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
	HAL008034	A. BUILDING: _____ B. WING _____	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

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D 000	Initial Comments The Adult Care Licensure Section and the Bertie County Department of Social Services conducted an annual survey on March 16-18,2016.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, record review, and interview, the facility failed to assure physican follow-up for 1of 5 sampled residents (#1) related to physician ordered wound care and failure to provide wound care. The findings are: Review of Resident #1's current FL-2 dated 11/07/15 revealed diagnoses included vascular dementia, lacunar stroke, diabetes, hypertension, hypothyroidism, anxiety, peripheral artery disease, and lumbar degenerative joint disease. Review of a physician's consultation note for Resident #1 dated 01/21/16 revealed: -Resident #1 had a non-stageable pressure ulcer to her right heel and a stage III pressure ulcer to her left lateral ankle. -There was a physician's order for Resident #1 to have daily dressing changes to the left lateral ankle to be irrigated with normal saline, bacitracin applied to ulcer site and then covered with absorbent dressing (ABD pad) secured with tape. -There was a physician's order for a dry dressing	D 273	Response to the cited deficiencies do not constitute an admission or agreement by the facts alleged or conclusions set fourth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with state law. 10A NCAC 13F .0902(b) Health Care It is the policy of Windsor House to assure proper referral and follow-up will meet the routine and acute health care needs of all residents. 1.Care Manager/SIC will verify orders upon return from physician's visit. A community tracking form has been implemented to ensure orders received have been followed through and documented in residents chart. 2.Upon resident's return from a physicians visit without a progress note the Care Manager and/or SIC will notify physician's office to ensure no new orders have been issued. A request for any office notes will be made and documented in the residents chart. 3.SIC/Medication Aides have been educated on the importance of follow-up on physician's visits and documentation. Documentation of this training is located in the QA Binder.	4/17/2016 4/17/2016 4/17/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Beth A Rue TITLE Executive Director (X6) DATE 04/6/2016

Approved as accepted 5/10/16 HS

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D 273	Continued From page 1 to right heel of Resident #1 but there was no frequency ordered for the dry dressing. -"Both pressure ulcers were of unknown chronicity and had no gross signs of infection". -Resident #1 was to return in 1 week for a follow-up appointment for wound care. Review of a physician's consultation note for Resident #1 dated 02/04/16 revealed: -There was a physician's order for Resident #1 to continue daily dressing changes to the left lateral ankle to be irrigated with normal saline, bacitracin applied to ulcer site and then covered with absorbent dressing (ABD pad) secured with tape. -There was a physician's order to keep the right heel of Resident #1 dry. -No dressing was ordered for the right heel of Resident #1. -Resident #1 was to return in 1 week for a follow-up appointment for wound care. Review of a physician's consultation note for Resident #1 dated 02/11/16 revealed: - A new physician's order was written for daily wound care for Resident #1's pressure ulcers to left lateral ankle and right heel to be irrigated with normal saline, bacitracin applied to ulcer sites and then covered with absorbent dressings (ABD pad) secured with tape. - Resident #1 was to return in 1 week for a follow-up appointment for wound care. - There were no new physician's consultation notes or orders after 02/11/16 for wound care. Review of the Electronic Medication Administration Records (eMARs) for Resident #1 revealed: - It was documented on the February 2016 eMAR Resident #1 received wound care to her left ankle as ordered by the physician on 02/11/16 through	D 273		

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D 273	Continued From page 2 02/29/16. - There was no documentation on the February 2016 eMAR of any wound care provided to right heel as ordered by the physician for Resident #1 from 02/11/16 through 02/29/16. - It was documented on the March 2016 eMAR Resident #1 received wound care to her left ankle as ordered by the physician on 03/01/16 through 03/16/16. - There was no documentation on March 2016 eMAR of any wound care provided to right heel as ordered by the physician for Resident #1 from 03/01/16 through 03/16/16. Observation of Resident #1 on 03/17/16 at 12:45 p.m. revealed: - Resident was sitting in the activity room with her rolling walker in front of her. - Edema was noted to both lower legs and ankles of Resident #1. - Resident was sitting with both legs dependent. Interview with Resident #1 on 03/17/16 at 12:45 p.m. revealed: - Resident complained of pain to both feet. - The staff put a bandage on her left foot every day because she had a sore on her ankle. - Resident #1 was not sure if she had ever been to the doctor for any wound care for her ankles or feet. Interview with a Medication Aide (MA) on 03/17/16 at 3:10 p.m. revealed: - Resident #1 started going to the doctor for wound care to her left ankle about 2 months ago. - Resident #1 had a dressing to her left ankle. - Staff provided daily wound care to the Resident #1's left ankle. - Resident #1 had her wound care to her left ankle done on first shift.	D 273		

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D 273	Continued From page 3 - She wasn't sure what type of wound care was provided to the left ankle of Resident #1. - Resident #1 had never had a dressing to her right foot/heel. - She was not sure when Resident #1 had been last seen by the physician for wound care for her feet. Observation of Resident #1 on 03/17/16 at 3:10 p.m. revealed: - Resident #1 was seated at the nurse's station waiting to be transported for wound care appointment. - Resident had a dressing to left ankle and there was no dressing to right heel. - Resident #1's right outer heel had dry, peeling skin with a dark, grayish black scabbed-like area that measured approximately 1 ¼ inch long and ½ inch wide. - There was no drainage or odor to Resident #1's right heel. - Unable to assess if right heel of Resident #1 was healing. - The MA lifted up the dressing to Resident #1's left lateral ankle and there was an open area that measured approximately 1 inch long and ½ inch wide. - The wound site had yellowish interior base and there was no active drainage or odor. - The wound site to the left ankle of Resident #1 did not appear to be healing. Interview with the Administrator on 03/17/16 at 3:20 p.m. revealed: - He was unaware that Resident #1 had missed any wound care appointments. - Resident #1 had been going to the wound clinic but he was not sure of her last appointment. - Resident #1 was going to the wound clinic today.	D 273		

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D 273	Continued From page 4 - The Resident Care Coordinator (RCC) was in charge of follow-up on the wound care appointments for Resident #1. Interview with the RCC on 03/17/16 at 3:26 p.m. revealed: - She is responsible to follow-up for residents for their physician's appointments and new care orders. - Resident #1 had gone to her last wound care appointment on 02/11/16. - The wound clinic usually sent the physician's orders and the next appointment date with the Resident #1 when she returned to the facility. - No paperwork came with Resident #1 after her wound care appointment on 02/11/16. - She did not call the wound care clinic on 02/11/16 for follow-up for wound care orders or Resident #1's next wound clinic appointment. - She thought it was strange the consultation notes did not come with Resident #1 after her appointment on 02/11/16 but she did not call to follow-up with the wound clinic until 03/04/16. - The facility continued with the wound care orders received on 02/04/16 for Resident #1's left ankle. - She called the wound clinic on 03/04/16 and scheduled an appointment for Resident #1 on 03/17/16 for follow-up for Resident #1's left ankle. - The wound clinic did not tell her on 03/04/16 about new wound care ordered for Resident #1 on 02/11/16 for the left ankle and right heel. - The wound clinic did not tell her on 03/04/16 Resident #1 had missed any wound care appointments in February 2016. - She had not seen the 02/11/16 physician's consultation note until 03/17/16. - She did not know new wound care orders had been ordered on 02/11/16 for the left ankle and right heel for Resident #1.	D 273		

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D 273	Continued From page 5 - The wound clinic had a doctor who came to the local clinic site every two weeks. Review of care notes for Resident #1 dated 03/17/16 revealed the Supervisor reported to the RCC that the left ankle wound of Resident #1 was draining on 03/17/16. Review of a physician's order dated 03/17/16 revealed: - New wound care orders for Resident #1 were directed to apply Santyl ointment mixed with triple antibiotic ointment daily to left ankle and right heel, cover both wound sites with ABD pads, and secure with tape [Santyl ointment is used as a debriding agent to treat chronic dermal ulcers by selectively removing necrotic tissue without harming the granulation tissue of the wound sites]. - There was an order for Bunny boots to be applied to both heels of Resident #1 when in bed to relieve pressure to those areas. - Resident #1 to return for next wound care appointment on 03/24/16 at 3:00 p.m. Review of progress note for Resident #1 on 03/17/16 revealed: - Resident #1 had drainage from the wound on her left ankle. - There was a request for home health to treat wound due to new wound care orders. Interview with RCC on 03/17/16 at 4:50 p.m. revealed: - New wound care orders for Resident #1 now required the use of a debriding agent, Santyl. - The facility could not provide wound care using the debriding agent. -The facility had contacted home health to provide wound care due to new wound care	D 273		

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D 273	Continued From page 6 orders. Interview with a Medication Aide on 03/18/16 at 10:25 a.m. revealed: - She had provided wound care only to the left ankle of Resident #1. - She was unaware of any wound care orders for the right heel of Resident #1 prior to 03/18/16. - Resident #1 had started with wound care for the left ankle about a month and a half ago. - She didn't know of any issues with a decubitus ulcer to the right heel of Resident #1 prior to 03/17/16. - She wasn't sure of the last wound care appointment for Resident #1 prior to 03/17/16. - Wound care orders were given to the RCC to be faxed to the pharmacy and/or home health agency. Interview with a second Medication Aide on 03/18/16 at 11:15 a.m. revealed: - She wasn't sure of the last wound care appointment for Resident #1 prior to 03/17/16. - New wound care orders are handled by the RCC who faxed the orders to the pharmacy to put on the MAR for the medication aides to follow. Interview with the receptionist at the wound care clinic on 03/17/16 at 3:30 p.m. revealed: - Resident #1 had started coming to the wound care clinic in January 2016. - Resident #1 was seen by the physician at the wound clinic on 01/21/16, 02/04/16, and 02/11/16. - Resident #1 did not show up for appointments scheduled on 01/28/16 and 02/25/16. - There was no documentation in their records of the reasons for the missed appointments on 01/28/16 and 02/25/16. - Their office had been contacted by the facility on 03/17/16 to obtain the previous physician's	D 273		

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D 273	Continued From page 7 consultation notes. Interview with a nurse with the wound care clinic on 03/17/16 at 3:35 p.m. revealed: - Resident #1 was last seen at the wound clinic on 02/11/16. - Wound care instructions with new wound care orders were sent with Resident #1 on 02/11/16. - Wound care orders and new appointments were always sent with the resident when she returned to the facility. - An appointment was scheduled for 02/25/16 for Resident #1 but Resident #1 did not show. - She did not know if the facility had contacted their office about wound care orders from the appointment on 02/11/16 for Resident #1. - The facility had contacted the wound clinic on 03/17/16 with concerns about the left ankle of Resident #1. - Resident #1 was scheduled for an appointment at the wound clinic on 03/17/16 at 3:30 p.m. Telephone interview with Resident #1's wound clinic's physician on 03/18/16 at 12:20 PM revealed: -The physician felt that the resident's wound had gotten worse since the resident's last visit on 02/11/16. -At the resident's last visit, he ordered for the resident to return to the wound clinic in 2 weeks, but she did not return to the scheduled appointment. -He did not know why the resident had not returned to her scheduled appointment. -Resident #1 had an appointment with the physician on 03/17/16 and he had to change her wound care to include Santyl. Resident #1's Responsible Party could not be reached by the end of the survey.	D 273		

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D 273	Continued From page 8 Plan of Protection submitted by the facility on March 18, 2016 as follows: - The Care Manager/Supervisor in Charge will verify orders immediately for all residents on return from physician's visit. - The facility will implement a tracking form to ensure all orders received have been followed through completely and documented in the resident care notes. - If a resident returns from a physician visit and does not return with a progress note, the Care Manager/Supervisor will call the physician office and request office notes and follow up according to the orders received and document in the resident care notes. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 17,2016.	D 273	Response to the cited deficiencies do not constitute an admission or agreement by the facts alleged or conclusions set fourth in the statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (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: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure Metformin was administered as ordered for 1 of 5 sampled	D 358	10A NCAC 13F .1004(a) Medication Administration It is the policy of Windsor House to assure the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the residents record; and (2) rules in this Section and the facility's policies and procedure. 1. Medication Aides were educated on proper removal and documentation of discontinued medications on the eMAR. Documentation of attendance located in the QA Binder.	4/27/2016

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D 358	Continued From page 9 residents (#1) as related to physician's order to discontinue Metformin. The findings are: Review of Resident #1's current FL-2 dated 11/07/15 revealed diagnoses included vascular dementia, lacunar stroke, diabetes, hypertension, hypothyroidism, anxiety, peripheral artery disease, and lumbar degenerative joint disease. - There was an order for Metformin 500mg - 1 tablet by mouth once daily (Metformin is an oral medication used to control diabetes). Review of Emergency Room Discharge Instructions for Resident #1 dated 01/12/16 revealed: - There was a physician's order to discontinue Metformin for Resident #1 due to poor kidney function. Review of facility clarification form dated 01/20/16 revealed: - It was requested for clarification from the primary care physician to discontinue Metformin due to poor kidney function. - The primary care physician clarified to discontinue Metformin on 01/25/16. Review of the January 2016 Electronic MAR (eMAR) for Resident #1 revealed: - Metformin was documented as administered to Resident #1 on 01/13/16. - Metformin was documented on 01/14/16 as withheld and discontinued per doctor's order. - Metformin was documented as administered to Resident #1 on 01/15/16 through 01/29/16. - Metformin was discontinued on 01/29/16. Review of the February 2016 and March 2016 eMARs revealed Metformin was not transcribed on the eMARs.	D 358	2. Medication Aides will assure all discharge orders have been signed by the physician; faxed to the pharmacy and primary care provider. Facility will provide documentation of this process on a tracking form. These forms will be reviewed by MCM and filed in her office. 3. Medication Aides will remove any discontinued medications from the bubble pack and draw a line through the discontinued medication. The pill will be discarded in sharps and documented on the Medication Disposition Log. 4. Medication carts will be audited every week by MCM. Documentation of this will be kept in the MCM's office.	4/27/2016 4/27/2016 4/27/2016

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D 358	Continued From page 10 Observation of Resident #1's medication on hand on 03/17/16 at 3:05 p.m revealed Metformin was not on hand. Interview with a Medication Aide on 03/16/16 at 8:55 a.m. revealed: - Medications for residents were dispensed in blister packs for the morning and evening doses. - If a medication is discontinued, the medication aide removes the discontinued medication from the blister pack until the updated medication packs come in from the pharmacy. - The medication aide should document on the resident's eMAR the discontinued medication was not administered per physician order. Interview with Resident Care Coordinator (RCC) on 03/18/16 at 9:05 a.m. revealed: - Discontinued medication orders were given to her fax to the pharmacy. - Metformin was discontinued per physician's order on 01/13/16 for Resident #1 and the discontinued order was faxed to the pharmacy. - The medication aides removed the Metformin from the morning medication blister packs for Resident #1 after 01/13/16. - If a discontinued medication was not administered, the medication aides were supposed to document on the eMAR with a circle around their initials and note the medication was discontinued. - She did not understand why it was documented on the eMAR that Resident #1 was administered Metformin after 01/15/16. Interview with the same Medication Aide on 03/18/16 at 10:25 a.m. revealed: - She remembered when the Metformin for Resident #1 was discontinued in January 2016.	D 358		

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D 358	Continued From page 11 - She reviewed the January 2016 eMAR for Resident #1 and she documented that the Metformin was discontinued on 01/14/16. - She did not give Metformin to Resident #1 once the medication was discontinued on 01/14/16. - Discontinued medications were removed by the medication aide from the medication blister packs and thrown away. - Medication aides were supposed to document on the eMAR with circled initials and note that medications were discontinued. - She documented on the eMAR that she administered Metformin to Resident #1 on 01/19/16, 01/21/16, 01/22/16, and 01/29/16 but she didn't understand why she documented that way. - All medication orders and discharge instructions were handled by the RCC. Interview with a second Medication Aide on 03/18/16 at 11:15 a.m. revealed: - She faxed the emergency room discharge instructions to the pharmacy to discontinue the Metformin back in January 2016. - She spoke with the RCC and informed her the Metformin was discontinued per emergency room discharge instructions. - The medication aides were supposed to pull the Metformin from the morning medication blister pack until the pharmacy sent the new medication blister packs that did not contain the Metformin. - She documented on the January 2016 eMAR that she administered Metformin to Resident #1 on 01/15, 01/16, 01/17, 01/18, 01/20, 01/23, 01/24, 01/25, 01/27, and 01/28. - She remembered she took the Metformin out of the morning medication blister pack in January 2016 for Resident #1. - She did not document that the Metformin was withheld.	D 358		

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D 358	Continued From page 12 - There was no facility policy that addressed how to document discontinued medications on the eMAR. Based on observation, interview and record review, Resident #1 was not interviewable. Resident #1's pharmacy could not be reached by the end of the survey. Resident #1's Responsible Party could not be reached by the end of the survey.	D 358	Response to the cited deficiencies do not constitute an admission or agreement by the facts alleged or conclusions set fourth in the statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility neglected to maintained the residents' rights regarding health care. The findings are: Based on observation, record review, and interview, the facility failed to assure physican follow-up for 1of 5 sampled residents (#1) related to physician ordered wound care and failure to provide wound care. [Refer to TagD273, 10A NCAC 13F .0902(b) (Type A2 Violation)]	D914	G.S. 131D-21(4) DECLARATION OF RESIDENT'S RIGHTS It is the policy of Windsor House to assure each resident is free of mental and physical abuse, neglect and exploitation. 1. All Staff will review and sign Declaration of Resident Rights. Documentation of this review is located in the QA binder. 2. Ombudsman provided in-service on resident rights on March 22, 2016. Documention of this training is located in the QA Binder.	4/27/16 3/22/16

WINDSOR HOUSE
MEMORY CARE

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[redacted]
Facility Survey Consultant
Adult Care Licensure Section
Division of Health Service Regulation
2708 Mail Service Center
Raleigh, NC 27699-2708

16 March 2016

Re: Addendum to Plan of Correction for Annual Survey.

Response to the cited deficiencies do not constitute an admission or agreement by the facts alleged or conclusions set fourth in the statement of deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with state law.

10A NCAC 13F .902(b) Health Care It is the policy of Windsor House to assure proper referral and Follow-up will meet the routine and acute health care needs of all residents.

1. The Memory Care Manager will monitor the new order tracking system on a daily basis to ensure compliance for healthcare referral and follow-up.
2. The Memory Care Manager will assure the routine and acute health care needs of the residents by facilitating health care referral and follow up to include notifying the primary care physician, as necessary.
3. The Executive Director will meet weekly with the Memory Care Manager to ensure compliance.

Sincerely,

Keith Rivers
Executive Director

VKS
5/16/16

MERIDIAN
SENIOR LIVING