. and 8:00 p.m. from 09/01/15 - 09/17/15 and 09/27/15 - 09/29/15.
- Seven doses were not administered due to resident not swallowing or spitting out.
- Nineteen doses were not administered due to the resident being in the hospital.
- One dose was not administered due to resident let it dissolve and run out of her mouth.
- A total of 33 doses were documented as administered.

Review of pharmacy dispensing records from 06/25/15 - 10/02/15 revealed:
- Three supplies of Lamictal 25mg tablets were dispensed since the resident's admission on 06/25/15.
- There was 62 tablets dispensed on 06/25/15.

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- There was 62 tablets dispensed on 07/29/15.
- There was 62 tablets dispensed on 09/04/15.

Review of medications on hand on 10/01/15 revealed:
- One supply Lamictal 25mg tablets was on hand that was dispensed on 09/04/15.
- There were 59 of the 62 tablets remaining in the bubble card.

Review of pharmacy dispensing records, medications on hand, and the June 2015 - September 2015 MARs revealed:
- A total of 186 Lamictal 25mg tablets had been dispensed since admission on 06/25/15.
- A total of 127 Lamictal 25mg tablets had been used from the supplies dispensed.
- A total of 161 Lamictal 25mg tablets were documented as administered from 06/25/15 - 09/29/15.
- Staff documented 161 tablets were administered but only 127 tablets had been used from the supplies dispensed.

Interview with the medication aide on 10/01/15 at 3:00 p.m. revealed:
- Resident #1 would sometimes hold the medications in her mouth and not swallow or spit out.
- Those medications would have been wasted and not included in the current supply.
- They would document on the MAR if a medication was not administered.
- He did not know why there was so many Lamictal tablets on hand for the resident.

Interview with the Resident Care Coordinator (RCC) on 10/02/15 at 10:20 a.m. revealed:
- When Resident #1 was admitted to the facility on 06/25/15, she came from a local psych

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hospital.
- The resident did not have any medications with her when she was admitted.
- They ordered her medications from the primary pharmacy when she was admitted on 06/25/15.
- Staff were supposed to document if a medication was not taken on the MARs.
- She did not know why there was so many Lamictal tablets on hand for Resident #1.

Interview with a medication aide on 09/30/15 at 1:30 p.m. revealed:
- Prior to recent hospitalization on 09/18/15, Resident #1's hands and arms would shake "real bad".
- She did not think the shaking was from a seizure.
- The resident was holding food in her mouth and would let it run out of the side of her mouth.

Telephone interview with the nurse at Resident #1's primary care physician's (PCP) office on 10/02/15 at 11:23 a.m. revealed:
- The PCP was out of the office and unavailable for interview.
- The PCP usually went to the facility for on-site visits with the residents.
- She did not see anything in their records about ER visits for seizures.
- The PCP may be aware from his on-site visits.
- The resident was supposed to receive Lamictal 25mg twice daily.

B. Review of Resident #1's current FL-2 dated 06/25/15 revealed:
- An order for Risperdal 2mg daily at bedtime. (Risperdal is an antipsychotic.)
- An order for Lorazepam 0.5mg twice daily. (Lorazepam is for anxiety.)
- An order for Artane 5mg 3 times a day. (Artane

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is used to treat side effects of antipsychotics.)

Review of mental health visit form dated 07/24/15 revealed:
- An order to increase Risperdal to 3mg at bedtime.
- An order to increase Lorazepam to 0.5mg 3 times a day.
- An order to decrease Artane to 5mg twice a day.

Review of the July 2015 medication administration record (MAR) revealed:
- The orders dated 07/24/15 to change Risperdal, Lorazepam, and Artane were not included on the MAR.
- Risperdal 2mg continued to be documented as administered only at bedtime at 8:00 p.m. through 07/31/15.
- Lorazepam 0.5mg continued to be documented as administered twice daily through 07/31/15.
- Artane 5mg continued to be documented as administered 3 times daily through 07/31/15.

Review of a medication review dated 08/03/15 revealed the pharmacist noted the order changes dated 07/24/15 had not been made on the MARs.

Review of the August 2015 MAR revealed:
- The orders dated 07/24/15 to change Risperdal, Lorazepam, and Artane were not started until 08/03/15.
- Risperdal 3mg at 8:00 p.m. continued to be documented as administered through 08/03/15.
- Lorazepam 0.5mg twice daily continued to be documented as administered through 08/03/15.
- Artane 5mg 3 times daily continued to be documented as administered through 08/03/15.

Interview with a pharmacist at the primary care

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| D 358 | Continued From page 104<br>pharmacy on 10/02/15 at 9:28 a.m. revealed:<br>- They received the orders dated 07/24/15 via fax on 08/03/15.<br>- The changes were made to the MARs at that time.<br><br>Interview with the Resident Care Coordinator (RCC) on 10/02/15 at 9:34 a.m. revealed:<br>- She or the medication aide on duty at the time an order is received are responsible for faxing the order to the pharmacy.<br>- They do not document or get confirmation when orders are faxed.<br>- The orders dated 07/24/15 must have been overlooked.<br>______________________________<br><br>Review of the facility's plan of protection dated 10/02/15 revealed:<br>- The facility will check all orders in residents' records immediately along with the medication carts and the medication administration records.<br>- The facility will monitor staff administering medications periodically.<br>- Documentation will be in place.<br>- The Resident Care Coordinator will monitor orders and get clarifications when a resident is new, returns from the hospital, and/or physician's visit.<br>- The facility will contact the nurse and pharmacist to assist in monitoring medication passes.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2015. | D 358 | | |
| D 482 | 10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives | D 482 | | |

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| D 482 | Continued From page 105<br><br>10A NCAC 13F .1501Use Of Physical Restraints And Alternatives<br>(a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be:<br>(1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes;<br>(2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule;<br>(3) the least restrictive restraint that would provide safety;<br>(4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.<br>(5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;<br>(6) applied correctly according to the manufacturer's instructions and the physician's order; and<br>(7) used in conjunction with alternatives in an effort to reduce restraint use.<br>Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing | D 482 | | |

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| D 482 | Continued From page 106<br>frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to assure physical restraints, including side rails were used only after an assessment and care planning process had been completed and used only after alternatives had been tried and a physician's order obtained for 1 of 1 sampled residents (#4) with restraints. The findings are:<br><br>Review of Resident #4's current FL-2 dated 02/04/15 revealed diagnoses of chronic pain, left hemiplegia, hypertension, benign prostate hyperplasia, smoker, dyslipidemia, and peripheral vascular disease.<br><br>Observation and interview with Resident #4 on 09/29/15 at 10:30 AM revealed:<br>-Resident was in his bed with bilateral side rails that were both up.<br>-Resident was a bilateral amputee and had a trapeze bar attached to his bed.<br>-Resident could move around some in the bed using the trapeze bar such as pulling up in bed and repositioning.<br><br>Review of Resident #4's record revealed:<br>-The resident did not have any physician's order for the side rails.<br>-There was no assessment for use of side rails. | D 482 | | |

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| D 482 | Continued From page 107<br><br>Interview with a Personal Care Aide (PCA) at the facility on 09/30/15 at 12:43 PM revealed:<br>-PCA has been working at the facility for about 10 years and usually works on the hall with Resident #4.<br>-The staff has to put the side rails up and down for the resident as he can't do this for himself.<br>-When he is in the bed they leave the side rails up all the time.<br>-They leave them up so that the resident does not roll out of the bed on the floor.<br>-They are used for safety.<br>-The resident is total care and requires assistance with all ADL's including bathing, dressing, and transferring.<br>-She did not recall the resident ever rolling out of the bed since she has been working with him.<br><br>Interview and observation of Resident #4 on 09/30/15 at 12:56 PM revealed:<br>-The resident wants the side rails up on the bed so that he does not roll off the bed on the floor.<br>-The resident currently had one side rail up and one down<br>-He attempted to pull the one down up but was unsuccessful at this time.<br>-Resident stated that he can't pull the rails up and down on the bed without assistance from a staff member.<br><br>Interview with a second PCA at the facility on 09/30/15 at 1:11 PM revealed:<br>-PCA has been working at the facility for about 6 months and is usually a floater so he works on all the halls.<br>-He always puts both side rails up due to the resident being at high risk for falls.<br>-The resident attempts to get things off the floor that he drops and the side rails prevent him from falling and injuring himself. | D 482 | | |

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-The resident is unable to put the side rails up and down without assistance from a staff member.
-Nothing else has been tried in the place of the side rails.
-He checks on the resident about every 2 hours when he works with him sometimes longer if he is busy.
-The resident has never rolled out of bed since he has been working at the facility.

Interview with the Resident Care Coordinator (RCC) on 09/30/15 at 2:30 PM revealed:
-The resident's record has been thinned and all the other material was in the shed out back.
-It would take quite a few days to go through and get the files.
-She is going to call the MD and have a new order to use side rails.
-The side rails are used for safety of the resident and not for restraints.

Interview with the Resident #4 on 09/30/15 at 5:31 PM revealed:
-He could sit up on the side of the bed if the side rails were not there.
-He has never asked the staff to put them down to try due to him being afraid of falling if he were to sit on the side of his bed.
-The resident has never fallen out of the bed since he has been in the facility.
-He feels it's because the rails are always up on his bed.

Interview with a third PCA at the facility on 10/01/15 at 15:15 AM revealed:
-He has been working at the facility for about 3 years and only works with Resident #4 when he floats like today.
-He does not ever take down or release the side

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rails due to safety issues with the resident falling.
-He does not recall the resident ever falling out of the bed since he has been there.
-He has never tried anything else as an alternative to the side rails.
-He checks on the resident about every 2 hours.

Interview with a fourth PCA on 10/01/15 at 10:18 AM revealed:
-She has been working at the facility for about 4 years and usually works on a different hall each shift.
-She only checks on Resident #4 when she comes in to check on his roommate about every 2 hours.
-She never takes down the side rails when Resident #4 is in the bed due to safety of resident falling out of bed.
-She has never tried any alternative measure to assist with the resident other than the side rails.
-The resident can turn himself in the bed when bathing.
- The resident is unable to get up out of the bed to his wheel chair without assistance from staff members.

Observation of Resident #4 on 10/01/15 at 11:06 AM revealed the resident pulled himself up in the bed with the trapeze bar and then the staff lifted him to put him in the wheel chair.

Telephone interview with Medical Doctor (MD) on 10/01/15 at 3:07 PM revealed:
-The resident required assistance to get in and out of the bed to his wheel chair.
-The resident has good upper body strength but the MD was unsure if he would be able to transfer independently.

Interview with a fifth PCA at the facility on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL033005 | A. BUILDING: ______ B. WING ______ | 10/02/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE CARE OF ROCKY MOUNT | 1650 COKEY ROAD ROCKY MOUNT, NC 27801 |

| (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 482 | Continued From page 110 | D 482 | | |

10/01/15 at 4:54 PM revealed:
-She had worked at the facility for a little over a year.
-She had worked with Resident #4 for about 2 years some was on the job and some was volunteer work.
-She attempts to round on each and every resident each hour but sometimes she gets busy.
-The resident's side rails are always up when he is in the bed.
-The resident gets upset with the staff when they do not put up the side rails after they put him in the bed.
-The resident has never fallen out of bed.
-She never used any alternative measures to assist with the resident other than the side rails.

Observation of Resident #4 on 10/01/15 at 5:00 PM revealed
-The Resident was totally dependent in transferring from the wheel chair to the bed.
-The staff placed him back in the bed from his wheel chair.
-The resident did assist with repositioning in the bed.

Interview with the Administrator on 10/02/15 at 11:32 AM revealed:
-She does not have anyone in the building that is using restraints at this time.
-No assessment for restraints had been done on Resident #4.
-She thought the side rails were used for safety.

Review of the facility's policy and procedure of restraints revealed:
-The Administrator will assure that each resident with a medical symptom that warrants use of restraints is assessed and a care plan is completed.

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **HERITAGE CARE OF ROCKY MOUNT** | **1650 COKEY ROAD ROCKY MOUNT, NC 27801** |

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| D 482 | Continued From page 111<br>-The assessment and care plan will be done prior to the resident being restrained and except for emergency situations.<br>-A Physician's order is required to apply any physical restraint.<br>-The order must be specific and must contain the type of restraint and when to be applied.<br>-All restraint orders must say observe the resident every 15 minutes, loosen every 2 hours for toileting and skin assessment, and alternatives will be listed on the order. | D 482 | | |
| D911 | G.S. 131D-21(1) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Resident's Rights<br>Every resident shall have the following rights:<br>1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure the right for each resident to be treated with respect, consideration, dignity, and full recognition of his or her individuality as related to staff behaviors. The findings are:<br><br>Based on interviews, the facility failed to assure residents were treated with respect, consideration, and dignity as related to the tone and way in which staff members speak to residents. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Standard Deficiency)]. | D911 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights: | D912 | | |

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| HERITAGE CARE OF ROCKY MOUNT | 1650 COKEY ROAD ROCKY MOUNT, NC 27801 |

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|---|---|---|---|---|
| D912 | Continued From page 112 | D912 | | |

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 observation, interview and record review, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to door alarms, personal care and supervision, licensed health professional support competency, health care and medication administration. The findings are:

1. Based on observation, interview and record review, the facility failed to assure 2 of 6 exit door alarms were activated with sufficient volume to alert staff which resulted in 1 of 7 sampled residents (#6) who was disoriented eloping from the facility. [Refer to Tag D067, 10A NCAC 13F .0305 (h) (4) Physical Environment. (Type A2 Violation)].

2. Based on observations, interviews and record review, the facility failed to ensure staff were competency validated to perform wound packing to a resident's scrotum (#3). [Refer to Tag D161, 10A NCAC 13F .0504 (c) Competency Validation for Licensed Health Professional Support Tasks (Type B Violation)].

3. Based on observation, interview and record review, the facility failed to provided supervision for 1 of 1 sampled residents (#6) known to be disoriented and to eloped from the facility. [Refer to Tag D270, 10A NCAC 13F .0901 (a) Personal

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| D912 | Continued From page 113 | D912 | | |

Care and Supervision. (Type A2 Violation)].

4. Based on observation, record review, and interview, the facility failed to assure referral and follow-up to meet the acute health care needs of 5 of 8 residents (#1, #3, #5, #6, #8) sampled as related to not obtaining a swallowing study for a resident with swallowing problems and not notifying the physician of hospitalization related to swallowing problems (#1), not obtaining home health services for packing a scrotal wound for a resident (#3), not notifying the physician of a resident's multiple falls (#6), not obtaining a psychiatric consult for a resident suspected to have depression (#5), and not coordinating with podiatrist for instructions and orders from appointment to remove toenail (#8). [Refer to Tag D273, 10A NCAC 13F .0902 (b) Health Care (Type B Violation)].

5. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 5 residents (#9 #10 #11) observed during the medication passes, including errors with medication for diabetes, mood disorder, constipation, prevention of heart disease and prevention of side effects from antipsychotics and 1 of 7 residents (#1) sampled for review related to medications for seizures, anxiety, psychosis, and side effects from antipsychotics. [Refer to Tag D358, 10A NCAC 13F .1004 (a) Medication Administration. (Type B Violation)].