Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: RECEI B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK ADULT CARE LICENSURE SECTION **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 000 Initial Comments D 000 The Adult Care Licensure Section and the Davie County Department of Social Services conducted an annual survey and a complaint investigation on 12/03/19 through 12/06/19 and 12/10/19 through 12/13/19. The complaint investigation was intiated by the Davie County Department of Social Services on 11/07/19. D 067 10A NCAC 13F .0305(h)(4) Physical Environment D 067 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, record reviews, and observations, the facility failed to ensure 1 of 5 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 5 sampled residents (Resident #5) who was constantly disorientated, had wandering behaviors and eloped from the facility without staff's knowledge. Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE 31301 STATE FORM XGC311 If continuation sheet 1 of 327

Keisha Banks

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SU COMPLE	
		HAL030007	B. WING		12/1:	3/2019
	ROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STAT STVIEW DRIVE /ILLE, NC 27028	E, ZIP CODE		
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D 067	12/03/19 between 9:4 -At 9:45am, the front was unlocked and did the facilityThe front door led to there was another un lobby area which led residentsThere was a third do which led to a smaller was propped open wi-Residents were obsemain entrance door, the smoking area, and the large lobby area to the there was no sound hopenedThere was also a door resident hallway in the that read, "Emergency-There was no sign reformed the other 3 doors and the observations of the fabetween 12/03/19 and There was no soundileading from the outsilobbyThere was no soundilarge lobby leading to The door between the small lobby area remains there was no sounding the was no soundin	the tour of the facility on a same and 11:15am revealed: door of the main entrance of not sound upon entering a large lobby area and locked door in the large to a smoking area for or in the large lobby area and this door the a door stopper. The door which led to the end door which led from the end when either door was the facility which had a sign by exit alarm will sound. The facility at various times of 12/12/19 revealed: and device on the door in the the outside smoking area. The large lobby area and the sined propped open and greated:	D 067			
		nd exited all three doors. acility on 12/04/19 at 5:58am				

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STATEMENT OF DEFICIENCIES (X1) P

	OF CORRECTION				(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		1:	2/13/2019
	PROVIDER OR SUPPLIER	191 CRE	ADDRESS, CITY, STATESTVIEW DRIVE VILLE, NC 27028	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 067	revealed: -There was a staff me -The side door to one was propped open wi was no alarm soundir -The main door to the was unlocked from the sound when the door -The door between the smaller lobby area was stopper and there was the door was propped -There was an alarm I medication aide (MA) Interview with a third s on 12/04/19 at 6:15an -The main door to the was never lockedThe door leading from smaller lobby area wa 3:00am and 5:00amOnce the door leading to the smaller lobby ar automatically locked fr alarm was automatica -Once the door was sh staff and residents cou the alarm would sound -The only way to deac the alarm keypad at th -She left the door betw lobby areas open at ni to go outside to smoke Interview with a third s (PCA) on 12/04/19 at 6 -The PCA was found a because his keys for the	ember outside at his car. of the resident hallways th a coat hanger and there ag with the door being open. facility (large lobby area) e outside and there was no was opened. e large lobby area and the as propped open with a door as no alarm sounding when open. keypad on the wall at the work station. Shift medication aide (MA) a revealed: facility (large lobby area) In the large lobby area to the as closed at night between ag from the large lobby area tea was closed, the door from the outside and the ally activated. The county of the door and all if anyone went out. tivate the alarm was from the MA station. The county of the large and small aght because residents liked the county of the door ween the large and small aght because residents liked the county of the door ween the large and small aght because residents liked the county of the door ween the large and small aght because residents liked the county of the door ween the large and small aght because residents liked the county of the door ween the large and small aght because residents liked the county of the door ween the large and small aght because residents liked the county of the door ween the large and small aght because residents liked the county of the door ween the large and small aght because residents liked	D 067			

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MOUTIPLE CONSTRUCTION A. BUILDING: A. BUILDING:		1		, ,	(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		1	2/13/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
THE HERI	TAGE OF CEDAR ROCK	191 CRE	STVIEW DRIVE	<u> </u>			
		MOCKS	/ILLE, NC 2702	28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
D 067	Continued From page	3	D 067				
	out. -He had taken the trasso he propped a coat keep it from locking be alarm from being activ. -He propped the door when it was time to ta saved him time. -When he propped the hanger, he had the Mait was propped open. -No resident had ever out the side door. -One resident (#5) had was brought back by particularly. -The interior front door small lobby areas had propped open until the 12:00am and 1:30am, closed and automatical	sh out using the side door, hanger in the side door to ack and to prevent the vated. open every night he worked ke the trash out because it e side door open with a coat A to turn off the alarm while left the building by going					
	4:50pm revealed: -She recalled when Re -She was not sure how sometimes staff left the dumped the trash.						
	7:33 pm revealed: -There were residents diagnosis of dementiaThere was no soundir large lobby area (wher small lobby area, or the smoking areaThe door between the areas was alarmed by deactivated at 7:00am.	ng device on the door to the in the door was open), the e door to the outside large and small lobby staff at 8:00pm and					

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	LETED
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THE HERI	TAGE OF CEDAR ROCK		LLE, NC 2702	28		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
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		<u>, </u>		DEFICIENCY)		
D 067	Continued From page	9 4	D 067			
	was usually with then					
	was assauly with thorn					
		5's current FL2 dated				
	10/04/19 revealed: -Diagnoses included:	fracture of left ankle, bipolar,				
	_	lux disease (GERD), and				
	anemia.					
	-Resident #5 was con	•				
	-The resident had inappropriate behavior, wandered and was verbally abusive at times.					
		, , , , , , , , , , , , , , , , , , , ,				
	Review of Resident #					
		sident #5 required limited g, toileting, ambulation, and				
	transfers.	y, tolicting, ambulation, and				
	Review of a report fro department dated 10/					
		nd by police officers on a				
		o blocks from the facility.				
		nd at 3:13 am and the				
	resident appeared dis	police officers that he was				
		d pain in his left arm, but				
		call medical assistance for				
	himThe resident was tran	nsported back to the facility				
	by the police.	roported back to the lacility				
	-The staff at the facility	y did not know the resident				
	had left the building.	ad baing hald area by -				
	door stop, which caus	ed being held open by a				
	• •	s how Resident #5 left the				
	building.					
	-No staff at the facility					
	Resident #5 left the fa	CHITY.				
	Review of Resident #5	5's Incident/Accident reports				
	revealed there were no	o Incident/Accident reports.				

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1	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	LETED
		HAL030007	B. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
THE HEDI	TAGE OF CEDAR ROCK	191 CREST	VIEW DRIVE			
I THE HERI	TAGE OF CEDAR ROCK		LE, NC 2702	8		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 067	Continued From page	9.5	D 067			
D 067	at 12:13 pm revealed -The Administrator at 10/02/19, the next more elopedShe told the Adminis better system to ident buildingResident #5 told her because he needed a would not call the ami -No one at the facility about anything involvi Interview with Reside revealed: -He had told staff on good and he wanted to -The staff ignored him nothing wrong with him -He left and was later they brought him back Interview with 4 reside and 6:10pm revealed: -The door between the small lobby area was alarmed around 11:00	the facility called her on brining after Resident #5 trator the facility needed a diffy when residents left the staff bulance and the staff bulance for him. The had called to inform her ling Resident #5. Int #5 on 12/05/19 at 9:11am 10/01/19 that he did not feel to go to the hospital. In and told him there was multiple on the facility. The facility is a facility on the facility of the hospital of the hospital of the hospital of the facility. The facility is a facility of the facility o	D 067			
		out of the facility all rd a sounding device on the by or the exit door to the				
	smoking areaThe door between the stayed propped open alarmed if it was open	e the large and small lobby during the day and only ed after being closed. ed were able to go out to				
	smoke during the nigh					

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PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 067 Continued From page 6 D 067 -Sometimes the door between the large and small lobbies was closed and alarmed and sometimes the door was not closed and alarmed. Interview with the Administrator on 12/12/19 at 9:37 am revealed: -She was aware Resident #5 eloped from the -She thought staff left the alarmed door open. -She talked with staff and notified Resident #5's guardian. -She had informed staff to watch all the residents , especially the residents that were easily agitated. Second interview with the Administrator on 12/12/19 at 6:20pm. -There was an alarm on the door at the end of each resident hallway at all times which sounded when the door was opened. -There was an alarm on the door between the large lobby area and the smaller lobby area, but it was only activated when the door was closed. -The door between the large and small lobby area was usually open throughout the day and did not have any sounding device while it was open. -The door leading from the outside of the facility to the large lobby and the door leading from the large lobby area to the outside smoking area did not have a sounding device and were never alarmed. -There were residents in the facility with a diagnosis of dementia and disorientation.

-She did not know of any residents in the facility

-She did not know there needed to be a sounding device on all exit doors accessible by residents when there was at least one resident in the facility who had wandering behaviors or disorientation.

The facility failed to assure all exit doors were

with any wandering behaviors.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		420	13/2019
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THE HERI	TAGE OF CEDAR ROCK		VIEW DRIVE			
			LE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD: CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE RIATE	(X5) COMPLETE DATE
D 080	resident who wander resulting in Resident without staff's knowle detrimental to the heat the residents and common accordance with G. Statistical violation. CORRECTION DATE VIOLATION SHALL N 2020. 10A NCAC 13F .0306 Furnishings 10A NCAC 13F .0306 Furnishings (a) Adult care homes (6) have a supply of b washcloths, sheets, p additional coverings a hand at all times; This Rule shall apply facilities. This Rule is not met a Based on observation failed to ensure all resaccessible supply of b towels and clean washall times. The findings are:	was at least one identified ed or was disoriented #5 eloping from the facility dge. This failure was alth, safety, and welfare of istitutes a Type B Violation. a plan of protection in . 131D-34 on 12/07/19 for EFOR THE TYPE B NOT EXCEED JANUARY 27, (a)(6) Housekeeping And Housekeeping And shall ath soap, clean towels, illow cases, blankets, and idequate for resident use on to new and existing as evidenced by: and interviews, the facility sidents had a readily ath soap, toilet paper, clean heloths on hand for use at	D 067	ATTACHED IS OUR LONG STAND POLICY REGARDING DOOR ALARMS AND WANDERING RESIDENTS. THIS IS CONTAINED POLICY AND PROCEDURE MANUAL. THE ADMINISTRATOR AND STAFF INEXPLICABLY, DID TO FOLLOW THIS PROCEDURE. THE HOME WAS CLOSED ON 2/7/2020 AND THE RESIDENTS WERE RELOCATED TO APPROPRIATE LEVELS OF CARE OF THE ASSISTANCE OF DAVIE COUD.S.S.	IN OUR NOT AS O WITH	

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 080 Continued From page 8 D 080 Interview with second shift housekeeper on 12/03/19 at 4:36pm revealed: -Resident supplies of toilet paper, soap, and paper towels were kept in a locked utility closet directly beside the laundry room and was accessible by staff. -Bulk paper towels, toilet paper, and soap were kept in another locked utility closet by the laundry room and was accessible only by the Administrator due to these supplies "getting missing from the staff utility closet." -This had stopped the theft of the supplies. Observation of the locked utility closet accessed by the Administrator on 12/03/19 at 5:02pm revealed: -There were no bars of soap. -There were no paper towels. Interview with the Administrator on 12/03/19 at 5:02pm revealed supplies (toilet paper, paper towels, and soap) were delivered to the facility every Thursday. Observation of residents' rooms on 12/04/19 between 9:15am and 10:12am revealed: -The men's bathroom had no handsoap. -There was one resident in room 204, there were no towels in the room. -There were 2 residents in room 103, there were no towels in the shared bathroom. -There were 2 residents in room 107, there were

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10:15am revealed:

no soap or towels in the shared bathroom.

Observation of the laundry room on 12/04/19 at

-There were 7 washcloths folded and on the shelf

-There was one bath towel folded on the shelf

behind the door of the laundry room.

behind the door of the laundry room.

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9:21am revealed:

the instructions of the owner.

but she did not indicate when.

and "they have disappeared."

towels and washcloths.

Interview with the Administrator on 12/06/19 at

-She ordered all the supplies for the building, including toilet paper, paper towels, and soap, per

-At one time, the facility had around 75-100

-She had ordered more towels and washcloths.

-She had purchased some towels and washcloths

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION In (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 080 Continued From page 10 D 080 Interview with the Supervisor on 12/06/19 at 10:00am revealed: -The Administrator was responsible for ordering the cleaning and other supplies. -There was "not always plenty of soap or towels." -There were 4 stacks of towels and 5 stacks of washcloths ordered in June or July 2019. -Staff was washing laundry as quickly as they could to make sure residents had clean washcloths and towels. Observation of the laundry room on 12/06/19 at 10:58am revealed: -There were 2 washcloths and 3 towels folded on the shelf behind the door. -There were 2 soiled washcloths waiting to be washed. Observation on 12/11/19 at 9:02am of the laundry room revealed that there were 7 washcloths and 4 towels folded on the shelf behind the door. Interview with a housekeeper on 12/11/19 at 9:02am revealed: -She was responsible for the laundry. -Laundry was also completed on 2nd and 3rd shifts. -She thought the facility may have had a total of 6 towels and 6 washcloths on hand. -The Administrator recently bought around 3 dozen new towels and washcloths but "they have disappeared." Interview with two residents on 12/11/19 at 9:23am and 9:25am revealed: -"I have never been given a towel so I bought one."

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washed."

-"I have 4 personal towels and 2 personal hand towels and I decide when they need to be

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE :	
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		HAL030007	B. WING		12 <i>l</i> ·	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK	191 CRES	TVIEW DRIVE			
	TAGE OF GEDAN NOON		LLE, NC 2702	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 080	-The residents did not dispenser because the Interview with the Adr 9:36am revealed: -She did not know whowels and washcloth-Residents may have cloths in the trashShe purchased 50 to last week and they has the example of the law 8:15am revealed that washcloths folded on Observation of room \$12:15pm revealed: -There were 2 residents.	t use the soap in the e soap was old. ministrator on 12/11/19 at at was happening with the s. tossed the towels and wash wels and 100 washcloths as all "disappeared." undry room on 12/12/19 at there were 8 towels and 16 the shelf behind the door. #207 on 12/11/19 at at the shelf behind the door.	D 080	ATTACHED ARE INVENTORY SHEETS SHETHAT ADMINISTRATOR IS SUPPOSED TO MONTHLY CHECK OF INVENTORY AND STO APPROPRIATE LEVELS. ACTUAL INSPECTION OF OWNER, INTO A UTILITY ROOM REVEALED ONE UNOPEN OF HAND SOAP AND TWO CASES OF TOIL PAPER. OWNER HAS NO EXPLANATION A ONSITE MANAGEMENT DID NOT SHOW T SURVEY TEAM.	CONDUCT TOCK LOCKED ED CASE JET S TO WHY	
	10A NCAC 13F .0406 (a) Upon employment home, the administrate any live-in non-resider tuberculosis disease in measures adopted by Services as specified including subsequent a Copies of the rule are contacting the Departr Services Tuberculosis	n compliance with control the Commission for Health in 10A NCAC 41A .0205 amendments and editions. available at no charge by ment of Health and Human Control Program, 1902 caleigh, NC 27699-1902.	D 131			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		42/42/2040
		HALUSUUU7			12/13/2019
	ROVIDER OR SUPPLIER TAGE OF CEDAR ROCK	191 CRES	DRESS, CITY, ST TVIEW DRIVE LLE, NC 2702		
0/0/15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE COMPLETE
D 131	Continued From page	e 12	D 131		
	facility failed to assure	ews and interviews, the e 9 of 12 sampled staff , I, J, and K) were tested for ease upon hire.			
	The findings are:				
	personnel record reversely -Staff E was hired on				
	revealed: -She was originally hir the facility in July 2019 09/05/19She could not recall t skin test.	on 12/12/19 at 10:37 am red in June 2019, she left 9, and was re-hired on the last time she had a TB e needed a TB skin test			
	5:35pm revealed: -She was responsible ensuring Staff E had a -The Licensed Health	TB skin test upon hire.			
		vith the LHPS nurse on vealed the facility staff did test for Staff E.			
	Refer to the interview 12/12/19 at 5:25pm.	with the Administrator on			
	2. Review of Staff A's,	personal care aide (PCA),			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL030007	B. WING		12/	13/2019
	PROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, ST TVIEW DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 131	personnel record reverstaff A was hired on There was no docume tests. Interview with Staff A revealed: -She was hired as a phousekeeper 3 years -She had two TB skin years agoBoth the first and the read as negative. Interview with the Adr 5:35pm revealed: -The corporate office transitioning personner and some staff membinsent to the corporate electronic recordsShe did not have Staff and the retrieve Staff A's TB telectronic recordShe knew Staff A need of TB skin tests in ordineeded to repeat her revealed: -Staff B was hired in A-Staff B had a TB skin and read as negative	ealed: 01/02/17. rentation of any TB skin on 12/12/19 at 8:38 am rersonal care aide and ago. tests when she was hired 3 secondTB skin tests were ministrator on 12/12/19at was in the process of el records to electronic files ers' paperwork had been office for scanning into ff A's TB skin test and she was unable to est documentation from the eded to have documentation er to be compliant or Staff A TB skin tests. with the Administrator on PCA, personnel record ugust 2019. test placed on 09/03/19	D 131			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	COMPLETED	
		HAL030007	B. WING		12/13/2019	
	PROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, ST TVIEW DRIVE LLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 131	Interview with Staff B revealed: -She was hired as a F-The Licensed Health (LHPS) nurse placed test and the skin test: -She did not have a s Interview with the Adr 5:35pmShe was responsible paperwork when she -She was responsible skin test was complet: -The LHPS nurse place tests for Staff B. Telephone interview with the TB skin test responsible skin test was completed to the staff B. Refer to the interview with the Adr 5:35pmShe placed Staff B. Refer to the interview with the Adr 5:35pm. 4. Review of Staff C's personnel record reversaff C was hired on -There was no document tests. Telephone interview with the Adr 5:35pm.	on 12/11/19 at 4:29pm PCA at the end of July 2019. Professional Support and read the first TB skin was negative. econd TB skin test. ministrator on 12/12/19 at for completing Staff B's was hired. for ensuring Staff B's TB ed upon hire. ced and read the TB skin with the LHPS nurse on evealed: TB skin test on 09/03/19 ead negative on 09/05/19. a second TB skin test for with the Administrator on medication aide (MA), ealed:	D 131			

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
					1	
		HAL030007	B. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	FATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK	191 CRES	IVIEW DRIVE			
		MOCKSVII	LLE, NC 2702	8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 131	Continued From page	2 15	D 131			
	done (date unknown).					
	2019.	ere read as negative in				
	2019.					
	Interview with the Adr	ninistrator on 12/12/19 at				
	5:35pm revealed:	initiation of 12/12/10 at				
	-The corporate office	was in the process of				
		el records to electronic files				
	and some staff memb	ers' paperwork had been				
		office for scanning into				
	electronic records.					
	-She did not have Sta					
		and she was unable to est documentation from the				
	electronic record.	est documentation from the				
		eded documentation of a TB				
	skin test upon hire.	saca accamentation of a 15				
		oordinator (RCC) was				
		Staff C and ensuring Staff C				
		n tests; the facility had not				
	had a RCC since late	•				
	-	for assuring Staff C had				
		skin tests in order to be				
	skin tests.	needed to repeat her TB				
	SKIII ICSIS.					
	Refer to the interview 12/12/19 at 5:25pm.	with the Administrator on				
	5. Review of Staff F's	medication aide (MA),				
	personnel record reve					
	-Staff F was hired on (
		test placed on 09/03/19				
	and was read as nega					
	_	entation of a second TB				
	skin test.					
		on 12/11/19 at 5:00pm				
		IA on 08/16/19				
	Interview with Staff F crevealed: -She was hired as a M	·				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7551251110.			
		HAL030007	B. WING		12/13/2019	
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
THE HER	TAGE OF CEDAR ROCK	•	STVIEW DRIVE			
	OUR MARRY OF		ILLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 131	Continued From page	e 16	D 131			
		Professional Support and read her TB skin test vas negative.				
	5:35pm.	ministrator on 12/12/19 at				
	paperwork when she -She was responsible	for ensuring Staff F's TB				
	skin test was complet -The LHPS nurse plac tests for Staff F.	ed upon hire. ced and read the TB skin				
	12/12/19 at 8:35pm re	vith the LHPS nurse on evealed she placed Staff F's /19 and the TB skin test 9/05/19.				
	Refer to the interview 12/12/19 at 5:25pm.	with the Administrator on				
	revealed: -Staff G was hired on -Staff G had a TB skir	test placed on 11/07/19				
	and read as negative -There was no docum- skin test.	on 11/09/19. entation of a second TB				
	Interview with Staff G revealed: -She was hired as a c	on 12/12/19 at 8:30pm				
	-She had a TB skin te					
	5:35pm.	for completing Staff Cla				
	paperwork when she					
	 She was responsible skin test was complete 	for ensuring Staff G's TB ed upon hire.				

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPE	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	LETED
		HAL030007	B. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
THE HEB!	T405 05 05040 000V	191 CRES	TVIEW DRIVE	:		
INE HEKI	TAGE OF CEDAR ROCK		ILLE, NC 2702	8		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORT OR	ESC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	MATE	DATE
						<u> </u>
D 131	Continued From page	e 17	D 131			
	-The Licensed Health	Professional Support				
		and read the TB skin tests				
	for Staff G.					
		vith the LHPS nurse on				
		evealed she placed Staff G's				
	read as negative on 1	/19 and the TB skin test				
	read as negative on i	1709/19.				
	Refer to the interview	with the Administrator on				
	12/13/19 at 5:25pm.					
	•					
		medication aide (MA),				
	personnel record reve					
	-Staff I was hired on 0					
		tation a TB skin test was				
	and there was no sign	ne TB skin test was not read				
	Nurse (RN).	lature by a registered				
	, ,	nal documentation of a TB				
	skin test.					
	Interview with Staff I o	n 12/11/19 at 4:38 pm				
	revealed:					
	-She was hired as the	-				
	03/13/19 and she ther					
		st completed upon hire at d a second TB skin test				1
	done (date unknown).					
		ninistrator on 12/12/19 at				
	5:35pm.					
	-The corporate office v					
		l records to electronic files				
		ers' paperwork had been				
	sent to the corporate of electronic records.	oπice for scanning into				
	-She did not have State	ff I's TR skin test				
		and she was unable to				
		st documentation from the				

A. BUILDING: HAI 030007 B. WING 12/13/	
HAI 020007 B WNG	
HAL030007 B. WING 12/13/	3/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE HERITAGE OF CEDAR ROCK MOCKSVILLE, NC 27028	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
D 131 Continued From page 18 electronic record. -Alt the time Staff I was hired, the Resident Care Coordinator (RCC) was responsible for completing the paperwork for staff; the facility had not had a RCC since late April 2019. -There were 3 to 4 Licensed Health Professional Support (LHPS) nurses since Staff I was hired and she did not have additional documentation on Staff I's TB skin test placed on 04/12/19. -She was responsible for assuring Staff I had documentation of her TB skin tests in order to be compliant, or she needed to repeat her TB skin tests. Refer to the interview with the Administrator on 12/12/19 at 5:25pm. 8. Review of Staff J's, medication aide (MA), personnel record revealed: -Staff J was hired on 03/13/19. -There was documentation a TB skin test was placed on 04/12/19; the TB skin test was not read and there was no signature by a RN. -There was no additional documentation of a TB skin test. Telephone interview with Staff J on 12/12/19 at 9:35am revealed: -She worked at the facility as a MA for almost a yearShe was hired by the Resident Care Coordinator (RCC)The facility's Licensed Health Professional Support (LHPS) nurse placed and read the first TB skin test and the LHPS nurse did not return to place the second TB skin tests with another LHPS nurse, and the TB skin tests results were negative (date unknown).	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			D. VARING		
		HAL030007	B. WING		12/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	TATE, ZIP CODE	
THE HERI	TAGE OF CEDAR ROCK		TVIEW DRIVE		
			LLE, NC 2702		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 131	Continued From page	e 19	D 131		
	Interview with the Adr 5:35pm. -The corporate office transitioning personne and some staff memb sent to the corporate electronic records. -She did not have State documentation onsite retrieve Staff J's TB to electronic record. -The RCC was responsible skin tests were correcord. -There have been 3 to J was hired and she of documentation for State 104/12/19. -She was responsible documentation of TB compliant, or she need tests. Refer to the interview 12/12/19 at 5:25pm. 9. Review of Staff K's, personnel record reversals. Telephone interview was 138 pm revealed: -She was hired as the beginning of October 25.	was in the process of el records to electronic files ers' paperwork had been office for scanning into ff J's TB skin test and she was unable to est documentation from the ensible for ensuring Staff J's empleted and in Staff J's enpleted and in Staff J's entry and she was since Staff lid not have additional eff J's TB skin test placed on for assuring Staff J had skin tests in order to be ded to repeat her TB skin with the Administrator on endication aide (MA),	D 131		
	as a MAWhen she was hired, documentation of the tests and both TB skin	first and second TB skin			

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PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 131 Continued From page 20 D 131 ATTACHED IS A COPY OF OUR NEW HIRE negative; she did not know when the TB skin test CHECKLIST CONTAINED IN OUR POLICY were administered or read. & PROCEDURE MANUAL, THIS INCLUDES THE PROCEDURE FOR THE Interview with the Administrator on 12/12/19 at TWO-STEP TB TEST. 5:35pm. -The corporate office was in the process of THE RESPONSE OF ADMINISTRATOR IS transitioning personnel records to electronic files INCORRECT. WE DO NOT "REMOVE and some staff members' paperwork had been RECORDS" OF ANY KIND TO OUR sent to the corporate office for scanning into CORPORATE OFFICE. WE MAY FROM electronic records. TIME TO TIME, REQUEST AN -She did not have Staff K's TB skin test ELECTRONIC COPY BUT, THAT IS ALL. documentation onsite and she was unable to THE HOME WAS CLOSED ON 2/7/2020 retrieve Staff K's TB test documentation from the AND THE RESIDENTS WERE RELOCATED electronic record. TO APPROPRIATE LEVELS OF CARE -She was responsible for assuring Staff K had WITH THE ASSISTANCE OF DAVIE documentation of her TB skin tests in order to be COUNTY D.S.S. compliant, or Staff K needed to repeat her TB skin tests. Refer to the interview with the Administrator on 12/12/19 at 5:25pm. Interview with the Administrator on 12/12/19 at 5:25pm revealed: -The Resident Care Coordinator (RCC) was responsible for personnel records and for auditing personnel records; the facility had not had a RCC since late April 2019. -She was responsible for assuring personnel records were completed since there was currently no RCC at the facility.

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-There was a high turnover rate for staffing and ensuring all new staff met the necessary requirements, while also maintaining personnel

-She was responsible for auditing personnel records and she had not audited staffs' personnel

-The "obligation for staffing duties interfered with her administrative duties" and her responsibility

records, was difficult to manage.

records because of time constraints.

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1	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER:	A. BUILDING:		COMPLETED
		HAL030007	B. WING		12/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
THE HER	ITAGE OF CEDAR ROCK	191 CRE	STVIEW DRIVE		
THE HER	TIAGE OF CEDAR ROOM		/ILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 131	in the personnel files, The facility failed to a (Staff A, B, C, E, F, G) tuberculosis disease the transmission of TI failure to assure testir completed, was detrir and welfare of the restrype B Violation. The facility provided a accordance with G.S. this violation. CORRECTION DATE	sskin tests were completed, and up to date. ssure 9 of 12 sampled staff is, I, J, and K) were tested for which increased the risk of B disease. The facility's ang for tuberculosis was mental to the safety, health, sidents and constitutes a plan of protection in 131D-34 on 01/10/20 for	D 131		
D 137	(a) Each staff person shall: (5) have no substantia North Carolina Health according to G.S. 131 This Rule is not met a Based on observation reviews, the facility fai sampled staff (Staff B, had no substantiated for shall be sha	Other Staff Qualifications at an adult care home ated findings listed on the Care Personnel Registry E-256; s evidenced by: s, interviews and record	D 137		

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/13/2019	
	ROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STA' STVIEW DRIVE /ILLE, NC 27028	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROPERTY)	D BE COMPLETE	
	was completed. Interview with Staff B revealed: -She had worked at the She was a PCA and including bathing, feed assistance. Interview with a resider revealed: -Staff B was a PCA at Staff B assisted the rebathing, changing incomplete devices of the staff B assisted the rebathing, changing incomplete devices of the staff B assisted the rebathing, changing incomplete devices of the staff B was responsible HCPR check upon hire. She did not know why not in her personnel reneeded to be checked. She did not know if Staff B's HCPR check for review, and she did HCPR check was local	a personal care aide ord revealed: ugust 2019. entation a HCPR check on 12/11/19 at 4:29pm e facility for three months. provided resident care ding, and toileting ent on 12/12/19 at 4:00pm the facility. esident with transferring, ontinence briefs, and getting ninistrator on 12/12/19 at for ensuring Staff B had a e. or Staff B's HCPR check was ecord and Staff B's HCPR in order to be compliant. eaff B had a HCPR check	D 137			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL030007	B. WING		12/	13/2019
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, S' TVIEW DRIVE LLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 137	2. Review of Staff I's, personnel record reveStaff I was hired on 0 -There was no docum was completed. Interview with Staff I or revealed: -In March 2019, she was Director and she then -She passed medicationeded, she provided like bathing and transform of Staff I 12:00pm revealed Staff I 12:00pm revealed Staff I was a medications to resider evealed Staff I was a medications. Interview with the Adm 5:35pm revealed: -In March 2019, the Referch was responsible ensuring Staff I had a -She did not know Staff I's HCPR check for review, and she did HCPR check was local Refer to the interview with 12/12/19 at 5:25pm.	medication aide (MA), ealed: 13/13/19. entation a HCPR check on 12/11/19 at 4:38 vas hired as the Activity's transitioned to a MA. ons to residents, andwhen personal care to residents, ferring assistance. on 12/12/19 from 8:00am to ff I administered nts at the facility. ent on 12/12/19 at 3:32 pm MA and administered her ninistrator on 12/12/19 at esident Care Coordinator e for hiring Staff I and HCPR check upon hire. ff I's HCPR check was not d and Staff I needed a to be compliant. from hire was unavailable d not know where Staff I's ted at the present time. with the Administrator on nistrator's personnel record	D 137			

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE S	
	HAL030007	B. WING		12 <i>l</i> -	13/2019
NAME OF PROVIDER OR SUPPLIER THE HERITAGE OF CEDAR ROCK	191 CREST	PRESS, CITY, ST VIEW DRIVE LLE, NC 2702			
PREFIX (EACH DEFICIENCY MU	EMENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
and administered her median Interview with the Admin 5:25pm revealed she was documentation of her HC Review of the Administrated documentation revealed HCPR check was comples substantiated findings. Interview with the Admini 5:35pm revealed: -She was hired on 11/01/2 at the facility in January 2-She did not know if the complession of	tation a HCPR check ton 12/12/19 at 3:32 pm tor was a medication aide edications. histrator on 12/12/19 at as able to provide CPR check. ator's HCPR the Administrator's eted on 12/11/19 with no histrator on 12/12/19 at /18 and started working 2019. corporate office had CPR check upon hire; her ras unavailable for the He Administrator on istrator on 12/12/19 at r maintaining personnel as in the process of ecords to electronic files ers' paperwork had been ce for scanning into rer rate for staffing at the ew staff met the		ATTACHED IS A COPY OF OUR NEW H CHECKLIST. IT INCLUDES A "REGISTRY"CHECK FOR ALL POSITION HOME OFFICE IS NOT RESPONSIBLE F THESE CHECKS. IT IS THE RESPONSIB OF THE ADMINISTRATOR TO DO THESE CHECKS. THE COMMENT REGARDING "ELECTRONIC RECORDS WERE TRANSITIONING TO HOME OFFICE" IS INCORRECT.	NS. THE FOR ILITY SE	

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		18				
		HAL030007	B. WING		12 <i>l</i> ′	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK	191 CREST	VIEW DRIVE			
	THOSE OF OEDAN NOON		LE, NC 2702	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 137	Continued From page	25	D 137			
	personnel records wa -She was responsible	es difficult to manage. For auditing personnel not audited personnel	_ ,			
D 139	10A NCAC 13F .0407 Qualifications	7(a)(7) Other Staff	D 139			
	(a) Each staff person (7) have a criminal ba	Other Staff Qualifications at an adult care home shall: ickground check in 114-19.10 and 131D-40;				
	This Rule is not met a TYPE B VIOLATION	as evidenced by:				
	Based on observations, interviews and record reviews, the facility failed to assure 7 of 12 sampled staff (Staff B, E, F, G, I, J, and K) had a criminal background check completed prior to hire.			ATTACHED IS OUR NEW HIRE CHECK WHICH INCLUDES DOING THE CRIMI BACKGROUND CHECK. THE PROCEDUTE FOR THIS ARE ALSO ATTACHED. THE ADMINISTRATOR FAILED TO FOLLOW PROCEDURE. WHEN THE OWNER RECORD	NAL URES UTHIS EEIVED	
	The findings are:			THIS HAD NOT BEEN PROPERLY DON THESE WERE COMPLETED BY THE HO OFFICE. A COPY OF THIS IS ATTACHE	OME	
	personnel record reverse -Staff B was hired in A-There was no documbackground check was	August 2019. entation a criminal s completed on Staff B. entation of a consent for a		HOME WAS CLOSED ON 2/7/2020 AND RESIDENTS WERE RELOCATED TO APPROPRIATE LEVELS OF CARE WITH ASSISTANCE OF DAVIE COUNTY D.S.S	ALL H THE	
	revealed: -She had worked at th -She was a PCA and p	on 12/11/19 at 4:29pm The facility for three months. provided personal care to thing, feeding, and toileting				

1	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED
		HAL030007	B. WING	-	1:	2/13/2019
	PROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STATE STVIEW DRIVE VILLE, NC 27028	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 139	-The Administrator cowhen she was hired, for a criminal backgrohiredShe did not know whe check was not in her plant of the resident with a resident revealed Staff B was at the resident with transincontinence briefs, and linterview with the Administration of the staff of the corporate office of transitioning personner and some of the staffs to the corporate office filesShe did not have Starcheck onsite and she be staff of the corporate office filesShe was responsible ensuring Staff B had a prior to hire. Refer to interview with 12/12/19 at 5:25pm. 2. Review of Staff E's, personnel record reveals ackground check for identifying title, could resident to the could record	impleted her paperwork and she signed a consent und check when she was by her criminal background personnel record. Internal background personnel record. Internal background personnel record. Internal background petting dressed. Internal background personnel record. Internal background personnel record. Internal background personnel records to electronic files by paperwork had been sent for scanning into electronic for hiring Staff B and personnel background check from the electronic for hiring Staff B and personnel background check personnel background check from the determinel background check personnel background personnel	D 139			

Division of Health Service Regulation

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 139 Continued From page 27 D 139 There was no documentation of a consent for a criminal background check. Interview with Staff E on 12/12/19 at 10:37 am revealed: -She was originally hired in June 2019, she left the facility in July 2019, and she was re-hired at the facility on 09/05/19. -She worked as a medication aide and administered medications to residents. -She never had a criminal background check at the facility. -She did not sign a consent for a criminal background check. -She did not know a criminal background check was a requirement for her job. Interview with a resident on 12/12/19 at 4:00pm revealed Staff E was a MA at the facility and Staff E administered medications to the resident. Interview with the Administrator on 12/12/19 at 5:40pm revealed: -She did not know the document presented as a background check for Staff E did not meet the requirements for a criminal background check regarding not indicating what records were checked, and for covering "statewide". -She did not have additional documentation for Staff E's criminal background check.

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prior to hire.

12/12/19 at 5:25pm.

personnel record revealed: -Staff F was hired on 08/16/19.

-She was responsible for hiring Staff E and ensuring Staff E had a criminal background check

Refer to interview with the Administrator on

3. Review of Staff F's, medication aide (MA)

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	.DING:	COMPLETED
HAL030007 B. WING	G	12/13/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CI 191 CRESTVIEW D MOCKSVILLE, NC	PRIVE	•
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There was no documentation a criminal background check was completed for Staff F. -There was no documentation of a consent for a criminal background check. Interview with Staff F on 12/11/19 at 5:00pm revealed: -She worked as a MA at the facility since 08/16/19. -She administered medications to residents at the facility. -She never had a criminal background check completed. -She did not sign a consent for a criminal background check was a requirement for her job. Interview with a resident on 12/12/19 at 4:00pm revealed Staff F was a MA at the facility and Staff F administered medications to the resident. Interview with the Administrator on 12/12/19 at 5:40pm revealed: -She did not know a criminal background check was not completed for Staff F. -She was responsible for hiring Staff F and ensuring Staff F had a criminal background check prior to hire. Refer to interview with the Administrator on 12/12/19 at 5:25pm. 4. Review of Staff G's, a cook, personnel record revealed: -Staff G was hired on 10/15/19. -There was no documentation a criminal background check was completed on Staff G. -There was no documentation of a consent for a criminal background check.		

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDING: _			
		HAL030007	B. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK	191 CRE	STVIEW DRIVE			
		MOCKS	VILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 139	Continued From page	29	D 139			
	revealed: -She was hired as a ckitchen at the facility setThe Administrator cowhen she was hired, a for a criminal backgrowhiredShe did not know why check was not in her perform 8:30am to 9:00am preparing food and sebreakfast meal in the colline of the comporate office with the corporate office filesShe did not have Staffs to the corporate office files.	mpleted her paperwork and she signed a consent und check when she was by her criminal background personnel record. In the kitchen on 12/12/19 on revealed Staff G was rving the residents' their dining room. Ininistrator on 12/12/19 at ff G did not have a criminal per personnel record. If records to electronic files paperwork had been sent for scanning into electronic ff G's criminal background was unable to retrieve Staff and check from the for hiring Staff G and criminal background the Administrator on medication aide (MA) aled:				

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STATE FORM KGC311 If continuation sheet 30 of 327

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 139 Continued From page 30 D 139 -There was documentation presented as a background check for Staff I that was void of any identifying title, could not be determined if it was statewide, and did not meet requirements for a criminal background check. -There was no documentation of a consent for a criminal background check. Interview with Staff I on 12/11/19 at 4:38 pm revealed: -In March 2019, she was originally hired as the Activity's Director and she then transitioned to a

-She "remembered signing papers" but shedid not know if she signed a consent for a criminal background check.

-The Administrator was responsible for personnel records and assuring the criminal background check was in her record.

-She did not know why the Administrator did not have documentation of criminal background check in her personnel record.

Observation of Staff I on 12/11/19 from 8:00am to 12:00pm revealed Staff I administered medications to residents at the facility.

Interview with the Administrator on 12/12/19 at 5:40pm revealed:

- -She understood that the document presented as a background check for Staff I did not meet the requirements for a criminal background check. -At the time Staff I was hired, the Resident Care
- Coordinator (RCC) was responsible for ensuring criminal background checks were completed prior to hire.
- -She did not have additional documentation for Staff I's criminal background check.
- -She was responsible for assuring Staff I had a criminal background check prior to hire.

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			LETED
		HAL030007	B. WING		424	42/2040
NAME OF S	DOMEST OF SUPPLIES				121	13/2019
NAME OF F	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	TE, ZIP CODE		
THE HER	TAGE OF CEDAR ROCK		STVIEW DRIVE			
			VILLE, NC 27028			
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TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
D 139	Continued From page	31	D 139			
	Refer to interview with	the Administrator on				
	12/12/19 at 5:25pm.					
	6. Review of Staff J's,					
	personnel record reve					
	-Staff J was hired on (
	-There was document	Staff J that was void of any				
		not be determined if it was				
		meet requirements for a				
	criminal background c					
		t for a criminal background				
	check.					
	Talanhana intansiaw w	ith Stoff Lon 10/10/10 -t				
	9:35am revealed:	rith Staff J on 12/12/19 at				
	-She was hired as a M	A in February 2019				
		Resident Care Coordinator				
	(RCC), and currently the					
		nel records since there				
	was no longer a RCC					1
		inal background check at				
	the facilityShe did not sign a cor	seent for a criminal				
	background check.	isent for a criminal				
	Interview with a resider	nt on 12/12/19 at 4:00pm				1
	revealed Staff J was a	MA at the facility, and Staff				
	J administered medical	tions to the resident.				- 1
	Interview with the Admi	inistrator on 12/12/19 at				
li.	5:40pm.	ii				
	•	ne document presented as				
		r Staff J did not meet the				
	requirements for a crim	inal background check.				
	-At the time Staff J was	hired, the RCC was				
	responsible for ensurin					
	checks were completed					- 1
	-She did not have addit	ional documentation for				

MALE OF PROVIDER OR SUPPLIER THE HERITAGE OF CEDAR ROCK SUMMAY STATEMENT OF DEPICIENCES SUMMAY STATEMENT OF DEPICIENCES SUMMAY STATEMENT OF DEPICIENCES BEACH CORRECTION OF SUPPLIER TAX DATE DEPOCH OF CEDAR ROCK SUMMAY STATEMENT OF DEPICIENCES BEACH CORRECTION SHOULD BE CARRY TAX REQUALATORY OF LEE EMPTIFYING SHY FALL TAX TO SEE THE PROVIDER OF THE APPROPRIATE DEPOCH CORRECTIVE ACTION SHOULD BE CARRY TAX DEPOCH CORRECTIVE ACTION TO THE APPROPRIATE CORRECTION OF CARRY TAX DEPOCH CORRECTIVE ACTION TO THE APPROPRIATE CORRECTION OF CARRY TAX DEPOCH CORRECTIVE ACTION TO THE APPROPRIATE CORRECTION OF CARRY TAX DEPOCH CARRY TAX DEPOCH CORRECTIVE ACTION TO THE APPROPRIATE CORRECTION OF CARRY TAX DEPOCH CORRECTIVE ACTION TO THE APPROPRIATE CORRECTION TO THE APPROPRI	AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
THE HERITAGE OF CEDAR ROCK MOCKSVILLE, NC 27288 Octobro Commence Comm			HAL030007	B. WING		12	2/13/2019
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 139 Continued From page 32 Staff J's criminal background check -She was responsible for assuring Staff J had a criminal background check prior to hire. Refer to the interview with the Administrator on 12/12/19 at 5:40pmShe was not occumentation of a consent for a criminal background check was not completed for Staff KThere was no documentation of a consent for a criminal background check with the Administrator on 12/12/19 at 5:40pmShe did not remember if she signed a consent for a criminal background check. Interview with the Administrator on 12/12/19 at 5:40pmShe did not know a criminal background check. Interview with the Administrator on 12/12/19 at 5:40pmShe did not know a criminal background check. Interview with the Administrator on 12/12/19 at 5:40pmShe did not know a criminal background check was not completed for Staff K and ensuring Staff K had criminal background check. Interview with the Administrator on 12/12/19 at 5:40pmShe did not know a criminal background check prior to hire. Refer to the interview with the Administrator on 12/12/19 at 5:25pm.			191 CRE	STVIEW DRIVE	E, ZIP CODE	•	
Staff J's criminal background check. -She was responsible for assuring Staff J had a criminal background check prior to hire. Refer to the interview with the Administrator on 12/12/19 at 5:25pm. 7. Review of Staff K's, medication aide (MA) personnel record. -Staff K did not have a hire date in her personnel record. -There was no documentation a criminal background check was completed for Staff K. -There was no documentation of a consent for a criminal background check. Telephone interview with Staff K on 12/12/19 at 4:38 pm revealed: -She was hired as the Activity's Director at the beginning of October 2019 and she also worked as a MA. -She could not remember if she signed a consent for a criminal background check. Interview with the Administrator on 12/12/19 at 5:40pm. -She did not know a criminal background check was not completed for Staff K. -She was responsible for hiring Staff K and ensuring Staff K had a criminal background check prior to hire. Refer to the interview with the Administrator on 12/12/19 at 5:25pm revealed: -She was responsible for personnel records and ensuring records were completed.	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
01 114 4 1141		Staff J's criminal back-She was responsible criminal background of Refer to the interview 12/12/19 at 5:25pm. 7. Review of Staff K's, personnel record reversation of K did not have a record. There was no docum background check was no docum criminal background check was a management of Cotober 2 as a MA. She was hired as the beginning of October 2 as a MA. She could not remem for a criminal background interview with the Adm 5:40pm. She did not know a criminal background completed for She was responsible ensuring Staff K had a prior to hire. Refer to the interview with the Adm 5:25pm revealed: She was responsible for s	iground check. for assuring Staff J had a check prior to hire. with the Administrator on medication aide (MA) caled: a hire date in her personnel centation a criminal scompleted for Staff K. centation of a consent for a consent for a consent for a consent for a consent	D 139			

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12	2/13/2019
	ROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, S STVIEW DRIVI	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 139	records and she had not audited personnel records because of time constraints. -There was a high turnover rate for staffing at the facility and ensuring all staff had a criminal background screen prior to hire, while also maintaining personnel records was difficult to manage. The facility failed to obtain a criminal background check for 7 of 12 sampled staff (Staff B, E, F, G, I, J, and K). The facility's failure of not knowing if Staff B, E, F, G, I, J, and K had a criminal record history was detrimental to the health, safety and welfare of the residents and constitutes a TypeB		D 139			
	Violation. The facility provided a accordance with G.S. this violation. CORRECTION DATE	plan of protection in 131D-34 on 12/12/19 for				
	10A NCAC 13F .0501 And Competency (a) An adult care home who provide or directly provide personal care complete an 80-hour p competency evaluation the Department. Direct on duty in the facility to performance of staff di 80-hour training and co	to residents successfully bersonal care training and in program established by the supervise means being oversee or direct the uties. Copies of the	D 150			

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 150 Continued From page 34 D 150 mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the ATTACHED ARE OUR COMPANY POLICIES facility failed to assure 4 of 11 sampled staff (Staff USED FOR EMPLOYEES THAT ARE HIRED TO C, D, I, and J) who provided personal care to WORK IN PCS AND/OR MED TECH AREAS. residents had documentation of successful ADMINISTRATOR FAILED TO FOLLOW THESE PROCEDURES. THE OWNER CONTRACTED completion of an 80 hour personal care training WITH A NURSE TO COME IN AND REVIEW & and competency evaluation program. SIGN OFF ON EMPLOYEES THAT HAD MET THE REQUIREMENTS, THIS WAS COMPLETED The findings are: ON JANUARY 23, 2020. 1. Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C was hired on 08/27/18. -There was no documentation Staff C had completed an 80 hour personal care training and competency evaluation program. Interview with Staff C on 12/12/19 at 4:20pm revealed: -She was rehired on 01/02/19 -She had worked at the facility off and on since -She supervised personal care aides (PCA) when she worked at the facility.

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HAL030007	B. WING		12/13/2019	
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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	ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH CORRECTIVE ACTION SHOULD PROVIDE AC		
	care tasks residents reshe thought she had personal care training but she did not have confidence of the facility should have to the facility should have 80 hours of personal training to retrieve staff C's 80 documentation from the facility at 5:25pm. Refer to interview with 12/12/19 at 5:25pm. Refer to interview with 12/12/19 at 5:25pm. Review of Staff D's, personnel record reveaus Staff D was hired on 1-There was no documentation from the staff of the corporate office files.	h bathing residents, and any other personal needed assistance with. taken the 80 hours of on two different occasions, documentation available, we the documentation for nal care training on file. Ininistrator on 12/12/19 at for ensuring Staff C personal care training and n program. If the process of a records to electronic files in paperwork had been sent for scanning into electronic files in paperwork had been sent for scanning into electronic files in paperwork had been sent for scanning into electronic files in paperwork had been sent for scanning into electronic files in paperwork had been sent for scanning into electronic files in the personal training file electronic file. DA NCAC 13F .0902(a) pervision (Type B file Administrator on the Licensed Health LHPS) nurse on 12/12/19 personal care aide (PCA), aled: 0/12/16.	D 150			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY PLETED
		HAL030007	B. WING		12	/13/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
THE HER	ITAGE OF CEDAR ROCK		ESTVIEW DRIVE			
	OUR MARKET OF		VILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 150	Continued From page	36	D 150			
	competency evaluation	n program.				
	Attempted telephone 12/12/19 at 2:00pm w	interview with Staff D on as unsuccessful.				
	[Refer to Tag D 269 1 Personal Care and Su Violation)].	0A NCAC 13F .0902(a) upervision (Type B				
	Refer to interview with the Administrator on 12/12/19 at 5:25pm.					
	Refer to interview with the Licensed Health Professional Support (LHPS) nurse on 12/12/19 at 8:30pm.					
	3. Review of Staff I's, personnel record reve -Staff I was hired on 0 -There was no docume completed an 80 hour competency evaluation	aled: 3/13/19. entation Staff I had personal care training and				
	nursing assistantShe had personal car -She did not know who in the facilityShe assisted resident like bathing and assist -The facility should hav	e training in the past. Fore her paperwork may be s with personal care tasks fing residents with transfers.				
	5:35pm revealed: -She was responsible t	inistrator on 12/12/19 at for ensuring Staff I				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED
		HAL030007	B. WING		1:	2/13/2019
	ROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STATE STVIEW DRIVE VILLE, NC 27028	E, ZIP CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
	completed an 80 hour competency evaluation. The corporate office of transitioning personner and some of the staffs to the corporate office files. -She did not have does hour personal training to retrieve Staff I's 80 documentation from the [Refer to Tag D 269 10 Personal Care and Sulviolation)]. Refer to interview with 12/12/19 at 5:25pm. Refer to interview with 12/12/19 at 5:25pm. Refer to interview with Professional Support (at 8:30pm. 4. Review of Staff J's, personnel record reverses and some completed an 80 hour competency evaluation. Interview with Staff J or revealed: -She had been employ than one yearShe had not performe assistance for the resideransferring residents.	comprogram. cumentation that Staff I personal care training and in program. was in the process of per records to electronic files by paperwork had been sent for scanning into electronic cumentation of Staff I's 80 onsite and she was unable thour personal training the electronic file. OA NCAC 13F .0902(a) pervision (Type B the Administrator on the Licensed Health (LHPS) nurse on 12/12/19 medication aide (MA), aled: 3/13/19. entation Staff J had personal care training and in program.	D 150			

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PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ΙD **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 150 Continued From page 38 D 150 the past, maybe December 2018 or January 2019, and she had not complete a Certified Nursing Assistant course. -She did not turn in documentation for completing the 80 hour personal care training and competency evaluation program to the facility when she was hired because she was not able to obtain documentation from the facility where she took the course. -She supervised personal care aides (PCAs) when she worked. -She did not know she needed documentation for 80 hours of personal care training to supervise PCAs. -She routinely worked Friday, Saturday, and Sunday on the 7:00am to 7:00pm shift. Interview with the Administrator on 12/12/19 at 5:35pm revealed: -She was responsible for ensuring Staff J completed an 80 hour personal care training and competency evaluation program. -She did not have documentation that Staff J completed an 80 hour personal care training and competency evaluation program. -She would contact Staff J and work on getting documentation for her 80 hour personal training. [Refer to Tag D 269 10A NCAC 13F .0902(a) Personal Care and Supervision (Type B Violation)].

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Refer to interview with the Administrator on

Refer to interview with the LHPS nurse on

Interview with the Administrator on 12/12/19 at

12/12/19 at 5:25pm.

12/12/19 at 8:30pm.

5:25pm revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED
		HAL030007	B. WING		12/13/2019
	PROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, S STVIEW DRIVI VILLE, NC 270	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	-She was responsible records and ensuring to dateShe was responsible records and she had records because of tir. There was a large stand there had not bee Coordinator (RCC) sir was difficult for her to. She was responsible provided residents' pe 80-hour personal care evaluation program witemploymentThe LHPS nurse confacility. Interview with the LHP 8:30pm revealed: -She had been the factor monthsShe did not conduct a care trainings at the factor trainings at the factor monthsThe Administrator did complete any trainings The facility failed to entraining and competent completed for 4 of 7 sa (Staff C, D, I, and J) propersonal care to the restaff directly supervising the risk for improper perincluding not transferring two person transfer, incresulting in a second response being bathed according to the restaff directly according to the resulting in a second response to the resulting resulting response to the resulting result	for maintaining personnel they were complete and up for auditing personnel not audited any personnel not audited any personnel ne constraints. aff turnover at the facility, en a Resident Care nee April 2019, therefore, it manage personnel records for ensuring staff that insonal care completed the training and competency ithin 6 months of ducted PCA trainings at the ducted PCA trainings at the sility's LHPS nurse for 3 any in-service or personal cility. The facility is at the facility in the facility in the facility is at the facility. The facility is at the staff providing is idents and prior to the staff provided in a resident who required continent care not provided is ident developing skin	D 150	ATTACHED IS A CHECKLIST OF ITEMS REQUIRED FOR ANY EMPLOYEE THAT THE PCS TRAINING PROGRAM AND/OR MED TECHS. ALSO, ATTACHED IS OUR POLICIES REGADING THE TRAINING ATTHE SKILLS CHECKLIST. THIS IS A REQUIREMNT OF OUR ADMINISTRATO ASSURE THAT THIS IS PROPERLY COMPLETED AND DOCUMENTED PER SEQUIREMENTS. OUR ADMINISTRATO FAILED TO DO THIS DEPSITE ALL OF THE PROCEDURES BEING IN PLACE.	NEEDS FOR ND OR TO STATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMPL	.ETED
		HAL030007	B. WING		12/1	13/2019
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
THE HEDI	TAGE OF CEDAR ROCK	191 CREST	TVIEW DRIVE	•		
THE REN	TAGE OF CEDAR ROCK		LE, NC 2702	28		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 150	Continued From page	40	D 150			
	foot sore. This failure health, safety and wel constitutes a Type B \	was detrimental to the fare of residents which //iolation.	<i>B</i> 130			
	The facility provided a accordance with G.S. this violation.	plan of protection in 131D-34 on 12/11/19 for				
	CORRECTION DATE VIOLATION SHALL N 2019.	FOR THIS TYPE B OT EXCEED JANUARY 27,				
D 161	10A NCAC 13F .0504 For LHPS Tasks	(a) Competency Validation	D 161			
	Licensed Health Profe (a) An adult care home non-licensed personne not practicing in their li governed by their practicensing laws are com demonstration for any	e shall assure that el and licensed personnel censed capacity as tice act and occupational petency validated by return personal care task aph (a)(1) through (28) of chapter prior to staff d that their ongoing				
	This Rule is not met as Based on record review facility failed to assure B, C, and F) were com	vs and interviews, the 3 of 11 sampled staff (Staff				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		SURVEY
	01 0011112011011	DENTI TOATION NOWIBER.	A. BUILDING	::	COM	PLETED
		HAL030007	B. WING		12	/13/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
THE HER	ITAGE OF CEDAR ROCK	191 CRES	STVIEW DRIVE	9 6		
			ILLE, NC 2702	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 161	Continued From page	÷ 41	D 161			
	Licensed Health Profetasks including ambul transferring, finger stiend administration.	essional Support (LHPS) ation with assistive device, ck blood sugars and insulin				
	The findings are:					
	personnel record reversal personnel record reversely as hired in Arthere was no docume competency validation. Interview with a residence revealed Staff B assis	August 2019. entation of a LHPS a. ent on 12/12/19 at 4:00pm ted the resident with changing incontinence				
	revealed: -She had worked at th -She was a PCA and p	bathing for residents who the transfers.				
	5:35pm revealed she of not LHPS competency Telephone interview w 12/12/19 at 8:30pm rev -She had not complete validation for Staff BThe Administrator had complete Staff B's LHF	ith the LHPS nurse on				
	12/12/19 at 5:25pm.	vian are Administrator on				

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STATE FORM

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK MOCKSVILLE, NC 27028 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 161 Continued From page 42 D 161 Refer to the telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 2. Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C was hired on 08/27/18. -There was no documentation of a LHPS competency validation. -There was no documentation of a Medication Administration Skills Validation checklist. Review of residents' electronic Medication Administration Records (eMARs) revealed there was documentation Staff C obtained finger stick blood sugars and administered insulin 21 times in October 2019, 13 times in November 2019, and 7 times in December 2019. Telephone interview with Staff C on 12/12/19 at 4:20pm revealed: -She worked off and on at the facility since 2010 and she recently came back to work at the facility in January 2019. -She administered residents' medications including insulin and she obtained residents' finger stick blood sugars. -She assisted residents with bathing, transferring with an assistive device, and other personal needs (incontinent care and ambulation). -She had not been competency validated for LHPS tasks.

Interview with the Administrator on 12/12/19at 5:35pm revealed she did not know Staff C was

Telephone interview with the LHPS nurse on

-She had not completed LHPS competency

not LHPS competency validated.

12/12/19 at 8:30pm revealed:

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	' '	E SURVEY PLETED
		HAL030007	B. WING		12	/13/2019
	PROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, S TVIEW DRIVE LLE, NC 2702	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFILE OF THE APPROPROPROPROPROPROPERTY)	D BE	(X5) COMPLETE DATE
D 161	Refer to the interview 12/12/19 at 5:25pm. Refer to the telephone nurse on 12/12/19 at 8:3. Review of Staff F's, personnel record reve-Staff F was hired on 0-There was no docume competency validation. There was no docume Administration Skills V Review of residents' exaministration Record was documentation St blood sugars and adm October 2019, 11 time FSBS 3 times and instance and administered insulusing staff F was hired as a She obtained resident and administered insulusing a sisted resident applied anti-thrombotic She had not been con LHPS tasks. Refer to the interview with 12/12/19 at 5:25pm.	d not requested for her to PS competency validation. with the Administrator on einterview with the LHPS 3:30pm. medication aide (MA), aled: 08/16/19. entation of a LHPS . entation of a Medication alidation checklist. ectronic Medication s (eMARs) revealed there aff F obtained finger stick inistered insulin 12 times in s in November 2019, and ulin 7 times in December MA on 08/16/19. s' finger stick blood sugars in injections. s with transfers, and chose for residents.	D 161			

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Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PI

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		SURVEY PLETED
			A. BUILDING	<u></u>		
		HAL030007	B. WING		12	/13/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
THE HER	ITAGE OF CEDAR ROCK	191 CRE	STVIEW DRIVE	:		
			VILLE, NC 2702	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCEO TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 161	Continued From page	: 44	D 161			
	nurse on 12/12/19 at	8:30pm.				
D 164	5:25pm revealed: -The Resident Care Coresponsible for ensurincluding LHPS compondedThe RCC position has 2019 and now she (Acresponsible for ensurincompetency validated -There was currently reassure staff were LHP-The obligation for state her administrative duting responsibility of ensuring competency validated prior to staff performingshe had not audited aduties and time construction. The LHPS nurse was the LHPS competency validated prior to staff performingshe had not audited and time construction. The LHPS nurse was the LHPS competency validated prior to staff performingshe had not audited and time construction. The LHPS nurse was the LHPS competency validated prior to staff performingshe had been the LHPS competency.	d been vacant since April dministrator) was ng staff were LHPS. To process in place to PS competency validated. Iffing duties interfered with her sing staff were were by a nurse for LHPS tasks g tasks. It is staff records due to staffing aints. Tresponsible for completing avalidations. With the LHPS nurse on vealed: PS nurse at the facility for 3 HPS competency validation lity. The nurse of the total LHPS competency Training On Care Of	D 164			

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PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 164 Continued From page 45 D 164 An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes: (b) insulin action: (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms: (f) blood glucose monitoring; universal precautions; (g) universal precautions: (h) appropriate administration times; and (i) sliding scale insulin administration. ATTACHED IS A COPY OF OUR POLICIES AND This Rule is not met as evidenced by: PROCEDURES THAT WERE IN PLACE AT THE TYPE B VIOLATION TIME OF THE STATE SURVEY. THE BOOK THAT CONTAINS THIS, AND ALL OF OUR Based on observations, record reviews and PROCEDURES, WERE IN THE interviews, the facility failed to assure 2 of 7 staff ADMINISTRATOR'S OFFICE AT THE TIME OF SURVEY. THEY ARE CONSTANTLY sampled (Staff F) and the Administrator who

administered insulin and obtained finger stick

1. Review of Staff F's, medication aide (MA)

care of the diabetic resident prior to the

administration of insulin.

The findings are:

blood sugars for residents completed training on

REMINDED TO MAKE USE OF THIS BOOK AS

THE HOME WAS CLOSED ON 2/7/20 WITH THE

ASSISTANCE OF DAVIE COUUNTY D.S.S. AND

MUCH AS NEEDED. THE ADMINISTRATOR

FAILED TO FOLLOW THESE PROCEDURES.

THE RESIDENTS WERE PLACED IN

APPROPRIATE LEVELS OF CARE.

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL030007	B. WING		12/13/2019
	ROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STAT STVIEW DRIVE VILLE, NC 27028	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
	personnel record reverstaff F was hired on There was no docume training on care of the Review of residents' experience of the Administration Record was documentation Sublood sugars and adm October 2019, 11 time FSBS 3 times and ins 2019. Interview with Staff F revealed: Staff F was hired as a She administered resobtained residents' fin Interview with the Adm 5:35pm revealed: Staff F was a MA and checking finger stick be administering insulin in She had a notebook to diabetic training and sedocumentation that Staff F needed to conform the diabetic resident Second interview with 6:05pm revealed: She had training on in she started working at who trained her. She did not have doctored.	ealed: 08/16/19. Inentation Staff F completed e diabetic resident. Electronic Medication dis (eMARs) revealed there taff F obtained finger stick ninistered insulin 12 times in es in November 2019, and ulin 7 times in December on 12/11/19 at 5:00pm a MA on 08/16/19. Idents' insulin and she ger stick blood sugars. Ininistrator on 12/12/19 at I was responsible for clood sugars and enjections to residents. Inhalt contained staffs' the did not have aff F completed training on sident. Inplete the training on care to in order to be compliant. Staff F on 12/11/19 at I sulin administration when the facility but did not say the say alternation for the training. In the say alternation for the training.	D 164		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	ES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMPI	
		HAL030007	B. WING		12/	13/2019
NAME OF PROVIDER OR SUP		191 CREST	DRESS, CITY, ST IVIEW DRIVE LLE, NC 2702			
PREFIX (EACH D	DEFICIENC	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPER DEFICIENCY)	BE	(X5) COMPLETE DATE
documentation diabetic in-sec 11/21/19 by a Administration Medication A errors that we are to Tag Medication A [Refer to Tag Medication A Refer to inter Consultant of the Administration was document finger stick bits 4 times in Notice 11/21/19 by a few and the Administration of the Adm	signed dion form of ervice for the Admir's audit of Administration detection of the Administration of the Administration of the Admirier with the Admirier with the Admirier of the Admirier o	abetic administration and on 12/11/19 revealed a staff was conducted on nistration in response to the of resident electronic ation Records (eMARs) and cted on the eMARs. DA NCAC 13F .1004(a) ation (Type B Violation)]. S. 131D-4.4 ACHInfection ents (Type B Violation)]. In the contracted Pharmacy 19 at 9:40am. In the Administrator on inistrator's personnel record I not have a documented Id a Medication Clinical 12/27/18. ssed the State medication	D 164			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	COMPLETED
		HAL030007	B. WING		12/13/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST		
THE HERI	TAGE OF CEDAR ROCK		LLE, NC 2702		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 164	Interview with the Adri 5:35 revealed: -She was hired as the 2018 and started work 2019She administered me including insulin, and finger stick blood suggeshe completed training because the corporate of transitioning persor files and her paperwo corporate office for so [Refer to Tag D358 10 Medication Administrate [Refer to Tag D932 G. Prevention Requirement Refer to interview with Consultant on 12/10/10 Refer to interview with 12/12/19 at 5:25pm. Telephone interview with 12/12/19 at 5:25pm. Telephone interview with 12/12/19 at 5:25pm.	e Administrator in November king at the facility in January edications to residents, she obtained residents' ars. Ings, but she did not have documentation onsite to office was in the process and records to electronic rk had been sent to the anning into electronic files. INDA NCAC 13F .1004(a) ation (Type B Violation)]. S. 131D-4.4 ACHInfection the contracted Pharmacy 9 at 9:40am. In the contracted Pharmacy 9 at 9:40am. In the Administrator on the Administrator on diabetic resident. In with return demonstration line class. In this trator on 12/12/19 at	D 164		

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PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 164 D 164 Continued From page 49 April 2019. -The facility's contracted pharmacy offered facility staff an online training on care of the diabetic -She was responsible for scheduling MA training and ensuring MAs completed the training on care of the diabetic resident. -She was responsible for personnel records and ensuring they were complete and up to date. -There was a large staff turnover at the facility, and she did not have a RCC therefore, it was difficult for her to manage personnel records. -The obligation for staffing duties interfered with her administrative duties and interfered with her responsibility of ensuring staff were trained on the care of the diabetic resident. -The corporate office was in the process of transitioning personnel records to electronic files and some of the staffs' paperwork had been sent to the corporate office for scanning into electronic files. -She did not have some staff information onsite, and she was unable retrieve all staff diabetic training documentation from the electronic file. -She did not audit personnel records to ensure all training had been completed, including training on the care of the diabetic resident because of time constraints.

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-In November 2019, she identified that MAs were administering insulin incorrectly and she had an

The facility failed to assure 2 of 7 staff sampled (Staff F) and the Administrator who administered insulin completed training on care of diabetic residents resulting in two residents administered incorrect dosages of insulin placing the residents at risk for hypoglycemia and hyperglycemia and staff sharing glucometers between residents with orders for finger stick blood sugar testing, placing

in-service on insulin with the MAs.

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1	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	1 ' '	E SURVEY PLETED
		HAL030007	B. WING		12	1/13/2019
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, STATE TVIEW DRIVE	E, ZIP CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 164	and increasing the ris This failure was detrir and welfare of resider B Violation. The facility provided a accordance with G.S. this violation. CORRECTION FOR		D 164			
D 167	staff person on the procompleted within the cardio-pulmonary res management, including provided by the American Red Cross, American Safety and First Aid, or by a train certification as a train from one of these org person trained accordancess at all times in valve pocket mask for cardio-pulmonary res.	Training On esuscitation eshall have at least one emises at all times who has last 24 months a course on suscitation and choking ag the Heimlich maneuver, ican Heart Association, National Safety Council, Health Institute or Medic er with documented er on these procedures anizations. The staff ling to this Rule shall have the facility to a one-way ruse in performing suscitation.	D 167			
	certification as a train from one of these org person trained accord access at all times in valve pocket mask for cardio-pulmonary res	er on these procedures anizations. The staff ling to this Rule shall have the facility to a one-way ruse in performing uscitation.				

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STATE FORM

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 12/13/2019 HAL030007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 167 D 167 Continued From page 51 WITHOUT KNOWING SPECIFICALLY WHOSE Based on observations, record reviews and RECORDS THAT WERE CHECKED, I CANNOT interviews, the facility failed to assure at least one FULLY VERIFY THIS. I DO KNOW THAT UPON staff was always on the premises who had REVIEW, THERE WAS A NOTEBOOK THAT completed within the last 24 months a course on THE SURVEY TEAM DID NOT SEE, (COPIES OF cardio-pulmonary resuscitation (CPR) for 27 of 69 TRAINING ATTACHED) THAT CONTAINED shifts sampled for 23 days in September 2019, NINE, CURRENT STAFF MEMBERS THAT HAD October 2019, and November 2019. UP-TO-DATE CPR TRAINING. THERE IS ALSO A LIVE-ON STAFF MEMBER THAT LIVES ON THE PROPERTY WITHIN 50 FEET OF THE The findings are: BUILDING, THAT IS ON PREMISES EVERY NIGHT, EXCEPT FOR VACATIONS AFTER 11 Review of 13 staff personnel records revealed: PM. HER CPR TRAINING WAS CURRENT AS OF -Staff A, D, H, I, J, L, and M had documentation of THE STATE SURVEY. CPR certification within the past 24 months. -Staff B, C, E, F, H, and K had no documentation CANNOT EXPLAIN WHY ADMINISTRATOR of completing a course in CPR in the past 24 DID NOT SHOW THIS TO SURVEY TEAM. IT WAS IN HER OFFICE ON HER DESK. months. AS OF 2/7/2020, All RESIDENTS HAVE BEEN Review of the staffing schedule and the punch PLACE IN AN APPROPRIATE LEVEL OF CARE time detail reports for 69 shifts sampled for 23 WITH THE ASSISTANCE OF DAVIE COUNTY days in September 2019, October 2019, and D.S.S. AND THE FACILITY HAS BEEN CLOSED. November 2019 revealed: -Staff A, D, H, I, J, L, and M did not work or worked partial shifts for 27 of 69 shifts. -Staff B, C, E, F, H, and K worked various shifts for the 23 sampled days. -There was 1 of 23 days for first shift when there was no CPR certified staff on the premises. -On 11/18/19 from 7:00am to 1:15pm, there was no CPR certified staff on the premises. -There were 19 of 23 days for second shift when there was no CPR certified staff on the premises. -Examples of second shifts when there was no CPR certified staff on the premises included: 09/23/19, 09/24/19, 09/25/19, 10/04/19, 11/04/19, and 11/14/19 from 7:00pm to 11:00pm.

XGC311

-There were 7 of 23 days for third shift when there was no CPR certified staff on the premises. -Examples of third shifts when there was no CPR certified staff on the premise included: 09/21/19, 09/22/19, and from 11:00pm to 7:00am, on

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 167 Continued From page 52 D 167 10/05/19, 11/03/19, and 11/19/19 from 1:00am to 7:00am. Confidential interview with a facility staff revealed: -Not all staff were CPR certified. -Not every shift had at least one staff certified in -Staff H, personal care aide (PCA), and Staff M, medication aide (MA), had their CPR certification, and they lived within 500 feet of the facility, therefore, the Administrator believed that Staff H and Staff M met the staffing requirements for the facility's CPR coverage. Interview with Staff F, MA, on 12/11/19 at 8:38am revealed: -The Administrator was responsible for the staffing schedule. -She was not CPR certified. Interview with Staff H, PCA, on 12/11/19 at 4:50pm revealed: -She worked at the facility for 17 years and she lived next door to the facility. -She was CPR certified. -She was never told she was expected to cover shifts where there was no staff working who had not completed CPR certification. -Staff M was no longer employed at that facility and left in October 2019. -She did not know which staff had CPR certification or the shifts that did not have CPR

Division of Health Service Regulation

coverage.

revealed:

certification to the facility.

Interview with Staff C, MA, on 12/12/19 at 4:20pm

-She had not provided documentation of CPR

-She did not know where her CPR certification

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE HERITAGE OF CEDAR ROCK

191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

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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
D 167	card was located, and she did not know when her CPR certification expiredShe thought she took CPR in February 2018. Interview with the Administrator on 12/12/19 at 5:25pm revealed: -The Resident Care Coordinator (RCC) was responsible for personnel records and for auditing personnel records to assure staff had all qualifications including CPR.	D 167		
	-She was responsible for ensuring personnel records were completed since there was currently no RCC at the facilityShe was responsible for auditing personnel records and she had not audited staff records because of time constraintsThe obligation for regular staffing interfered with her administrative duties; she was responsible for ensuring staff with CPR were appropriately scheduledShe was responsible for the schedule and assuring staff with CPR certification were always on the premises in the absence of the RCC.			
	-When she completed the schedule, she scheduled staff with CPR on each shift from memoryThe CPR cards in the personnel records were all the CPR cards she had available onsite at the facilityShe had seen certification cards for the staff that			
	had CPR certification, except for Staff CShe did not know where Staff C's CPR certification card was locatedStaff H and Staff M had CPR and they resided within 500 feet of the facility; she thought Staff H and Staff M residing within 500 feet would meet the CPR staffing requirements for the facilityStaff M no longer worked at the facility since the beginning of October 2019.			
livisian of Haal	-She did not know that one staff with CPR			

Division of Health Service Regulation

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 167 Continued From page 54 D 167 completed within the last 24 months needed to always be on the premise. The facility failed to assure staff on duty for 27 shifts had completed a course on CPR within the last 24 months which resulted in no staff available who had completed CPR certification, in case of an emergency requiring cardio-pulmonary resuscitation of a resident. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-21 on 12/10/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27. 2020. D 188 10A NCAC 13F .0604(e) Personal Care And D 188 Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40

residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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D 188	or capacity of 40 or mechart, see Rule .0606 (B) Second shift (after duty for facilities with to 40 residents; and 1 four additional hours of additional 10 or fewer census or capacity of staffing chart, see Rull (C) Third shift (evening per 30 or fewer resident census). (For .0606 of this Subchap (D) The facility shall homeet the needs of the residents equal to the by Medicaid. As used "heavy care resident", residing in an adult ca "heavy care" by Medicis receiving enhanced (E) The Department sifit determines the needs	ore residents. (For staffing of this Subchapter.) froon) - 16 hours of aide a census or capacity of 21 6 hours of aide duty plus of aide duty for every residents for facilities with a 40 or more residents. (For e .0606 of this Subchapter.) fig) - 8.0 hours of aide duty ents (licensed capacity or staffing chart, see Rule ter.) finave additional aide duty to facility's heavy care amount of time reimbursed in this Rule, the term, means an individual re home who is defined as eaid and for which the facility	D 188			
This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing at the facility for 8 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019.						

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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INE HERI		VILLE, NC 27028		
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D 188	Continued From page 56	D 188		
	The findings are:			
	Review of the facility's 2019 license revealed the facility was licensed for an Assisted Living with a capacity of 40 beds.			
	Review of the resident census report dated 09/21/19 revealed there was a census of 31 residents, which required 20 staff hours on first and second shift.			
	Review of the staff time cards dated 09/21/19 revealed: -There were 14 total personal care aide (PCA) hours provided on first shift. There was a			
	shortage of 6 aide hoursThere were 19 total PCA hours provided on second shift. There was a shortage of 1 aide hour.			
	Review of the resident census report dated 09/23/19 revealed there was a census of 31 residents, which required 24 staff hours on third shift.			
	Review of the staff time cards dated 09/23/19 revealed there were 15 total staff hours provided on third shift. There was a shortage of 1 aide hour.			
	Review of the resident census report dated 10/05/19 revealed there was a census of 31 residents, which required 24 staff hours on third shift.			
	Review of the staff time cards dated 10/05/19 revealed there were 19.5 total staff hours provided on third shift. There was a shortage of 4.5 supervisor hours (There was no			
	Supervisor/medication aide (MA) within 500 feet			

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STATE FORM 6899 XGC311 If continuation sheet 57 of 327 Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMPL	LETED
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D 188	Continued From page	÷ 57	D 188			
	of the facility).					
		et census report dated ere was a census of 31 ired 24 staff hours on third				
	Review of the staff time cards dated 11/03/19 revealed there were 17.5 total staff hours provided on third shift. There was a shortage of 6.5 aide hours. Review of the resident census report dated 11/06/19 revealed there was a census of 31 residents, which required 24 staff hours on third shift.					
	revealed there were 7 on third shift. There whours and 6 supervise	te cards dated 11/06/19 total staff hours provided as a shortage of 9 aide fr hours (There was no				
	Review of the resident census report dated 11/14/19 revealed there was a census of 31 residents, which required 24 staff hours on third shift. Review of the staff time cards dated 11/14/19 revealed there were 15 total staff hours provided on third shift. There was a shortage of 9 aide hours.					
	Review of the resident 11/15/19 revealed ther residents, which requireshift.	•				
		e cards dated 11/15/19 5 total staff hours provided				

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 188 | Continued From page 58 D 188 on third shift. There was a shortage of 9 aide hours. (There was no Supervisor/MA) within 500 feet of the facility). Review of the resident census report dated 11/16/19 revealed there was a census of 31 residents, which required 20 staff hours on second shift. Review of the staff time cards dated 11/16/19 revealed there were 9.75 total staff hours provided on second shift. There was a shortage of 8 aide hours and 2.25 supervisor hours. (There was no Supervisor/MA within 500 feet of the facility). Review of the resident census report dated 11/18/19 revealed there was a census of 31 residents, which required 20 staff hours on first shift and 24 hours on third shift. Review of the staff time cards dated 11/18/19 revealed: -There were 15 total staff hours provided on first shift. There was a shortage of 3 aide hours and 2 Supervisor hours (There was no Supervisor/MA within 500 feet of the building). -There were 16 total staff hour provided on third shift. There was a shortage of 8 aide hours. Review of the resident census report dated 11/19/19 revealed there was a census of 31 residents, which required 24 staff hours on third shift. Review of the staff time cards dated 11/19/19 revealed there were 10.75 total staff hours provided on third shift. There was a shortage of 10.25 aide hours and 3 supervisor hours. (There

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was no Supervisor/MA within 500 feet of the

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 59 D 188 D 188 facility). Review of the resident census report dated 11/20/19 revealed there was a census of 31 residents, which required 24 staff hours on third shift. Review of the staff time cards dated 11/20/19 revealed there were 16 total staff hour provided on third shift. There was a shortage of 8 aide hours. Confidential interview with a staff revealed the Administrator tried to have every shift covered, but there were shifts, specifically 3rd shift, that were short staffed. Confidential interview with a second staff revealed: -Overall, there were shifts that did not have enough staff. -There were nights when there was no MA available at the facility. Confidential interview with a third staff revealed -The Administrator was responsible for the schedule and the schedule was usually made a week in advance. -There was not enough staff on every shift and staffing was short on the weekends. -On Saturdays and Sundays, there were times when there were only 2 staff, 1 PCA and 1 MA. Confidential interview with a fourth staff revealed: -The schedule was completed by the Administrator.

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-The Administrator changed the schedule to reflect there was enough staffing to meet

minimum staffing requirements.

STATE FORM

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: = B. WING_ HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 188 Continued From page 60 D 188 -The Administrator documented on the time cards to show there was enough staffing at the facility. Confidential interview with a resident revealed: -There were nights when there was only one PCA and one MA. -The resident did not need any assistance with activities of daily living, but they were told in the past there was no MA to administer medications during the night. Confidential interview with a second resident revealed: -Staff told the resident they could not transfer the resident in and out of the bed and the staff could not change the resident's incontinence briefs because there was "not enough staff". -The "morning and night need help" with staffing. -The resident did not complain to the staff because there was "nothing [the resident] could do about it" because the resident had to rely on staff to assist with personal care. Interview with a MA on 12/11/19 at 5:00pm revealed the Administrator was responsible for the staffing schedule. Interview with the Administrator on 12/12/19 at 8:50am revealed: -She covered some shifts that were short of aide hours. -She was a medication aide and could administer "as needed" medications. -Her staff time card was current, and the time cards had been filled in for missed punches. -If she was not listed on the time card as working,

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5:25pm revealed:

she "must not have been [there]".

Interview with the Administrator on 12/12/19 at

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 188 Continued From page 61 D 188 -She was responsible for the schedule and assuring staffing needs were met. -If staff did not use the time card, then they were not accounted for and the staff were technically not at the facility. -She knew the time cards were the documents used to support staffing requirements. -She did not know there were shifts that were short staffed. -There had been a large turnover rate in the facility in the past year. -The "obligation for staffing duties interfered with her administrative duties" and her responsibility for ensuring the shifts was adequately staffed. -When there was no MA either scheduled or was on approved leave, she would "cover or a person [staff] that lived close by would come in" to the facility and administer medications to residents. Attempted telephone interview with a 3rd shift PCA on 12/12/19 at 5:07pm was unsuccessful. [Refer to Tag D269 10A NCAC 13F .0902(a) Personal Care and Supervision (Type B Violation)]. The facility failed to assure the minimum number of staff were present at all times to meet the needs of residents for 8 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019 resulting in an increased risk for improper personal care provided including not transferring a resident who required two person transfer, incontinent care not provided resulting in a second resident developing skin breakdown and bedsores, and residents not being bathed according to the bathing schedule regularly resulting in a third resident developing a foot sore. This failure was detrimental to the health,

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safety and welfare of the residents and

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
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D 188	Continued From page	62	D 188				
	constitutes a Type B	Violation					
	constitutes a Type B	violation.					
	The facility provided a accordance with G.S. this violation.	plan of protection in 131D-34 on 12/23/19 for					
	CORRECTION DATE VIOLATION SHALL N 2020.	FOR THE TYPE B OT EXCEED JANUARY 27,					
D 214	10A NCAC 13F .0605 Care Aide Supervisor	(c) Staffing Of Personal	D 214				
	10A NCAC 13F .0605 Aide Supervisors	Staffing Of Personal Care					
	census of 31 to 60 res be in the facility or with immediately available, this Subchapter. In fac suppression with a cap residents, the supervise	ilities with a capacity or idents, the supervisor shall nin 500 feet and as defined in Rule .0601 of cilities sprinklered for fire pacity or census of 31 to 60 sor's time on duty in the ay be counted as required					
	This Rule is not met as TYPE B VIOLATION	s evidenced by:					
	hours of supervision w toward personal care is staffed with 16 hours of supervisor hours when within 500 feet of the fa	first and second shifts					

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STATEMENT OF DEFICIENCIES (X1) PI

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
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D 214	Continued From page	: 63	D 214		
	an unsprinkled facility				
	The findings are:				
		s 2019 license from the vice Regulation revealed			
		ed for an Assisted Living			
	, ,				
	5:20pm revealed:	ninistrator on 12/12/19 at			
	 The current facility ce was not sprinklered. 	ensus was 31 and the facility			
		sor who was a medication 500 feet of the building			
	feet of the facility mee	ntly a staff living within 500 ting the qualifications of a aide(PCA) Supervisor as			
	of November 2019.	alasti siy sapariloo. as			
	Review of the residentime cards dated 10/0	t census report and Staff 5/19 revealed:			
	-There was a census of facility, which required	of 31 residents in the I 24 staff hours on third			
	shiftThere were 19.5 total	staff hours provided on			
	third shiftThere was a shortage	e of 4.5 Supervisor hours			
	(from 2:30am to 7:00a				
	Review of the resident	t census report and Staff 6/19 revealed:			
	-There was a census				
	shift.				
	shift.	off hours provided on third			
		e of 9 aide hours and 6 n 12:00am to 6:00am).			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPLI			
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NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST.	ATE, ZIP CODE				
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D 214	Continued From page 64	D 214				
	Review of the resident census report and Staff time cards dated 11/16/19 revealed: -There was a census of 31 residents in the facility, which required 20 staff hours on first and second shift. -There were 24.5 total staff hours provided on first shift. There was a shortage of 2.0 Supervisor hours. -There were 9.75 total staff hours provided on second shift. There was a shortage of 8.00 aide hours and 2.25 Supervisor hours (from 7:45pm to 11:00pm) Review of the resident census report and Staff time cards dated 11/18/19 revealed: -There was a census of 31 residents in the facility, which required 20 staff hours on first shift. -There were 15 total staff hours provided on first shift. There was a shortage of 3 aide hours and 2 Supervisor hours (from 1:00pm to 3:00pm). Review of the resident census report and Staff time cards dated 11/19/19 revealed: -There was a census of 31 residents in the facility, which required 24 staff hours on third shift. -There were 10.75 total staff hour provided on third shift. There was a shortage of 10.25 aide hours and 3 Supervisor hours (from 4:00am to 7:00am). Confidential interview with a staff revealed: -The Administrator tried to have every shift covered, but there were shifts, especially 3rd shift, that were short staffed. -There were nights on 3rd shift when MAs were not at the facility.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	(X3) DATE SURVEY COMPLETED		
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		HAL030007	B. WING		12/13/2019	
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
THE HER	TAGE OF CEDAR ROCK	191 CREST	VIEW DRIVE			
			LE, NC 2702	8		
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D 214	-Third shift did not always staffedThe PCAs were given the there was no MA, but the medication cart"The PCAs held onto get the keys. Confidential interview -MAs on first shift were staffedThird shift usually had -"There were no MAs" shift and there were no -"Nobody [passed] med MA"When there was no Mashift MA administered they left the facility and shift would be expected administer the medical aresidents' medication advance so the MA was aln the past, the PCA were no MAs were handed the PCA when a MA was achedule and knew the were no MAs; the Administrator was schedule and knew the were no MAs; the Administrator was schedule and knew the were no MAs; the Administrator was chedule and knew the were no MAs; the Administrator was schedule and knew the were no MAs; the Ad	wwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwwww	D 214	DEFICIENCE)		
	Confidential interview	with a resident on 12/12/19				

Division of Health Service Regulation

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MI II TIE	DI E CONCEDITORIO			
	OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		HAL030007	B. WING		12/	13/2019	
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
THE HER	ITAGE OF CEDAR ROCK	191 CRE	STVIEW DRIV	Ē			
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(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	OPPECTION		
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				DEFICIENCY))		
D 214	Continued From page	e 66	D 214				
	revealed:						
		ne resident's medication four					
	times a day.						
		past that there was no MA					
	to administer medicat						
		ed at the facility, there was a					
		row that there was "no one					
	here to give medicine	including pain medications					
	that were ordered "as						
		there were "sporadic times					
		v up at night" and they were					
	told they could not rec						
	-When the resident did						
	medication as schedu	led, they would have to lay					
	in pain unable to sleep	o, and if they did fall asleep,					
	the pain would be so b	oad it would wake them up.					
	-When the resident did	not receive their pain					
	medication, they voice	ed their concerns to the MA				- 1	
1		or the next day and the MA				- 1	
	and Administrator both	n apologized and said they				1	
	would "try to see if the	y could do better".				1	
						1	
	Interview with a MA or					- 1	
	revealed she supervise	ed personal care aides					
	(PCA) when she worke	ed at the facility.					
						-	
	Interview with a PCA of	on 12/11/19 at 4:50pm					
The state of the s	revealed:						
		ility for 17 years and she				1	
	lived next door to the fa					- 1	
		usekeeper, and a cook at				- 1	
	the facility.					1	
	-She supervised PCAs	, housekeeping staff, and					
	kitchen staff when ther	e was no other staff					
	available to supervise.					- 1	
	-She was not a MA, sh	e did not have the MA				- 1	
	training, and "never pa	ssed medications".				1	
		nad lived next door to the				1	
		per 2019, he was no longer					
employed at the facility.					- 1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
THE HERI	THE HERITAGE OF CEDAR ROCK		STVIEW DRIVE				
			VILLE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 214	Continued From page	e 67	D 214				
	worked at the facility. Interview with a third revealed: -She worked as a MA facility for almost a ye-She supervised staff facility. Interview with a fourth 10:37am revealed: -She was originally hit the facility in July 2011 the facility in July 2011 the facility on 09/05/19. She worked as a MA medications to reside: -She supervised PCA was no other staff availate with the Adm 5:25pm revealed: -She was responsible ensuring the Supervision or Interview with the Adm 5:25pm revealed: -She did not know the have a Supervisor or Interview as Interview with the Adm 5:25pm revealed: -She did not know the have a Supervisor or Interview with the Adm 5:25pm revealed: -She did not know the have a Supervisor or Interview with the Rund of t	as responsible for the upervised staff when she MA on 12/12/19 at 9:35am and Supervisor at the ar. when she worked at the MA on 12/12/19 at red in June 2019, she left 9, and she was re-hired at 9. and administered ats. s at the facility when there allable to be a Supervisor. Ininistrator on 12/12/19 at for the schedule and or staffing needs were met are were shifts that did not MA. ge turnover rate in the					

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING. HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK MOCKSVILLE, NC 27028 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 214 Continued From page 68 D 214 her administrative duties and her responsibility for ensuring the shifts was adequately staffed. -There was a PCA that lived within 500 feet of the facility. -There was a MA and Supervisor that had lived within 500 feet of the facility, but he no longer worked at the facility since the beginning of October 2019. -When there was no MA, she would "cover or a person that lived close by would come in" to the facility and administer medications to residents. -She was aware medications were missed

-She did not know PCAs were given the medication cart keys. -MAs had a process and were to store the keys in

occasionally due to staffing; "possibly the person wasn't here or if the person came in late, then it was too late to administer the medications".

a secure location at the end of their shift if a MA was late or was not in the building.

Attempted telephone interview with Staff D, a third shift PCA, on 12/12/19 at 5:07pm was unsuccessful.

[Refer to Tag D269 10A NCAC 13F .0902(a) Personal Care and Supervision (Type B Violation)].

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].

The facility failed to assure all shifts were adequately staffed with a Supervisor present at all times to meet the needs of residents for 5 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019, which increased the risk for improper personal care provided including not transferring a resident who required two person transfer, incontinent care not

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
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			ILLE, NC 2702	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	DBE	(X5) COMPLETE DATE
D 214	provided resulting in a developing skin break residents not being be bathing schedule reguresidents not administ ordered resulting in a lovenox for 3 days who having to be transport injection and placed the clotting; a resident not pain medication result experiencing severe pof time; two residents dosages of insulin placed the properties of the pain that the provided a days placing the resident pain that the provided and injection and infection and infection and infection administered a diuretic for continued swelling with multiple missed doreducer placing the reschest pain (#1). This fathe health, safety and and constitutes a Type The facility provided a accordance with G.S. this violation.	a second resident adown and bedsores, and athed according to the ularly resulting in a third foot sore. There were 5 tered medications as resident not administered according to the resident ted to the hospital for an the resident at risk for blood at administered a narcotic ting in the resident administered amounts administered incorrect cing the residents at risk for perglycemia; a resident not antiseptic to a wound for 3 tent at risk for further skin on; a resident not coplacing the resident at risk in his feet; and a resident oses of a gastric acid sident at risk for having allure was detrimental to welfare of the residents at B Violation. ———————————————————————————————————	D 214			
	10A NCAC 13F .0703(Medical Exam & Immu 10A NCAC 13F .0703	(a) Tuberculosis Test, nizatio Tuberculosis Test, Medical	D 234			
					1	- 1

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Based on record reviews and interviews, the facility failed to assure 1 of 5 residents sampled (#4) was tested for tuberculosis (TB) disease upon admission.

The findings are:

Review of Resident #4's current FL2 dated 10/02/19 revealed diagnoses included hyponatremia, chronic diastolic congestive heart failure, protein calorie malnutrition, and mass of small intestine.

Review of Resident #4's Resident Register revealed Resident #4 was admitted to the facility on 09/25/19.

Review of Resident #4's admissions documents revealed:

-Resident #4 was admitted to the facility from a local hospital.

-There was no documentation of a TB skin test.

Interview with a first shift medication aide (MA) on 12/12/19 at 11:46am revealed she was not sure

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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D 234	pago i i		D 234		
	who was responsible were completed, but to contracted nurse com Interview with the Sup 3:47pm revealed: -The Administrator wa TB skin tests were con-The first TB test for a completed upon admis-She thought Resident completed and it shou Interview with the facil 12/12/19 at 8:24pm re-She had not complete Resident #4She thought Resident step TB skin test alrea Interview with the Adm 6:20pm revealed: -The facility's contracte for completing TB skin-She or the Supervisor contacting the nurse to residents.	for ensuring TB skin tests hought the facility's pleted the TB skin tests. pervisor on 12/12/19 at a seresponsible for ensuring impleted for residents. The resident should have been seion to the facility. The table in her resident record. The resident record is the facility of the facility and the faci	D 234		
	provided during the sur				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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	10A NCAC 13F .0901 Supervision 10A NCAC 13F .0901 Supervision (a) Adult care home sicare to residents accoplans and attend to arneeds residents may lithemselves. This Rule is not met as TYPE B VIOLATION Based on observations reviews, the facility fail was provided to 8 of 1 #5, #7, #8, #11, #12, # care to three residents residents having to wa #8, and #20), and resident #10. The findings are: 1. Review of Resident 10/04/19 revealed: -Diagnoses included from the supervision of th	(a) Personal Care and Personal Care and taff shall provide personal ording to the residents care by other personal care on unable to attend to for se evidenced by: se, interviews and record ed to assure personal care as a sampled residents (#1, #18, and #20) including foot (#5, #12, and #18,); it for incontinence care (#7, dents with a yeast rash (#1) #5's current FL2 dated acture of left ankle, bipolar, by disease (GERD), and tantly disoriented.		MED TECH SHIFT REPORTS (COPY OF ATTACHED) SHOULD HAVE BEEN COMPLETED AT THE END OF EACH S'ANY CONCERNS OF RESIDENTS, INCIBEHAVIOR, REFUSAL OF SHOWER/BAINFECTIONS, ETC. SHOULD HAVE BEID DOCUMENTED. THIS IS THEN GIVEN SUPERVISOR/RCC AND ULTIMATELY FOLLOWED UP ON, BY ADMINISTRATOUR POLICY IS FOR THERE TO BE ON STAFF MEMBER FOR EVERY 20 RESID AT THE TIME OF THE SURVEY, THE HAD 31 RESIDENTS AND WAS SCHEDITWO PCS WORKERS FOR 1ST AND 2ND THE SUPERVISOR WAS ALSO A LICEN MED TECH AND CNA. IT WAS HER RESPONSIBILITY TO ASSIST AND ASS ALL PERSONAL CARE TASKS HAD BE COMPLETED ON A DAILY BASIS AND CHECK WEEKLY FOR ACCURACY IN CHARTING AND CHANGES IN LEVEL OF CARE. ADMINISTRATORWAS TO SIGN THE END OF EACH MONTH AS CERTIFICATION OF COMPLETED THE SU ON 12/13/19, THE OWNER'S CAME IN O 12/16/19 AND BEGAN SUPERVISING AN ASSISTING IN CORRECTING PROBLEM HAD BEEN IDENTIFIEDBY THE SURVE ALL RESIDENTS WERE SEEN BY EITHIF FACILITY DOCTOR OR THEIR PERSON PHYSICIAN WITHIN A FOUR WEEK PEI FACILITY WAS CLOSED ON 2/14/2020 A ALL RESIDENTS WERE RELCOATED TO APPROPRIATE LEVELS OF CARE WITH ASSISTANCE OF DAVIE COUNTY D.S.S	HIFT. LUDING ATH, EN TO THE TO BE TOR. E PCS DENTS. OME ULING SHIFTS. ISED URE EN TO OF OFF AT CS. LIRVEY N ID IS THAT CYORS. ER THE AL RIOD. AND O THE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA iDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
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D 269	Continued From page	÷ 73	D 269			
	wandering behavior a times.	nd was verbally abusive at				
	bathing, dressing and -Resident #5 required eating, toileting, ambut Review of the facility's Care Record shower revealed: -Resident #5 was indeskin careResident #5 should reper weekResident #5 was schent 11/01/19, 11/04/19, 11/18/19, 11/22/19, 11/18/19, 11/15/19 with skin careThere was no docum shower in December 2019 documentation of care. Observation of Reside 8:53am revealed: -The resident's feet we patches of dry skin.	extensive assistance with grooming. Ilmited assistance with alation, and transfers. November 2019 Personal record for Resident #5 spendent with showers and receive a shower two times reduled for a shower on 1/08/19, 11/11/19, 11,15/19, a shower on 11/14/19 and receive a shower on 11/14/19 and rec				
	-There were loose flakes like a chalky substance that fell to the floor from both the resident's feetThe resident's toenails on the first three toes were black and had a thick build up that could not be determined if it was the resident's toe nail or dirtThere was a black substance scattered					
	h Senice Population					

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hurting.

around Thanksgiving.

-Resident #5 usually did not get showers because the resident complained about his feet and legs

-The last time she showered Resident #5 was

-She did not continue asking Resident #5 about taking a shower because he usually cursed and said, "you can't tell me to do a [expletive]thing."

Interview with another PCA on 12/12/19 at

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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D 269	Continued From page	275	D 269			
D 269	10:15am revealed: -Resident #5 dressed staff to dress himShe did not provide s because he usually re-She had not observe -Resident #5 was son-Personal care was proposed allowed. Interview with the Admenication and refused showersIf the resident was be refused showers the Formedication aide (MA) -The MA needed to as and figure out the best of the MA was unable issue, she needed to resident's PCP or contimes. Interview with the Meron 12/06/19 at 3:50pm -If Resident #5 refused regarding Resident #5 refused	chowers for Resident #5 refused. d the resident's feet. netimes combative. rovided only if the resident Resident #5 was combative ecoming combative and PCA needed to make the aware. resess what was going on t way to address the issues. to figure out or resolve the report the problem to the sider changing the shower retal Health Provider (MHP) revealed: d showers due to anxiety he d. residents to see him. remember Resident #5. staff should make a g residents' skin after ed.	D 269			
	2. Review of Resident	#12's current FL2 dated				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	(X3) DATE SURVEY COMPLETED		
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disorder, and deep veresident #12 was interested wheelchair. -Resident #12 was interested wheelchair. -Resident #12 was interested work in and wore incontinent. Review of Resident #03/20/18 revealed: -Resident #12 require eating, toileting and degree with the require ambulation, bathing, and an are resident #12 groome supervision with eating resident #12 was distributed with the resident #12 was distributed with the resident #12 was distributed with the resident #12 was seed as per week. -The showers were degree week. -The showers were degree week. -The showers were degree week. -The documented day were 11/14/19, 11/15/1	diabetes mellitus, psychotic ein thrombosis. termittently disoriented. mi-ambulatory with a continent of bladder/bowel briefs. 12's Care Plan dated ed limited assistance with ressing. Ed extensive assistance with and transferring. Ed himself and required g. sruptive with behaviors. al Care Record for Resident 19 shower schedule ed limited assistance with the duled for showers three excumented as scheduled for 4/19, 11/06/19, 11/08/19, 11/15/19, 11/8/19, 11/20/19, 11/27/19 and 11/29/19. The resident showered 19 and 11/20/19. al Care Record for Resident 19 revealed there was no exprovided.	D 269			

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ago.

-The last time she provided shower and foot care to Resident #12 was one and one-half weeks

-She did not provide foot care to Resident #12 because he often complained about his feet and

-The Administrator and the Supervisor were

legs hurting when touched.

aware the resident's feet hurt.

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I HE HEK	TAGE OF CEDAR ROCK	MOCKSVII	LE, NC 2702	28		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 269	Interview with a secor 9:38am revealed: -Resident #12 had ne from herSometimes he did no so he got a bed bathHe did not get his fee -Resident #12's feet dhe had a shower. Interview with the Adn 10:09am revealed: -She was not aware st Resident #12 refusing showersAfter a week of refusi Primary Care Provider -Staff should offer a be resident refused a shown as the staff should offer a bear sident #18 was interesident #18 was interesident #18 was ser functional limitations on -Resident #18 required with bathing, dressing, communication. Review of Resident #101/22/19 revealed: -Resident #18 required with bathing, dressing, communication. Review of Resident #101/22/19 revealed: -Resident #18 required eating, toileting, ambult transferringResident #18 required bathing and groomingResident #18 had disr	ver refused personal care it want to take a full shower, it washed with a bed bath, id not get cleaned unless ininistrator on 12/12/19 at taff had problems with personal care, like ing showers she wanted the in	D 269	DEPICIENCY)		
	behaviors.					

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES. (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 269 Continued From page 79 D 269 -Resident #18 had a history of mental illness and was currently being seen by mental health. Observation of Resident 18's feet on 12/03/19 at 3:55pm revealed: -The resident's feet were chalky white with ashy -The white ashiness covered the resident's feet from his toes to the heel of his feet, and partway up the resident's ankle. Review of the Personal Care Record for Resident #18 for November 2019 shower schedule revealed: -Resident #18 required extensive assistance with -Resident #18 had scheduled for showers and "bed-baths." -On the bed-bath days at some point staff were to "wash off the resident and apply powers and creams." -The staff documented for this task were the MA and PCA. -The showers and bed-baths were documented as scheduled for Resident #18 on 11/01/19 (shower/first shift), 11/05/19 (bed-bath), 11/06/19 (bed-bath),11/07/19 (shower/first shift), the rest of the week there was no documentation. -There was no documentation the above schedule had completed for Resident #18. Review of the Personal Care Record for Resident #18 for December 2019 revealed there was no documentation of care provided Interview with a personal care aide (PCA) on 12/10/19 at 5:20pm revealed: -Her duties and responsibilities were specifically showers. -There was a shower schedule, however she

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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THE HERITAGE OF CEDAR ROCK 191 CREST		ORESS, CITY, ST FVIEW DRIVE LLE, NC 2702	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 269	showered residents a -Although Resident # for first shift, she tried the second shiftWhen she attempted usually refused the sh and fought a lotShe attempted three Resident #18 to take a aloneSometimes she gave he allowed herMost of the times a b the resident's feetShe only provided for to catch Resident #18 -When Resident #18 -When Resident #18 -When Resident #18 -She had heard the m needed medications of #18She did not know if th Provider (PCP) was n Interview with a first st 10:01am revealed: -She had to do everytt #18She had to assist with dressedThe staff getting Resi responsible for providi shaving, trimming fing to the resident's feetSometimes Resident and would fight staff.	s needed. 18 showers were scheduled to give him a shower on to shower Resident #18, he lower, became combative to four times to get a shower, then she left him Resident #18 a bed-bath if ed-bath excluded washing of care when she was able in a good mood. Was agitated he hit walls, is. It #18's agitation and a daily issue. Edication aide (MA) say as lid not work for Resident the resident's Primary Care offied. In getting the resident dent #18 dressed was ing personal care like: ernails and applyinglotion #18 became combative moative "we just put him in	D 269		

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PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 269 Continued From page 81 D 269 down." -She did not tell the MA every time Resident #18 was combative and refused personal care. -She did not know if the resident's PCP or mental health provider was notified. Interview with the Mental Health Provider (MHP) on 12/11/19 at 3:13pm revealed: -He was aware Resident #18 had behaviors with agitation, but he did not know the resident refused showers. -He had previously suggested to staff that they should use the as needed anxiety medications and if the anxiety medication it did not work, they were supposed to contact him. Interview the Administrator on 12/12/19 at 9:49am revealed: -She expected staff to provide personal care like putting lotion on the residents, even when it was not the resident's shower day. -She did not know Resident #18 refused personal care (showers) and was combative. -She had been verbalizing to staff to use Resident #18's as needed medications when he was

4. Review of Resident #7's current FL2 dated 10/04/19 revealed:

Based on record reviews, observation, and interviews it was determined that Resident #18

Primary Care Provider (PCP).

was not interviewable.

-She did not tell staff to document when Resident #18 had behaviors or when they notified the

-Diagnoses included anxiety, diabetes mellitus type II, gastroesophageal reflux disease, hypertension, schizophrenia, and mental retardation.

combative.

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how often.

revealed:

-She did not know what the odor was in her room.

Review of the facility incontinence care sheets

12/03/19, 12/04/19, and 12/05/19.

times on 12/02/19 and 12/03/19.

-Resident #7 provided her own incontinence care on 11/29/19, 11/30/19, 12/01/19, 12/02/19,

-Resident #7 was provided incontinence care 3

Review of the Personal Care Record for Resident

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STATEMENT OF DEFICIENCIES (X1) PI

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	LETED
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		HAL030007	B. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
THE HED	TAGE OF CEDAR ROCK	191 CRES	TVIEW DRIVE			
I THE HERI	TAGE OF CEDAR ROCK		LLE, NC 2702	8		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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D 269	Continued From page	≥ 83	D 269			
	#7 for November 201					
		f extensive assistance by				
	_	had the option of receiving				
		h, bed bath, or sponge bath.				
		hlighted which indicated				
	when Resident #7 sho	ould have had a bath.				
	-Resident #7 should h	nave had a bath twice a				
		/07/19, 11/12/19, 11/14/19,				
		19 totaling 6 baths in the				
	month of November 2					
		tation Resident #7 received				
	a sponge bath on 11/	16/19, 11/20/19, and				
	11/22/19.					
	-There was no docum	nentation regarding refusals.				
	Review of the Person	al Care Record for Resident				
	#7 for December 2019	9 revealed:				
	-Resident #7 required	extensive assistance by				
	staff with bathing and	had the option of receiving				
	a shower, shower/bat	h, bed bath, or sponge bath.				
	-There were days high	nlighted which indicated				
	when Resident #7 sho	ould have had a bath.				
	-Resident #7 should h	nave had a bath twice a				
	week on 12/03/19 and	d 12/05/19, but there was no				
		ent #7 was given a bath.				
	-There was no docum	entation regarding refusals.				
	Intoniou with a acces	ad shift naraanal care side				
		nd shift personal care aide				
	(PCA) on 12/06/19 at	b:01pm revealed: dents every 2 hours and as				
	needed for incontinen	•				
		ce care. idents a bed bath unless				
	they needed a shower					
	•	it on the Personal Care				
	Record, but tried to do					
	incontinence care she					
	-She physically check					
	beginning of her shift	to see if they needed				
	incontinence care.					
	-She was sometimes	told by other PCAs a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL030007	B. WING		12/13/2019
	ROVIDER OR SUPPLIER	191 CRES	DDRESS, CITY, STA STVIEW DRIVE VILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 269	incontinence care pro- Resident #7 usually in when she started her noticed any skin brea. Interview with another 12/06/19 at 5:36pm re- She started each shi see if they needed incontinence care. Interview with a found reside "got mad about it." -She had found reside "got mad about it." -She told the Administ would look to see who and would correct the First shift was usually baths. Interview with a first so 12/12/19 at 11:46pm incompared with urine and residents were found linens were more soiled personal care not being weekendResident #7 had multitand the resident was at the start of her shiftResident #7 needed a incontinence care. Interview with a Super 12:48pm revealed:	which meant there was no wided to the resident. needed incontinence care shift, but she had not kdown. It second shift PCA on evealed: If by checking residents to continence care. ents many times soaked and trator who told her she o worked the previous shift issue. It responsible for giving their linens were soiled. If their linens were soiled. If their linens were soiled and ed on Mondays due to not provided over the siple incontinence episodes almost always drenched at assistance with bathing and exaministrator incontinence epided on third shift.	D 269		

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previous shift.

assistance with incontinence care.

-She had received complaints from staff on all shifts that they were finding residents needing incontinence care at the beginning of their shifts. -She suggested to staff to round together at the change of shifts to make sure all residents had been provided incontinence care by staff on the

-She would like for staff to check residents for incontinence care every 2 hours and more often for residents who had multiple incontinence

-There should be documentation of incontinence

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STATEMENT OF DEFICIENCIES (X1) P

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING NAME OF PROVIDER OR SUPPLIER THE HERITAGE OF CEDAR ROCK (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) ID PROVIDER'S PLAN OF CORRECTION (X6) ID PROVIDER	AND PLAN C	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		
THE HERITAGE OF CEDAR ROCK 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		
THE HERITAGE OF CEDAR ROCK MOCKSVILLE, NC 27028 (X4) ID PROVIDER'S PLAN OF CORRECTION	NAME OF PR	
MOCKSVILLE, NC 27028 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	TUE UEON	
V.1).5	INE NEKII	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CONTROL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	
D 269 Continued From page 86 D 269	D 269	
D 269 Care at least every 2 hours on the incontinence care sheets. -Resident #7 had multiple incontinence episodes and should be checked on more frequently than every 2 hours for incontinence care. 5. Review of Resident #8's current FL2 revealed: -Diagnoses included diabetes mellitus, gout, vitamin D deficiency, anemia, heart failure, accelerated hypertension, vascular dementia, acute renal failure, and acute encephalopathyResident #8 was semi-ambulatory with a walkerResident #8 was incontinent of bowel and bladder and wore incontinence briefs. Review of Resident #8's Care Plan dated O4/24/19 revealed: -Resident #8 was contised and forgetful at timesResident #8 was contised and forgetful at timesResident #8 needed limited assistance with toileting, extensive assistance with dressing, and extensive assistance with grooming/personal hygiene. Review of Resident #8's licensed health professional support evaluation and review dated O9/25/19 revealed Resident #8 remained incontinent and was on a bowel and bladder training program. Review of the facility incontinence care sheets revealed: -Resident #8 was checked 6 times for incontinence care on 11/29/19 and was documented as unsoiled 5 times and soiled 1 timeResident #8 was checked 3 times for incontinence care on 11/29/19 and was documented as unsoiled 5 times and soiled 1 timeResident #8 was checked 3 times for incontinence care on 11/29/19 and was		

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

IDENTIFICATION NUMBER:

A. BUILDING: _____

COMPLETED

HAL030007

B. WING _

12/13/2019

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

	MOCKS	/ILLE, NC 27028		
(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 269	Continued From page 87 -Resident #8 was checked 4 times for incontinence care 12/01/19 and was documented as "BR" 1 time. (There was no documentation of what BR meant.) -On 12/02/19, there were 4 entries documented as "Bed." (There was no documentation of what Bed meant.). There was a second incontinence care sheet dated 12/02/19 revealing Resident #8	D 269		
	was checked 2 times for incontinence care and was unsoiled both times. -On 12/03/19, there were 4 entries documented as "Bed." (There was no documentation of what Bed meant.). There was a second incontinence sheet dated 12/03/19 revealing Resident #8 was checked 1 time for incontinence care and was unsoiled. -On 12/04/19, there were 3 entries documented			
	as "Bed." (There was no documentation of what Bed meant.). There was documentation Resident #8 was checked for incontinence care 1 time and was soiledResident #8 was checked 2 times for incontinence care on 12/05/19 and was unsoiled both times. There was a second incontinence care sheet dated 12/05/19 revealing Resident #8 was checked 2 times for incontinence care and was soiled 2 times.			
	Review of the Personal Care Record for Resident #8 for November 2019 revealed: -Resident #8 was scheduled to receive a shower 3 times a week on Mondays, Wednesdays, and Fridays and had the option of receiving a shower, shower/bath, bed bath, or sponge bathResident #8 should have had a bath on 11/01/19, 11/04/19, 11/06/19, 11/08/19, 11/11/19, 11/13/19, 11/15/19, 11/18/19, 11/20/19, 11/22/19, 11/25/19, 11/27/19, and 11/29/19 totaling 14 baths in the month of November 2019.			

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STATE FORM

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briefs herself.

-She sometimes had to get up from her bed or chair to go tell staff she needed to be changed . -She had been told by staff, "We don't have time

-She had multiple incontinence episodes and needed assistance with incontinence care. -She needed assistance with incontinence care. but she sometimes changed her incontinence

to change you or your bed."

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STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL030007	B. WING		12	2/13/2019
	ROVIDER OR SUPPLIER	191 CRE	ADDRESS, CITY, STATE STVIEW DRIVE VILLE, NC 27028	E, ZIP CODE		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 269	-Her briefs were very them and she dispose trashcan in her roomShe gave herself a b -She did not remembe bath or shower. Interview with Resider 12/05/19 at 10:12am resident #8 had incompleted the night and sometime first shift for her inconchangedResident #8 always retime for incontinence shiftsResident #8 had missitimes due to her inconsiderResident #8 sometime for staff to change her night beforeStaff offered Resident once every two weeks Interview with a person 12/05/19 at 5:35pm resident #8 required careShe had found Resid beginning of her shiftResident #8 changed briefs sometimes and when she checked her shed occumented on sheets every time incorprovided for residents	wet when she changed ed of the briefs in the ed bath sometimes. Er ever refusing to have a ser ever refusing to have a ent #8's roommate on revealed: Ontinence episodes during tinence briefs to be enad to wait long periods of care on second and third esed breakfast numerous entinence briefs being es had to wait until dinner es soiled sheets from the ent #8 a shower or bath about soiled. It was a shower or bath about entire every 2 hours to see if a needed. It was a soiled at times at the entire the entirence was hardly ever soiled to the incontinence care ontinence care ontinence care was	D 269			
	-one doubted the inco	nunence care sneets and				

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PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (D (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 269 Continued From page 90 D 269 the Personal Care Records were correct for residents because sometimes the PCAs forgot to fill them out or just did not fill them out. Interview with a second PCA on 12/06/19 at 5:01pm revealed: -Baths were usually given on first shift. -She provided a bed bath as needed unless she felt a resident needed a shower. -She did not document personal care on the Personal Care Records, but she tried to document on the incontinence care sheets. -She checked on residents every 2 hours and as needed for incontinence care. -She physically checked residents to see if they needed incontinence care. -She found residents wet each day when she started her shift. -She was sometimes told by other PCAs on previous shifts a resident "wanted her" which meant there was no incontinence care provided to the resident. -She did not really check on Resident #8 because she "was okay." -Another PCA started helping Resident #8 and took away her independence so Resident #8 decided she was not going to the bathroom anymore. -Resident #8 could provide her own incontinence care and did not need any help.

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revealed:

"got mad about it."

Interview with third PCA on 12/06/19 at 5:36pm

-She started each shift by checking residents to

-She had found residents many times soaked and

-She had found Resident # 8 soiled and her linen

see if they needed incontinence care.

soiled before when she started her shift. -She told the Administrator who told her she

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE)
		HAL030007	B. WING		12/13/2	019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
		191 CREST	VIEW DRIVE			
THE HERI	TAGE OF CEDAR ROCK		LE, NC 27028	8		
(VA) ID	SLIMMARY ST			PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 269	Continued From page	91	D 269			
	would look to see who and would correct the -First shift was usually baths.	o worked the previous shift issue. y responsible for giving				
	Interview with a fourth 5:57pm revealed: -She assisted with pe showers, and incontin	rsonal care including baths,				
	-If Resident #8 had food in her personal refrigerator, she would stay in her room during meal times and not get out of bed or allow staff to					
	assist with incontinent -Resident #8 refused					
	incontinence care mo assistance with baths	re often than she refused				
	-Resident #8 refused days a week.	baths about 4 days out of 7				
	-When Resident #8 reshe let the oncoming	fused a bath or shower, shift PCA know.				
	-She did not documer					- 1
		ets or on Personal Care mow if other PCAs were				
	documenting.	HOW IT OTHER POAS WEIE				
		t of paper who she provided				- 1
	showers to and left the aide (MA) desk for the	e paper at the medication				
	Interview with the Adn 6:15pm revealed:	ninistrator on 12/06/19 at				
		osed to document on the				
	Personal Care Record	ds each time a resident was				
	given a bath.					
		nal Care Records had not				
		she had instructed staff to				
	complete when baths	were given. iven either 2 days a week or				- 1
	3 days a week.	ven either 2 days a week of				
		anyone regularly refusinga				
	bath or incontinence of	are.				

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STATE FORM KGC311 If continuation sheet 92 of 327

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		HAL030007	B. WING		12/13/2019
NAME OF F	ROVIDER OR SUPPLIER		DRESS, CITY, ST		
THE HER	TAGE OF CEDAR ROCK		TVIEW DRIVE ILLE, NC 2702		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 269	-She did know about Resident #8 refused personally spoke to Rher to allow staff to prolif a resident did refuse care, the resident sho providing personal caresistance with incompassistance with incompassistance with incompassistance with incompassistance care at the suggested to state change of shifts to make been provided incontinuous care at least every 2 hours of the suggested to state change of shifts to make provided incontinuous care ever for residents who had episodes. Resident #8 had multiple resident #9 revealed: Review of Resident #9 resident #10 resident #11 was an assistance with bathir resident #11 was incompassed in the side of the resident #11 had da bladder and occasion bowel.	of a few times when personal care and she desident #8 and encouraged dovide care. We a bath or incontinence and not be left without staff received the resident for timence care. Implaints from staff on all inding residents needing the beginning of their shifts. Iff to round together at the aske sure all residents had mence care by the previous aff to check residents for any 2 hours and more often multiple incontinence tiple incontinence enours on the incontinence and	D 269		

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING: _	CONSTRUCTION	1 '	TE SURVEY MPLETED	
		HAL030007	B. WING		1:	2/13/2019
	PROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STA STVIEW DRIVE /ILLE, NC 27028	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
D 269	documentation how on Resident #11's skin workers assistance assistance assistance assistance with dress. Review of the Person #8 for December 2019 documentation regard. Observation of Reside 5:26pm revealed: -Resident #11 was lay -A (PCA) pulled Reside a red area with a thin with 11's left breast and Fareas on her abdome. There was an odor errevealed the red areas. Interview with Reside 6:12pm revealed: -She needed assistant skinShe thought she recedid not know how man. Interview with the PCA revealed: -Resident #11's skin key had been lookingShe applied cream to provided personal carrother PCAs were applied. "They must have start this week."	ften care was refused. was normal. d supervision with toileting, with bathing, and limited ing. al Care Record for Resident P revealed there was no ling personal care provided. ent #11 on 12/11/19 at ying in bed in her room. lent #11's shirt up to reveal white layer under Resident Resident #11 also had red in. mitted when the PCA is. at #11 on 12/12/19 at the had any issues with her leived a bath regularly, but any times a week. A on 12/11/19 at 5:26pm booked better than what it a Resident #11 when she ie, but she was not sure lying cream to the areas. ted putting something on it with a first shift medication	D 269			

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STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA iDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY
		HAL030007	B. WING		12/	13/2019
	PROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, S STVIEW DRIVE ILLE, NC 2702		124	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 269	-Resident #11 had rai under her breast and -She had been having February 2019Resident #11 was promonths ago for 5 daysThe Diflucan helped it up. Review of Resident # Administration RecordThere was an entry for (Diflucan) 100mg table yeast dermatitisDiflucan 100mg was administered on 4 of 6 10/09/19, 10/10/19, arThere was no docum tablets were not admin complete the order for Interview with a second at 11:46am revealed Funder her breast and interview with the Adm 6:15pm revealed: -She had gotten complete the order for staff reporting the should have be a weeks and incontine provided at least every. She did not know of a bath or incontinence concerning the resident #11 refusing lef a resident did refuse.	sh in the folds of her skin in her groin area. g issues with rash since escribed Diflucan a few is to treat the rash. The rash, but it did not clear of for October 2019 revealed: for fluconazole of 1 tablet daily for 6 days for documented as 6 opportunities on 10/08/19, and 10/11/19. The entation why the other 2 point on the province of the form of the province of the province of the form of the province of	D 269			

Division of Health Service Regulation STATEMENT OF DEFICIENCIES

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION ()		(X3) DATE SURVEY COMPLETED	
				1			
		HAL030007	B. WING		12	/13/2019	
NAME OF PROV	IDER OR SUPPLIER			STATE, ZIP CODE			
THE HERITAG	SE OF CEDAR ROCK		TVIEW DRIVI LLE, NC 270				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETE DATE	
D 269 Co	entinued From page	95	D 269				
phy-Sh bre-Sh rass -Th -Re pass day -To Diffi -Sh Diffi reo -Sh hav staf dry abd 7. Fi reversible -Rese bow -Rese -Rese uppor	ysician (PCP) on 12 ne knew about the reast and in her abdo ne had to treat Resisted and the reast. The smell was "overwesident #11 had physice and she ordered as and on 10/31/19 The knowledge, the lucan were being us the did not know Resident for 2 days of the did not think Resident are thought Resident for erash under her brown of the folds of her solomen. Review of Resident are and wore incomposed and wore incomposed and wore incomposed and dressing. The work Resident #1 was and a sealed: The work Resident #1 was incomposed and wore incomposed and dressing. The work Resident #1 was ambusticed and work work incomposed and dressing. The work Resident #1's was ambusticed and was ambusticed work work incomposed and dressing.	dent #11 several times for whelming." wsician's orders for calazime I Diflucan on 10/04/19 for 6 for 10 days. calazime paste and sed as ordered. sident #11 did not receive he 6 days ordered. ident #11 missing 2 days of Diflucan having to be for 10 days. #11 might continue to reast and groin area due to ke sure Resident #11 was kin under her breast and #1's FL2 dated 10/04/19 erebral Palsy, seizure m, and arthritis. ambulatory. htinent of her bladder and tinent briefs. ssistance by staff with s care plan dated 01/22/19 ulatory with a wheelchair. d range of motion of her					

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) iD PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 269 Continued From page 96 D 269 bladder and bowels. -Resident #1 needed supervision with grooming and personal hygiene. -Resident #1 needed limited assistance by staff with getting dressed. -Resident #1 needed extensive assistance by staff with toileting and bathing. Observation of Resident #1 on 12/03/19 at 10:42am revealed: -Resident #1 was seated in a wheelchair in her room. -Resident #1's hair was unkempt and greasy. -A personal care assistant (PCA) assisted Resident #1 to lift her left breast; there was a trace of yellowish powder residue in the front and to the far side of her left breast with her skin being bright red and inflamed with red blistered -A PCA assisted Resident #1 to lift her right breast; the skin under her right breast had a very foul odor and had sticky, yellowish, clumpy powder under her right breast and her skin was bright red and inflamed. Review of the facility incontinence care sheets dated 11/29/19 through 12/05/19 revealed: -In the right-hand column, her assistance code was listed as "EA" (meaning extensive assistance). -On 11/29/19 Resident #1 provided her own incontinence care twice. -On 11/30/19 Resident #1 provided her own incontinence care once. -On 12/01/19 Resident #1 provided her own

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incontinence care once.

-On 12/02/19 Resident #1 was provided

incontinence care 3 times on 12/02/19; however, a second facility incontinence care sheet dated 12/02/19 revealed Resident #1 provided her own

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ B. WING_ HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK

THE HER	ITAGE OF CEDAR ROCK	SVILLE, NC 27028		
(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 269	incontinence careOn 12/03/19 Resident #1 was provided incontinence care once; however, a second facility incontinence care sheet dated 12/03/19 revealed Resident #1 provided her own incontinence careOn 12/04/19 Resident #1 provided her own incontinence care onceOn 12/05/19 Resident #1 provided her own incontinence care onceOn 12/05/19 Resident #1 provided her own incontinence care once. Review of the Personal Care Record for Resident #1 for November 2019 revealed: -Resident #1 required extensive assistance by staff with bathing and had the option of receiving a shower, shower/bath, bed bath, or sponge bathResident #1's bath days were highlighted in pinkResident #1 should have had a bath three times a week on 11/01/19, 11/04/19, 11/06/19, 11/08/19, 11/12/19, 11/12/19, 11/12/19, 11/12/19, 11/12/19, 11/13/19, 11/15/19, 11/18/19, and 11/29/19 totaling 13 baths in the month of November 2019Resident #1 received a shower on 11/14/19, 11/15/19, 11/18/19 and 11/20/19There was no documentation regarding refusalsResident #1 needed extensive assistance with providing her own skin care (wash face/hands/foot care) on 11/14/19, 11/15/19, 11/18/19, and 11/20/19. Review of the Personal Care Record for Resident #1 for December 2019 revealed: -Resident #1 required extensive assistance by staff with bathing and had the option of receiving a shower, shower/bath, bed bath, or sponge bathResident #1's bath days were highlighted in pinkResident #1's bath days were highlighted in pinkResident #1 should have had a bath three times a week on 12/02/19, 12/04/19, and 12/06/19, but there was no documentation Resident #1 was given a bath.	D 269		

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PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 269 D 269 Continued From page 98 -There was no documentation regarding refusals. -Resident #1 was provided skin care (wash face/hands/foot care). Interview with Resident #1 on 12/03/19 at 10:22am revealed: -The facility staff sometimes helped her with a bath. -The staff would not help her get dressed. -The skin under her breasts burned and was -The staff did not put her powder under her breast daily. Second observation of Resident #1 on 12/06/19 at 9:15am revealed: -Resident #1 was seated in a wheelchair in her room. -Resident #1's hair was unkempt and greasy hair. -Resident #1 had an odor of urine and feces with feces on the bed sheet and on the floor. -A PCA covered the dirty linen with clean linen and assisted the resident onto the bed and provided incontinent care for her. -Resident #1's skin was red on the bottom 4 inches of her buttocks. -The PCA got Resident #1 back to her wheelchair, assisted her to lift her shirt and left breast. There was a small amount of sticky powder present with the skin red, inflamed and an odor present. -The PCA got a wet washcloth with a drop of no rinse soap on it and made 1 swipe under the left -She did not rinse or dry under the resident's left

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breast or place a cloth to prevent the skin from

-The PCA then assisted to lift Resident #1's right

-The PCA used the same washcloth and made 1

breast; the skin was red and inflamed.

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STATEMENT OF DEFICIENCIES (X1) PI

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X3) DATE SURVEY	
AND PLAN	AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMPLETED	
		HAL030007	B. WING		12/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
		191 CRES	STVIEW DRIVE		
THE HERI	TAGE OF CEDAR ROCK		ILLE, NC 27028		
(X4) ID	SI IMMADV ST	ATEMENT OF DEFICIENCIES			
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 269	Continued From page	99	D 269		
	swipe under her right	breast			
		fry under the resident's right			
		n to prevent the skin from			
	touching.	to protone are stair norm			
	_	ave shoes on; both her feet			
		had dry, flaky, cracked			
	scaling.				
		both feet had a thick scaly			
		g on them with longtoenails			
	and the left great toe h	ad a broken, jagged nail.			
	Second interview with	Resident #1 on 12/06/19 at			
	9:06am revealed:				
	-Resident #1 did not k	now when she last had a			
	bath.				
	-Sometimes, she decli				
	-She still burned and h				
		o wait for staff to assist her			
	with incontinence care				
		en she saw a foot doctor			
	doctor came to the fac	ine too long when the foot			
		long her feet had been dry			
	and scaly.	long her leet had been dry			
	-Her feet only got clear	ned when she took a			
	shower.				
	-No one ever put lotion	on her feet.			
	-She would like lotion of	on her feet, but no one			
	would assist her.				
	Third observation of P	esident #1 on 12/11/19 at			
	9:30 am revealed:	SOIGETILE TOTAL TELEFORM			
		lent #1 to lift her left breast;			
	her skin was reddened				
	improved, with a light p				
	-A PCA assisted Resid				
		ddened, without odor, but			
	had improved.				
	-Resident #1's feet wei				
	flaky cracked scaling a	nd her toes had a thick,			
vision of Health	Service Regulation				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		HAL030007	B. WING		12/	13/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE HED	IT4.05.05.050.55.55.50.	. 191 CRE	STVIEW DRIVE			
THE HEK	ITAGE OF CEDAR ROCK		VILLE, NC 27028			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		BBOUIDEDIO DI ANI GE		_
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 269	Continued From page	100	D 269			
	scaly yellowish white	coating on them				
	, , , , , , , , , , , , , , , , , , , ,	oodanig on alom.				
	9:23am revealed: -Resident #1's breast					
	-Staff had been putting her powder on her and					
	had placed a a cloth under her breasts.					
	-She had a bath yeste	erday.				
r	Interview with a PCA revealed:	on 12/06/19 at 8:50am				
	-She made rounds ev	en/ 2 hours, but some				
	residents required rou					
	-She rounded on Resi					
		would let her know if she				
	needed to be changed	d.				
	-Resident #1 changed	I herself at times.				
	Interview with another 5:55pm revealed;	PCA on 12/10/19 at				
	-She started her shift of	off by checking the				
	residents who were us					
		the residents every 2 hours				
	to make sure they wer					
	-A lot of residents requ	uired assistance with				
	incontinent care.					
		when they smelled like				
	they needed a bath.	documented on the flow				
	sheets located at the					
	-She had not bathed R					
	-She had only aided w					
		because she usually did				
	her own care.					
	-She knew Resident #	1 had a rash under her				
		orted the rash because				
	"basically everyone kn	ew".				
		ew Resident #1 had the				
		since she was hired as the				
	Administrator.					

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING_ HAL030007 12/13/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 269 | Continued From page 101 D 269 -Resident#1's feet were not bad but she "could not specify" as she did not work much with Resident #1. Interview with a medication assistant (MA) on 12/12/19 at 3:29pm revealed: -Resident #1 required assistance with her bath. -When Resident #1 refused her bath, her rash flared up. -MAs were responsible for ensuring the residents had a bath. -Sometimes, there was only one shower room available for the residents use. -Most of the time there would only be 1 PCA on first shift so the MAs had to assist her with the residents' care. Interview with a third PCA on 12/12/19 at 4:33 pm -The MAs were responsible for ensuring that personal care tasks were completed each shift by the PCAs. -She made rounds every 2 hours for each resident, and every hour for residents that "have frequent urination." -There was a sheet at the nurses' station showing which residents got showers on each day. Interview with a second MA on 12/12/19 at 4:45pm revealed:

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remove it

pm revealed:

-The PCAs were responsible for providing

-Resident #1 had a rash under her breast for a

-She tried to keep a soft cloth under her breast so her skin did not rub but the resident would

Interview with a fourth PCA on 12/12/19 at 4:46

personal care for the residents.

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 269 Continued From page 102 D 269 -The MAs were responsible for ensuring that personal care tasks were completed each shift by the PCAs. -She made rounds every 2 hours for each resident, or more if needed. -She and another PCA may give a shower when we feel like they need one, like if they had a bowel movement. -Resident #1 changes herself at times. Interview with a fifth PCA on 12/12/19 at 5:08 pm revealed: -She made rounds every hour for each resident. -Showers and baths were given to the residents as needed but she felt like they needed showers every other day. Interview with Resident #1's Primary Care Provider (PCP) on 12/06/19 at 11:16am revealed: -She had not checked Resident #1's skin recently. -Resident #1's rash had not been reported. -Facility staff used to keep Resident #1 bathed and her hair washed, now she hardly ever saw Resident #1 clean. -It had been over a week since Resident #1 had her hair washed which was why it was so greasy. -She had tried to teach staff how to dry Resident #1 after her bath to help prevent a rash. -She placed Resident #1 on the list to see podiatry and applied lotion to Resident #1's feet

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that day.

5:00pm revealed:

at least hourly.

every 2 hours at a minimum.

Interview with the Administrator on 12/10/19 at

-Rounds were supposed to be made by staff

-Residents with behaviors should be rounded on

-Staff knew the residents routine, so she did not

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	N IDENTIFICATION NUMBER: A. BUILDING:		:	COMPI	LETED
			1			
		HAL030007	B. WING		12/	13/2019
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		191 CRES	TVIEW DRIVE			
THE HER	TAGE OF CEDAR ROCK		LLE, NC 2702			
	OLIMATA DV OT		ILLE, NO 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 269	Continued From page	103	D 269			
			2 200			
	create to have have s					
	documentation showing	ng the residents had been				
	seen every 2 hours at	a minimal.				
	-Residents were provi	ided incontinent care every				
		had baths 2-3 times per				
	week with some resid	ents getting them more				
	often.					
	-She expected rounds	s to be made no less than				
		pected to know the habits of				
	each resident.	to this it the habite of				
	Interview with the Adn	ninistrator on 12/12/19 at				
	6:55pm revealed:	ministrator on 12/12/13 at				
	-	assistance from staff to get				
	her bath.	assistance nom stan to get				
		t had a problem with we set				
		f1 had a problem with yeast she saw an order to use a				
		er the resident's breast.				
		suppose to ensure a soft				
	cloth was under Resid					
		y documentation regarding				
	the yeast on Resident					
	-She expected Reside					
		s became an issue, staff				
	would let the physician					
		ould be checked when she				
	got a bath.	and to deciment 2.0				1
		osed to document on the				
		ls each time a resident was				
	given a bath.					I
		al Care Records had not				l
		he had instructed staff to				
	complete when baths	•				
		ven either 2 days a week or				I
	3 days a week.					1
	-She did not know of a					l
	refusing a bath or inco	ntinence care.				l
		e a bath or incontinent care,				l
	the resident should no	t be left without staff				
		e. A second staff should				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION		re survey MPLETED
		HAL030007	B. WING		1	2/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E. ZIP CODE	· · · · · · · · · · · · · · · · · · ·	
THE HED	T405 05 050 15 500	191 CRE	STVIEW DRIVE	-,		
THE HERI	TAGE OF CEDAR ROCK		VILLE, NC 27028			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(ME)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 269	Continued From page	2 104	D 269			
	offer to assist with car	re.				
	-She had received co	mplaints from staff on all				
		inding residents needing				
		he beginning of their shifts.				
		s the responsibility of the				
		ke rounds with the off-going				
		dents to ensure they were				
	dry.	A failed to communicate with				
	the off-going PCA, the					
		de incontinent care for the				
	residents who were so					
	-She would like for sta	aff to check residents for				
	incontinence care eve	ry 2 hours and more often				
	for "heavy wetters".					
		ald be documented every 2				
	hours on the incontine					
		bath/shower list up to date				
		y up to date, and all the				
		ed on the bath/shower list. e for updating the shower				
		to be documented on the				
	-No one currently audi	ted the PCA sheets.				
	-She was responsible	for ensuring the PCA				
	sheets were complete	d.				
	Interview with the Sup					
	11:09 am revealed the					
		e and did not have all the				
	residents listed on it.					
	8. Review of Resident revealed:	#20's FL2 dated 01/23/19				
		ementia, hypertension,				
		tive joint disease of the				
	lumbar spine.	, 5 4.00000 01 010				
	-Resident #20 was inte	ermittently disoriented.				
	-Resident #20 was ser	ni-ambulatory with use of a				
	h Service Regulation					UL

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	::	COMP	LETED	
		1141 000007	B. WING				
		HAL030007	D. WING		12/	13/2019	
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE			
THE HER	ITAGE OF CEDAR ROCK		TVIEW DRIVI				
0/4) IB	CHAMADY OT		ILLE, NC 270				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
D 269	Continued From page	105	D 269				
	cane or wheelchair.						
		continent of her bladder and					
	bowels and wore inco						
	and dressing herself.	d assistance with bathing					
	and arooming moreoni.						
	Review of Resident #2	20's care plan dated					
	01/22/19 revealed: -Resident #20 was an	nbulatory with aide of a					
	device.	ibulatory with alde of a					
		ited range of motion of her					
	upper extremitiesResident #20 had dai	ille imposition and a set to a					
	bladder and bowels.	ily incontinence of ner					
		get and needed reminders.					
		limited assistance with					
	grooming, personal hy toileting.	giene, getting dressed, and					
	•	extensive assistance by					
	staff with bathing.	,					
		ncontinence care sheets					
	dated 11/29/19 throug						
	was listed as "EA" (me	mn, her assistance code					
	assistance).	caring extensive					
	-On 11/29/19 Residen						
	incontinent care once						
	-On 11/30/19 Resident incontinence care one	•					
		t #20 was not provided					
	incontinence care.						
		t #20 was not provided					
		view of a second facility et dated 12/02/19 revealed					
	Resident #20 was not						
	care.						
	-On 12/03/19 Resident						
		view of a second facility et dated 12/03/19 revealed					
	moontinence care sile	et dated 12/03/18 fevealed					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING.	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/13/2019
	PROVIDER OR SUPPLIER	191 CREST	RESS, CITY, S' VIEW DRIVE		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 269	Resident #20 was not care. -On 12/04/19 Resident incontinence care. -On 12/05/19 Resident incontinence care. Review of the Persona #20 for November 207-Resident #20 require staff with bathing and a shower, shower/bath-Resident #20's bath opink. -Resident #20 should times a week on 11/0711/08/19, 11/12/19, 11/12/19, 11/12/19, 11/12/19, 11/12/19, and 11/22/11 -There was no docume-Resident #20 receive 11/20/19, and 11/22/11 -There was no docume-Resident #20 needed providing her own skir face/hands/foot care) of 11/22/19. Review of the Persona #20 for December 2011 -Resident #20 required staff with bathing and lashower, shower/bath-Resident #20's bath opink. -Resident #20's bath opink. -Resident #20 should latines a week on 12/02 12/06/19, but there was Resident #20 was given.	t #20 was not provided at #20 was not provided at #20 was not provided at Care Record for Resident 19 revealed: d extensive assistance by had the option of receiving h, bed bath, or sponge bath. days were highlighted in have had a bath three 1/19, 11/04/19, 11/06/19, 1/13/19, 11/27/19, and aths in the month of d a shower on 11/16/19, 9. entation regarding refusals. extensive assistance with a care (wash on 11/16/19, 11/20/19, and at Care Record for Resident 9 revealed: d extensive assistance by had the option of receiving h, bed bath, or sponge bath. ays were highlighted in have had a bath three 1/19, 12/04/19, and s no documentation	D 269		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HAL030007	B. WING		12/13/2019
	PROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STAT STVIEW DRIVE /ILLE, NC 27028	TE, ZIP CODE	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 269	-There was no docum provided skin care (with provided skin care (with 2:37pm revealed: -Resident #20 was in the hallway, looking in resident #20 was we carrying a wet pull-up resident #20's shirt with knees to cover herself-resident #20 placed pants by the doorway Interview with Resider 2:37pm revealed: -She had rolled down to assist her, but she with a person 12/10/19 at 5:55pm resident who were us she made rounds on to make sure they were. A lot of residents requincontinent careShe bathed residents they needed a bathResident baths were of she had not bathed Reshe had never assisted personal care until ear still in her night gownShe worked on 12/06/	tentation Resident #20 was ash face/hands/foot care) ent #20 on 12/06/19 at a wheelchair, rolling down a each room. earing only a shirt and was and a wet pair of pants. vas stretched over her f. the wet pull-up and her wet to the breakroom. at #20 on 12/06/19 at the hallway to look for staff was not able to find anyone. Shing up and putting on ther to the bathroom today. The total care assistant (PCA) on wealed; The total care assistant to the flow less. The total care assistance with the they smelled like documented on the flow less. The total care assistance with the they smelled like documented on the flow less.	D 269		

	OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		1	2/13/2019	
	PROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, S STVIEW DRIVE VILLE, NC 2702				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
D 269	another residentShe applied lotion to because she had dry -She told the Administ skin on her legs and f her some lotion to app. Interview with a medic 12/12/19 at 3:29pm re-MAs were responsible had a bathIf she did not know we care was, she reviewed Resident #20 remove when she was soiledThe bath/shower list were no new residents were no she updated the bath Administrator would not sometimes, boxes we shower rooms so resident their bath as schedule -Most of the time therefirst shift so the MAs heresidents' care. Interview with a secon pm revealed: -The MAs were resport personal care tasks we the PCAsShe made rounds every ho frequent urination." -There was a sheet at document when reside incontinent care.	Resident #20 weekly skin. rator Resident #20 had dry eet; the Administrator gave oly. cation aide (MA) on evealed: e for ensuring the residents that a resident's level of ed the care plan. ed her clothing at times, was outdated as some of longer at the facility and of on the list. //shower list, but the of accept it. ere stacked in one of the dents were not able to have d. e would only be 1 PCA on ad to assist her with the d PCA on 12/12/19 at 4:33 esible for ensuring that ere completed each shift by ery 2 hours for each ur for residents that "have the nurses' station to	D 269				

Division of Health Service Regulation

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION	1037 (22	(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/	13/2019
	PROVIDER OR SUPPLIER	191 CRES	DDRESS, CITY, S STVIEW DRIVI ILLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	BE	(X5) COMPLETE DATE
D 269	Continued From page	109	D 269			
	Interview with a second 4:45pm revealed: -The PCAs were responded and the resident #20 remove was hotResident #20 was changed and the revealed: -The MAs were responders and the revealed: -The MAs were responders and care tasks with the PCAsShe made rounds everesident, or more if neuron and the revealed incontinent episodeShe checked Resider Interview with a fourth pm revealed: -She made rounds every showers and baths was needed but she felt every other day. Interview with Resident Provider (PCP) on 12/-Facility staff had never Resident #20 had reminto the hallwayShe was concerned the resident responder with the resident #20 had reminto the hallway.	onsible for providing residents. ed her clothes when she ecked every 2 hours and as PCA on 12/12/19 at 4:46 pm insible for ensuring that ere completed each shift by ery 2 hours for each eded. A may give a shower when one, like if they have an int #20 every 2 hours. PCA on 12/12/19 at 5:08 ery hour for each resident. Fere given to the residents like they needed showers It #20's Primary Care 12/19 at 4:50pm revealed:				
	care and toileting.	assistance with personal provided with incontinence				

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING_ HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 269 Continued From page 110 D 269 care every 2 hours at a minimal. Interview with the Administrator on 12/12/19 at 6:55pm revealed: Resident #20 required assistance from a staff to get her bath. -The PCAs were supposed to document on the Personal Care Records each time a resident was given a bath. -She knew the Personal Care Records had not been completed, but she had instructed staff to complete when baths were given. -Baths were usually given either 2 days a week or 3 days a week. -She did not know of any resident regularly refusing a bath or incontinence care. -If a resident did refuse a bath or incontinent care. the resident should not be left without staff providing personal care. -Staff should re-approach the resident for assistance with incontinence care. -She had received complaints from staff on all shifts that they were finding residents needing incontinence care at the beginning of their shifts. -At shift change, it was the responsibility of the oncoming PCA to make rounds with the off-going PCA to check the residents to ensure they were dry. -If the on-coming PCA failed to communicate with the off-going PCA, then it became their responsibility to provide incontinent care for the residents who were left soiled.

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for "heavy wetters".

care sheets.

-She would like for staff to check residents for incontinence care every 2 hours and more often

-There should be documentation of incontinence care at least every 2 hours on the incontinence

-Staff tried to keep the bath/shower list up to date but it was not currently up to date, and all the

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 269 Continued From page 111 D 269 residents were not listed on the bath/shower list. -Baths were supposed to be documented on the PCA sheets. -No one currently audited the PCA sheets. -The Administrator was responsible for ensuring the PCA sheets were completed. Interview with a Supervisor on 12/13/19 at 11:09 am revealed: -The bath schedule was currently not up to date and did not have all the residents listed on it. -There was not usually staff at the desk because the was only 1 PCA scheduled to work on first shift and she stayed busy assisting residents. The facility failed to provide personal care assistance for 8 of 11 sampled residents which resulted in four residents not getting proper foot care (#1, #5, #12 and #18) resulting in discoloration and thick buildup on residents' feet and toenails, residents not provided proper incontinence care (#1, #7, #8, and #20) resulting in residents having to wait for incontinence care and a resident pulling her pants and briefs off in the hallway, and residents not provided appropriate skin care (#1 and #11) resulting in a rash causing pain, burning, and foul odors. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in

Division of Health Service Regulation

2020.

this violation.

accordance with G.S. 131D-34 on 12/05/19 for

THE CORRECTION DATE FOR THIS TYPE BE VIOLATION SHALL NOT EXCEED JANUARY 27,

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G:	(X3) DATE SURV COMPLETER	
	HAL030007	B. WING		12/13/2	019
NAME OF PROVIDER OR SUPPLIER THE HERITAGE OF CEDAR RO	191 CBE	DDRESS, CITY, S	STATE, ZIP CODE E	12.10/2	
THE HEALTH OF GEBANNA	MOCKS	VILLE, NC 270	28		
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ве с	(X5) OMPLETE DATE
D 270 Continued From p	page 112	D 270			
This Rule is not material to meet the needs (Residents #5 and weakness causing and a resident who knowledge (#5). The findings are: 1. Review of Residents who knowledge (#5). The findings are: 1. Review of Residents who knowledge (#5). The findings are: 1. Review of Residents who knowledge (#5).	901(b) Personal Care and 901 Personal Care and ride supervision of residents in each resident's assessed needs, rent symptoms. et as evidenced by: DN eviews, observation and ity failed to provide supervision of 2 of 5 sampled residents #12) who had muscle him to repeatedly fall (#12) o eloped without staff's ent #5's current FL2 dated ed fracture of left ankle, bipolar, reflux disease (GERD), and constantly disoriented. entation the resident had vior, wandered and was	D 270	IT IS NOT OUR POLICY(OUR POLICIE: ATTACHED) TO PROP ANY DOOR OP AVOID ALARMS GOING OFF. OWNER NEVER MADE AWARE (UNTIL THIS S THAT INCIDENT WITH RESIDENT #5 I OCCURRED. WHEN ISSUE WAS CITELE EMPLOYMENT OF EMPLOYEE RESPOFOR THIS ACTION WAS TERMINATED POLICIES WERE IN PLACE (SEE ATTACHMENT) FOR FALL PREVENTION STAFF HAD SIGNED THAT THEY UNDERSTOOD POLICY. THIS ISSUE SI HAVE BEEN ADDRESSED BY PCS STAADMINISTRATOR. AS OF 12/16/19, OWWERE ACTIVELY INVOLVED IN SEEIN RESIDENTS WERE BEING CARED FOR PROPERLY SUPERVISED. AS OF 2/7/20 RESIDENTS HAVE BEEN RELOCATED APPROPRIATE LEVELS OF CARE WITH ASSISTANCE OF DAVIE COUNTY D.S.:	EN TO WAS URVEY) EVER), NSIBLE). ON. HOULD FF AND NERS NG THAT AND 20, ALL TO H THE	

PRINTED: 01/13/2020

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 270 Continued From page 113 D 270 department dated 10/01/19 revealed: -Resident #5 was found by the police officers on dark street. -The location where the resident was found was almost two blocks from the facility. -It was 3:13am and the resident appeared disoriented. -The resident told the police officers that he was having chest pains and pains in his left arm, but facility staff would not call medical assistance for -The police officers transported the resident back to the facility. -The staff at the facility did not know theresident had left the building. -The door to the facility was observed as being held open by a "door stop," which caused the alarm to be deactivated. -The officer documented the door open was how Resident #5 left the building. -No staff at the facility could advise the police officer when and how Resident #5 left the facility. Interview with Resident #5's guardian on 12/05/19 at 12:13pm revealed: -The Administrator at the facility called her later in the morning on 10/01/19 after Resident #5 eloped. -She told the Administrator the facility needed a better system to identify when resident's leave the building. -Resident #5 told her that he left the facility because he needed an ambulance and the staff would not call the ambulance for him. Interview on 12/05/19 at 9:11am with Resident #5 -A few months ago, he left the facility because he

Division of Health Service Regulation

wanted to go to the hospital.

-He had been telling staff that he did not feel

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		HAL030007	B. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK	191 CRES	TVIEW DRIVE	Ĭ.		
			LLE, NC 2702	28		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Continued From page	114	D 270			
	good and was in pain. The staff refused to s The staff continued to the hospital and staff wrong with him. He left the facility to t The police stopped of transported him backs. He still never got to g Telephone interview was continued to the still never got to g Telephone interview was continued to the still never got to g Telephone interview was continued to the still never got to g Telephone interview was continued to the resident was unally independent decisions was dangerous. If the resident complation illness the facility staff. He had not received a regarding Resident #5 wanted to go to the hound the train on 12/12/19 at 4:50 pm. She recalled when Resident #5 got out. They checked on resident was not sure how sometimes staff left the dumped the trash, that Resident #5 got out. They checked on resident was not sure how some times the police to the facility. She did not contact the practitioner (PCP) or make had not complete	eend him to the hospital. o ignore his request to go to told him there was nothing ake himself to the hospital. In the street and the police to the facility. In the Mental Health //06/19 at 3:50pm revealed: fused and needed continual able to make good when a situation was ined about a non-factual should have notified him any pages or phone calls astating he was sick and spital. I shift medication aide (MA) I revealed: I scident #5 left the facility. I he got out but stated I door open when they I could possibly be how I dents every two hours. I long Resident #5 was brought the resident back I e resident's Primary Care	D 270			
4-1 611 1	Interview with the Admi	nistrator on 12/12/19 at				

(X2) MULTIPLE CONSTRUCTION

MAKE OF PROVIDER OR SUPPLER THE HERITAGE OF CEDAR ROCK 191 CRESTIVEW DRIVE MOCKSVILLE, NC 27028 PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, APP CODE		AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			(X3) DATE SURVEY COMPLETED	
THE HERITAGE OF CEDAR ROCK (A4)ID PREFIX TAG SUMMARY STATEMENT OF DEPICIENCIES INCAMORATION, PREFIX TAG CEACH DEPICIENCY MUST BE PRECEDED BY SPLIL, PLOYAGE (EACH DEPICIENCY MUST BE PRECEDED BY SPLIL) TAG D 270 Continued From page 115 9.37am revealed: -She was aware Resident #5 eloped from the facilityShe thought staff left the door openShe had informed staff to watch all the residents , especially the residents that were easily agitatedThe facility's policy was to provide supervision every two hours when providing incomfinent care to the residentsStaff should cell the PCP, however she found out one month ago, that mental health wanted to be called when a resident #12's current FL2 dated 10/21/19 revealed: -Diagnoses included diabetes melitius, hypertension, psychotic disorder, deep vein thrombose, esophageal reflux, and hypothyroidismResident #12 was semi ambulatory with a wheelchair. Review of Resident #12's Care Plan dated 0.3/20/18 revealed: -Resident #12 required limited assistance with ambulation, bathing, and transferring. Review of the contracted nurse's note dated 99/03/19 revealed: -Resident #12 required limited assistance with ambulation, bathing, and transferring. Review of the contracted nurse's note dated 99/03/19 revealed: -Resident #12 required limited assistance with ambulation, bathing, and transferring. Review of the contracted nurse's note dated 99/03/19 revealed: -Resident #12 required limited assistance with ambulation, bathing, and transferring.			HAL030007	B. WING		12	/13/2019	
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) D 270 Continued From page 115 9.37am revealed: -She was aware Resident #5 eloped from the facilityShe thought staff left the door openShe had talked with staff and notified Resident #5's guardianShe had informed staff to watch all the residents, especially the residents that were easily agitatedThe facility's policy was to provide supervision every two hours, but she had no specific time when staff should monitor the residentsStaff should observe the residentsStaff should observe the residentsStaff should when a resident was agitated. 2. Review of Resident was agitated. 2. Review of Resident #12's current FL2 dated 10/21/19 revealed: -Diagnoses included diabetes mellitus, hypertension, psychotic disorder, deep vein thrombosis, esophageal reflux, and hypothyroidismResident #12 was semi ambulatory with a wheelchair. Review of Resident #12's Care Plan dated 03/20/18 revealed: -Resident #12 required limited assistance with eating, folleting and dressingResident #12 required imited assistance with ambulation, bathing, and transferring. Review of the contracted nurse's note dated 09/03/19 revealed: -Resident #12 had increased weakness to both			191 CRES	TVIEW DRIVE				
9:37am revealed: -She was aware Resident #5 eloped from the facilityShe thought staff left the door openShe had talked with staff and notified Resident #5's guardianShe had informed staff to watch all the residents , especially the residents that were easily agitatedThe facility's policy was to provide supervision every two hours when providing incontinent care to the residentsStaff should observe the residents more often than every two hours, but she had no specific time when staff should monitor the residentsStaff should call the PCP, however she found out one month ago, that mental health wanted to be called when a resident was agitated. 2. Review of Resident #12's current FL2 dated 10/21/19 revealed: -Diagnoses included diabetes mellitus, hypertension, psychotic disorder, deep vein thrombosis, esophageal reflux, and hypothyroidismResident #12 was intermittently disorientedResident #12 was semi ambulatory with a wheelchair. Review of Resident #12's Care Plan dated 03/20/18 revealed: -Resident #12 required ilmited assistance with eating, toileting and dressingResident #12 required extensive assistance with ambulation, bathing, and transferring. Review of the contracted nurse's note dated 09/03/19 revealed: -Resident #12 had increased weakness to both	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE	
lower extremitiesResident #12 was observed in the hallway on his	D 270	9:37am revealed: -She was aware ResidentityShe thought staff left-She had talked with substitution with substitution and talked with substitution and talked with substitutionShe had informed state especially the residentThe facility's policy wevery two hours when to the residentsStaff should observe than every two hours, time when staff should call the Fone month ago, that more called when a resident substitutionReview of Resident 10/21/19 revealed: -Diagnoses included do hypertension, psychotic thrombosis, esophage hypothyroidismResident #12 was ser wheelchair. Review of Resident #103/20/18 revealed: -Resident #12 required eating, toileting and drawall resident #12 required ambulation, bathing, and Review of the contract 09/03/19 revealed: -Resident #12 had increased and resident #12 had increased re	the door open. staff and notified Resident aff to watch all the residents, ats that were easily agitated. as to provide supervision providing incontinent care the residents more often but she had no specific amonitor the residents. PCP, however she found out nental health wanted to be t was agitated. #12's current FL2 dated liabetes mellitus, ic disorder, deep vein al reflux, and ermittently disoriented. mi ambulatory with a 2's Care Plan dated d limited assistance with essing. d extensive assistance with nd transferring. ed nurse's note dated reased weakness to both	D 270				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
	HAL030007	B. WING		12/13/2019	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
THE HERITAGE OF CEDAR ROC	, 191 CRES	STVIEW DRIVE			
I THE HERITAGE OF CEDAR ROOF		ILLE, NC 27028			
(X4) ID SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	l ave	
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 270 Continued From pag	e 116	D 270			
hands and knees due himself up using a wa	e to not being able to hold alker.				
	cted nurse's note dated e resident had a decline in				
Support (LHPS) eval contracted nurse 11/	Review of the Licensed Health Professional Support (LHPS) evaluation dated by the contracted nurse 11/14/19 revealed: -The report was completed by a Registered				
Nurse (RN)Staff told her that Re	esident #12 had fallen twice				
todayThe resident's blood -The resident had rec	sugar was 113. cently returned from the				
hospital.					
	recommendations that nigh risk for falls due to				
11:04am revealed:	ent #12 on 12/04/19 at				
-The resident was sitt					
	ned forward with his head				
	ed weak and unable to hold				
	lked, he had his head down				
Interview with Reside 11:06am revealed:	nt #12 on 12/04/19 at				
-He always leaned for hold the upper part of	ward and was unable to his body up.				
-When he leaned forw sometimes fell to the	/ard, he just kept going and floor.				
-He fell to the floor at days more than once.	least once daily, and some				

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 270 Continued From page 117 D 270 -It hurt when he fell to the floor and sometimes, he received scratches and bruises. -He had never been to the hospital as a result of -Sometimes he fell out of bed onto the floor, and staff left him on the floor all night -Staff had to help him out of bed and into the wheelchair. -When in the wheelchair he was weak and unable to sit up straight, so he leaned forward which caused him to fall to the floor. -Some days staff put his wheelchair close to the bed so when he learned forward and was able to rest his head on the bed, but not all staff. -When in the bed he sometimes rolled out of the bed onto the floor due to muscle weakness. -The staff on the mid-night shift left him on the floor all night, they covered him up with a blanket. -In the morning the day shift staff got him off the Interview with a resident on 12/11/19 at 5:35pm revealed: -Within the past 3-4 months she had observed Resident #12 on the floor several times. -She observed Resident #12 sitting on the bed. then he will fall to the floor. -Resident #12 fell to the floor because he was bent over and was unable to sit up straight. -When she observed the resident on the floor, she informed staff.

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Interview with a first shift personal care aide (PCA) on 12/04/19 at 9:46am revealed: -Two weeks ago, Resident #12 complained he could not move his lower limbs and had pain

-Last month emergency medical services (EMS) were called because Resident #12 had symptoms of a stroke with weakness and he was unable to

when touched his (legs and feet).

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 270 Continued From page 118 D 270 move his limbs. -The resident had been to the hospital at least two times with the same stroke like symptoms. -Resident #12 had fallen at least ten times within the past two weeks due to the resident being unstable and unable to sit up in his wheelchair. -She had come to work many days on the first shift and found Resident #12 lying on the floor. -When Resident #12 was found on the floor she assisted the resident to the bed or to the wheelchair. -The third shift staff left the resident on the floor. Interview with the Supervisor on 12/12/19 at 12:15pm revealed: -Resident #12's falls used to be worse. -Her way of correcting the issue of the resident's falls was that she asked the Primary Care Provider (PCP) to check and change some of the resident's medications, which decreased the resident's falls. -She was aware Resident #12 still had falls. -No supervision or monitoring system had been put in place. -She had no control over the staff schedule and if there was not enough staff to continually watch Resident #12 it was not her fault. Interview with another first shift personal care aide (PCA) on 12/12/19 at 9:38am revealed: -Due to Resident #12 decline he has had a

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wheelchair.

couple of falls that she witnessed.

-Resident #12 was weak and he tended to lean forward in his wheelchair causing him to fall forward out of the chair onto the floor. -As far as she knew the resident had not sustained any injuries due to the falls.

-However, it was very common to see Resident #12 on the floor because he fell out of his

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	****	COMP	LETED
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		TIAE030007			12/	13/2019
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THE HERI	TAGE OF CEDAR ROCK		TVIEW DRIVE			
		MOCKSV	ILLE, NC 2702	8		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
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170		200 1021111 11110 1111 0111111 111011,	TAG	DEFICIENCE		DAIL
D 270	Continued From page	e 119	D 270			
	-It was the facility's po	olicy when a resident fell to				
		aide (MA) on duty to assess				
	the resident.					
	-The MA assessed the	e resident and gave the				
	information to the Adr	ministrator.				
		d been made aware the	li .			
	resident had many fal	Is because the MA had				
	completed documenta	ation and notified the				
	Administrator.					
	-Also, the Administrat					
		unable to recall specific				
	date), and she knew t					
	intentionally put himse					
		ent that happened a couple				
		e to recall the specific date)				
		s in the dining room and he table, which caused him to				
	fall to the floor.	table, which caused thirt to				
		nt #12 knocked all thefood				
	that was on the table t					
		nave any visible injuries, but				
	the fall was noted in th					
	notes.	1, 13, 11				
	-After the incident she	tried to put the resident's				
	wheelchair far enough	under the table so that				
	when the resident lear	ned forward, he would not				
	fall to the floor.					
		ent from falling on the floor in				
		d to push the resident's				
		e bed, so when the resident				
	leaned forward, he fell					
		worked, and the resident				
	did not fall on the floor					1
		Ill was about one week ago.				
		hat morning and Resident				
	#12 was in the bed.	a walkad by the reem and				
	the resident was on th	e walked by the room and				I
		e floor. system had been put in				
	_	lent #12 to ensure he did				
	Piace to Inomitor Resid	ient # 12 to ensure ne ala				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING:	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL030007	B. WING		12/	13/2019
	PROVIDER OR SUPPLIER	191 CREST	RESS, CITY, ST VIEW DRIVE LE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	not fall. -The Administrator har regarding suggestions #12 from falling. -She did not know if Raware the resident ha Interview with a first si 11:37am revealed: -Resident #12 had frewas usually found on A third shift PCA left in the bed sickShe often found the rechairThe Administrator and made aware the resident Hoor because she Also, Administrator arwitnessed the resident Resident #12 had slow was able to get himsel -Within the past month least six times when Rayer shiftShe documented each resident on the floor, a resident's conditionThe book with her docat the nurses' desk, buthe Administrator had staff regarding supervii #12 more frequently, swheelchairShe had not observed resulted from the residence where administered med She administered med staff regarding superviii #12 more frequently, swheelchair.	d not given instructions on how to keep Resident desident #12's PCP was defalls or not. Thiff MA on 12/12/19 at equent falls and almost daily the floor. The resident on the floor or desident slumped over in the equent falls and almost daily the floor. The resident on the floor or desident slumped over in the equent slumped over in the equent was frequently found on the reported it to them both, and the supervisor both had to on the floor. The floor weed down and no longer of out of bed. The she had witnessed at desident #12 had fallen on the floor was previously at now had disappeared. The never said anything to sing or monitoring Resident on the did not fall out of his the floor injuries that	D 270			

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL030007 B. WING 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 270 Continued From page 121 D 270 Telephone interview with a third shift medication aide (MA) on 12/12/19 at 4:50pm revealed: -Resident #12 often slid out of bed onto the floor. -She told the Administrator about the resident sliding out of the bed. -The Administrator did not tell them anything to do regarding monitoring or supervising the resident. so he did not slide out of bed. -Within the past month she found the resident on the floor two to three times. Interview with Resident #12's Primary Care Provider (PCP) on 12/12/19 at 4:30pm revealed: -Three to four months ago Resident #12 was walking and was able to get out of bed without assistance. -She had observed the resident on the floora couple of times during her visit. -The resident needed to be monitored more frequently due to the weakness he was currently experiencing but did not know if the facility provided continual supervision. -She had a great concern about the residents in general, and it was difficult not being able to do anything to help the residents. -Her concern was the residents were notbeing cared for. Review of the facility's nurse notes, incident reports and documentation in Resident #12's records revealed there were no documented

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day.

#12 falls.

10:09am revealed:

incidents or hospital reports related to Resident

Interview with the Administrator on 12/12/19 at

-She had seen the resident on the floor on his hands and knees, but to her Resident #12 did not

-She did not know Resident #12 was falling every

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 270 Continued From page 122 D 270 appear that he had fallen on the floor. -She thought the resident was on the floor on his hands and knees trying to stand up. -She knew the resident had declined in his ability to walk and stand but had not put any interventions in place because she did not know the resident had falls every day. The facility failed to provide supervision for 2 of 5 sampled residents (#5 and #12) regarding a resident that had multiple falls due to a decline in health and weakness of the lower extremities (#12) and a resident that eloped from the facility without staff's knowledge (#5). This failure was detrimental to the health safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/12/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020. D 273 10A NCAC 13F .0902(b) Health Care D 273 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.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 273 Continued From page 123 D 273 This Rule is not met as evidenced by: TYPE A2 VIOLATION REFERRALS TO OTHER APPOINTMENTS Based on record reviews, observations and AND/OR TREATEMENTS ARE SUPPOSED TO interviews the facility failed to contact the health BE ADDRESSED BY MED TECHS AND RCC. IT care and mental health providers and specialty IS THE ADMINISTRATOR'S RESPONSIBILITY health care providers for 7 of 11 sampled TO SEE THAT THESRE ARE COMPLETED residents (Residents #1, #3, #5, #9, #12, #14, PROMPTLY. (POLICY ATTACHED) and #18) regarding a resident with a pressure AS OF 2/7/2020, ALL RESIDENTS HAVE BEEN ulcer (#3), a resident with extreme muscle RELOCATED TO APPROPRIATE LEVELS OF weakness resulting in falls who missed a nerve CARE WITH THE ASSISTANCE OF DAVIE conduction study and two MRI appointments COUNTY D.S.S. (#12), a resident with swollen lower extremities that caused pain when walking (#5), a resident with aggressive/agitated behaviors that yelled at other residents, beat on the walls and threw chairs (#18), two residents with rashes which made the residents uncomfortable (#1 and #9) and a glucometer which did not work properly (#14).The findings are: 1. Review of Resident #12's current FL2 dated 10/21/19 revealed: -Diagnoses included diabetes mellitus, psychotic disorder, and deep vein thrombosis. Resident #12 was intermittently disoriented. -The resident was semi-ambulatory with a wheelchair. -Resident #12 was incontinent of bladder/bowel and now wore incontinent briefs. Review of Resident #12's Care Plan dated 03/20/18 revealed: -Resident #12 required limited assistance with eating, toileting and dressing. -Resident #12 required extensive assistance with

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ambulation, bathing, and transferring.

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING	<u>-1</u>)	12/13/2019	
	PROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, ST TVIEW DRIVE LLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 273	-Resident #12 grooms supervision with eatin -Resident #12's was of a local E (EMS) report dated 07-Staff informed EMS to acting like his normal -Resident #12 stated self, he felt weakResident #12 was as transported to the hose transported to t	ed himself and required g. disruptive with behaviors. Imergency Medical Services 7/17/19 revealed: hat Resident #12 was "not self." he didn't feel like his normal sessed as being weak and spital. 's order for Resident #12 ed the Primary Care ed a neurology consult to sident #12's abnormal gait 's office visit note for 8/13/19 revealed: en by the neurologist. re (nerve conduction study) 9 at 11:00am. Inurse's notes for Resident vealed: reased weakness to both served in the hallway on his not being able to hold ker. Is report from Resident ovider (MHP) dated	D 273			

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL030007 B. WING 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 273 Continued From page 125 D 273 Review of a hospital discharge summary report dated 09/07/19 revealed Resident #12 was seen for muscle weakness, generalized weakness and muscle spasm. It was recommended neurology be contacted. Review of a local EMS report dated 11/19/19 -Resident #12's chief complaint was altered mental status. -Resident #12 had low oxygen levels, with

his body. The weakness caused the resident to have "diminished grip strength."

identified weakness on the right and left sides of

Review of a second contracted nurse's notes for Resident #12 dated 10/01/19 revealed the resident had a decline in mobility.

Review of Resident #12's record revealed there was no documentation the resident had completed the nerve conduction study that was scheduled for 10/10/19.

Interview with a representative from the neurologist office on 12/11/19 at 9:59am revealed:

- -Resident #12 had seen the neurologist on 08/13/19.
- -At that appointment a nerve conduction study was scheduled for 10/10/19.
- -Resident #12 was a "no show" for the appointment.
- -As of today's, date (12/11/19) no one had called to reschedule Resident #12 for the appointment.

Interview with a second first shift medication aide (MA) on 12/12/19 at 11:37am revealed:

-She did not know Resident #12 had an

I A V		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	ULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	PLETED	
		HAL030007	B. WING		12/	13/2019	
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IVAIVIE OF P	ROVIDER OR SUPPLIER		DRESS, CITY, S	·			
THE HERI	TAGE OF CEDAR ROCK		STVIEW DRIVE				
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				DEFICIE	NCY)		
D 273	Continued From page	2 126	D 273				
	appointment for a ner	vo conduction at Idu					
		sed their appointments					
		bout the appointment or					
		rive the transportation van.					
		and the transportation van.					
	Interview with the Sup	pervisor on 12/12/19 at					
	12:13pm revealed:						
	-She did not know that	t Resident #12 had a nerve					
	conduction study sche						
		esident #12 to his neurology					
	-	t 2019 should have given					
		her to put the appointment					
	date on her calendar.	king the staff if there had					
		ting from the visit with the					
	neurologist in August						
	_	ay to identify the staff that					
	took Resident #12 to I						
	appointment back in A	•					
	-The Administrator wa	s responsible for ensuring					
	transportation was pro	ovided for residents to and					
	from doctor appointme						
		uling transportationwas					
	•	or the person driving the					
	van.	e the early manage attacked to					
		s the only person allowed to nce giving them access to					
	drive the van.	nce giving them access to					
	anvo ino van.						
	Interview with Resider	nt #12's PCP on 12/12/19 at					
	4:30pm revealed:						
	-Three to four months	ago Resident #12 was					
		to get out of bed without					
	assistance.						
	-It was frustrating, bec						
	consults for residents	and they were not					
	completed.	agu conquit in July 2040 for					
	Resident #12.	ogy consult in July 2019 for				l	
		ecline in his motor skills,				l	
	The resident had a de	TOTAL OF THE THOUSE SKIIIS,					

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		HAL030007	B. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	FATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK		IVIEW DRIVE			
0/4) 15	CHMMADV CT		LLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 127	D 273			
	lumbar stenosis (caus tingling, numbness, we the legs and feet)Without the proper to determinedIt was important for Fedone for her to provid -Previously, she made the residents because the appointments as self-the falls were an example the completedDue to the resident's	e referral appointments for the facility did not make the requested. It was the transfer of why it was the transfer of the fact decline she expected the resident was present for				
	10:29am revealed: -The Supervisor was a scheduling appointme -The Supervisor was a ensuring the residents transportation available. She did not know the nerve conduction stude. b. Review of a follow-Resident #12's PCP reordered a Magnetic Resident #12 and was Review of Resident #7	also responsible for had a secure means of le to all their appointments. resident had missed a ly on 10/10/19. Lup note dated 10/04/19 from evealed she had previously esonance Imaging (MRI) for swaiting for the results.				
	Interview with a repres office on 12/11/19 at 9					

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STATE FORM

Division of Health Service F	Regulation			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	B. WING		12/13/2019
NAME OF PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE	
THE HERITAGE OF CEDAR R	OCK 191 CRE	STVIEW DRIVE		
THE TENTH OF THE PARTY		VILLE, NC 27028		
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 273 Continued From	page 128	D 273		
-The Administrate canceled the app have transportation another appointmrulation -A second appointment and cancel the appointment scheduled, but she the appointment.	or at the facility called and cointment, stating she would on call back and schedule tent. It was scheduled for not show up for the appointment no one at the facility called to atment. It (12/11/19), there was no MRI eduled for Resident #12. Supervisor on 12/12/19 at d: That Resident #12 missed one of ents due to the housekeeper her family. It the resident had missed two is. It was responsible for ensuring is provided for residents to and	D 273		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE : COMPL	
		HAL030007	B. WING		12/	13/2019
	ROVIDER OR SUPPLIER	191 CRES	DDRESS, CITY, STAT STVIEW DRIVE ILLE, NC 27028	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	-A lot of residents mis because staff forgot at there was no one to continuous assistanceShe ordered a MRI in #12The resident had a dwhich caused her to blumbar stenosisWithout the proper to determinedIt was important for Edone in order to provict-Previously, she made the residents because the appointments as some appointments as some and the resident of the resident of the resident of the resident of the appointment of the standard for Resident of the resident	seed their appointments about the appointment or drive the transportation van. Int #12's PCP on 12/12/19 at a gago Resident #12 was a to get out of bed without an July 2019 for Resident seedline in his motor skills, believe the resident had set diagnoses could not be referral appointments for a the facility did not make she requested. In applied to have tests deproper treatment. The referral appointments for a the facility did not make she requested. In applied to have tests to determine the proper resident #12 to have tests to determine the proper resident #12. In fast decline she expected the resident was present for nots. In a point was present for nots.	D 273			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:		E CONSTRUCTION		COMPLETED	
		HAL030007	B. WING		12/	13/2019	
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, ST. TVIEW DRIVE		-!-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRIEM OF THE APPROPROPRIEM OF THE APPROPRIEM	D BE	(X5) COMPLETE DATE	
	ensuring the residents transportation availab c. Observation of Res 11:04am revealed: -The resident was sitti. The resident was learlying on the bedWhen the resident talhold his head up. Interview with Resider 11:06am revealed: -He always leaned for He was unable to holupWhen he leaned forw sometimes fell to the fill He fell to the floor at I days more than onceIt hurt when he fell to -Sometimes he fell out staff left him on the floor interview with a first shall within the past monthThe resident #12 had fall within the past monthThe resident's health Interview with a first shall within the past monthThe resident was ago, Resi could not move his low legs and feet were tou-Last month emergency were called at least two had symptoms of a street.	is had a secure means of le to all their appointments. ident #12 on 12/04/19 at ing in a wheelchair. It was facing the bed. Ined forward with his head liked, he used his hands to int #12 on 12/04/19 at ward. It ward in the interest in the	D 273				
	was unable to move hi	S IIIIDS.					

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 273 Continued From page 131 D 273 -The resident had been to the hospital at least two times within the past month with the same stroke like symptoms. -Resident #12 had fallen at least ten times within the past two weeks due to being unstable and unable to sit up in the chair. -She was not sure if the Primary Care Provider (PCP) had been notified because the facility's policy was for her to notify the MA, then the MA notified Supervisor and the Administrator. The Supervisor and Administrator notified the PCP. -She had come to work many days on the first shift and found Resident #12 lying on the floor. -The third shift staff left the resident on the floor. Interview with a second first shift personal care aide (PCA) on 12/12/19 at 9:38am revealed: -Resident #12 had significantly declined in health in the past four months. -No one could understand why some days Resident #12 can barely move, he is lethargic and can't get out of bed. -Resident #12 usually complained about the pain in his leas and feet. -At one point everyone thought Resident #12 had a stroke because he could barely move his legs and he cried out stating "it hurts" when she

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attempted to move his legs.

eat much food anymore.

bites and nothing else.

declined to get out of the bed.

of the bed.

-The resident did not like getting out of bed. -Resident #12 had declined so much that did not

-Yesterday (12/11/19), Resident #12 never got out

-The resident missed breakfast, but she was able to get the resident up for lunch and he ate two

-The resident did not eat any food for dinner and

Interview with a third first shift medication aide

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/	13/2019	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE ZID CODE	121	13/2013	
		191 CRES	STVIEW DRIVE	·			
THE HERI	TAGE OF CEDAR ROCK		ILLE, NC 2702				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETE DATE	
D 273			D 273				
	(MA) on 12/12/19 at 1						
		equent falls and was usually					
	found on the floor.	the resident on the floor or					
	in the bed really sick.	the resident on the noor or					
		resident slumped over in the					
	chair.						
		d the Supervisor were					
		as frequently found on the					
	floor because she rep						
	the floor.	ad witnessed the resident on					
	-She was not sure if the	ne PCP was notified					
	because that was the		1				
	Administrator and the						
		she should notify the PCP					
		t's falls or decline in health					
	until last week.	wed down and no longer					
	was able to get himse	_					
		n Resident #12 had fallen					
	•	at she had witnessed and					
	was totally dependent and transfers.	upon staff for ambulation					
	-She documented eac	h time she had seen the					
		and she documented the					
	resident's condition.	cumentation was previously					
		it had disappeared after the					
	surveyors entered the						
		nt #12's PCP on 12/12/19 at					
	4:30pm revealed:						
		ak especially in his legs.					
	several times with stro	n sent out to the hospital					
		d the resident had falls due					
	to the weakness in his						
	-She was in the facility						
		y she changed her schedule					

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL030007	B. WING		12/13/201	9
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	FATE, ZIP CODE	-	
		191 CRES	VIEW DRIVE			
THE HERI	TAGE OF CEDAR ROCK	•	LLE, NC 2702			
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES			TION	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COM	(5) PLETE ATE
D 273	Continued From page	133	D 273			
	to being in the facility.					
	to being in the facility	*				
		had informed Resident #12				
	had repeated falls.	ormed when the resident				
	had falls.	offiled when the resident				
	-The falls were an exa	ample of why it was				- 1
	important for Residen					- 1
	completed.	it #12 to have tests				
	•	to determine the proper				
	treatment to provide F					- 1
		staff to notify her regarding				- 1
	how frequently the res					
		· ·				
	Interview with the Adr	ninistrator on 12/12/19 at				- 1
	10:09am revealed:					- 1
	-She did not know Re	sident #12 had a fall every				- 1
	day.					- 1
		sident on the floor on his				
		to her Resident #12 did not				- 1
	appear that he had fal					- 1
		lent was on the floor on his				- 1
	hands and knees tryin					- 1
		nt had declined in his ability				- 1
	to walk and stand but					- 1
		because she did not know				- 1
	the resident had falls	every day.				
	2. Review of Resident	:#3's current FL2 dated				
		gnoses include closed head				
		weakness, and chronic				- 1
	pain.					
	Review of Resident #3	B's Care Plan dated				
	05/03/19 revealed:					
		lly dependent upon facility				
		ulation, bathing, dressing,				
	grooming, and transfe	•				
		ally dependent upon facility				
	staff for "pressure ulce	er prevention."				

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PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 134 D 273 Review of Resident #3's Primary Care Provider's (PCP) orders revealed: -There was an order dated 01/28/19 stating the resident needed frequent changes and positioning. -There was an order dated 05/13/19 that referred the resident to a home care agency to evaluate and treat a sacral wound. Review of a PCP order for Resident #3 dated 05/13/19 revealed a referral for home care agency to evaluate and treat sacral wound. Review of home care agency notes dated 05/15/19 revealed: -Resident #3 had a stage 1 pressure ulcer of sacral region. -Resident #3 required moderate to maximum assistance with moving and complete lifting without sliding against sheets. -The home care agency was waiting for orders from Resident #3's PCP in order to plan home care treatment. Observation of Resident #3's wound on 12/06/19 at 8:35am revealed: -Resident #3 was sitting in a motorized wheelchair. -There was a strong odor of urine coming from the resident and the resident's bed. -The resident's bed was observed soiled and wet. -The bed had a strong urine odor.

wet.

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in the front.

was wet.

#3 up to a standing position.

-The resident's pants were observed soaked wet

-Two personal care aides (PCAs) lifted Resident

-When the resident stood up the seat of his chair

-The back of Resident #3's pants was soiled and

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
		HAL030007	B. WING		12/	13/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE			
THE HEDI	TACE OF CEDAR BOOK	191 CREST	VIEW DRIVE				
THE HERI	TAGE OF CEDAR ROCK		LE, NC 2702	В			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	u .	(VE)	
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 273	Continued From page	: 135	D 273				
D 273	-One PCA pulled dow incontinent briefThe resident had a to near the lower bottomThe inner part of the area that was white at linterview with Resider 10:39am revealed: -He had a sore on his and burningThe sore had been thone yearIt healed up and then stayed soiled for a lone. Earlier in the year he the wound and it was here wanted some type ease the stringing and lit was hard to get star on the commode to ure. If he had to urinate, so incontinent briefThe PCAs put him on told him to go (urinate). Interview with a first start as:45am revealed: -The wound had been for two to three month. She did not tell anyor because the resident of the supervisor.	wo-inch diameter wound of his right buttock. wound had a pea-sized t the top of the wound. Int #3 on 12/03/19 at bottom, and it was stinging here for some time, close to came back when he g period of time. had staff take a picture of a little bigger than a quarter. e of cream for the wound to d burning. If to get him up and put him inate. taff told him to go in his two incontinent briefs and in the brief. hift PCA on 12/06/19 at on the resident's bottom s. he about the wound did not complain. As notified the MA, the MA	D 273				
	responsible for notifyir	ng the resident's PCP.					
		MA or Supervisor, but she					
		xactly who she had told					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILDING.			
		HAL030007	B. WING		12/13/	2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	FATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK	191 CRES	TVIEW DRIVE			
			LLE, NC 2702	8		
(X4) ID PREFIX TAG	(ÉACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	: 136	D 273			
	at 9:30am revealed: -She started working a facility in the fall of 20 -She did not know as what she had to look a -She verbally asked shealthcare needIn October 2019, one Resident #3 had a wo -She did not see the wand a different staff verwas healedShe did not ask to chhealedOnce when visiting the unable to recall the expression of the resident's informed staff the resident. Interview with another at 9:55am revealed: -She was aware that Fhis bottom.	as a contract nurse for the 19. the LHPS nurse exactly at for each resident. taff about each resident 's staff informed her that und on his sacrum. Yound because the resident erbally told her the wound eck to see if the wound was be facility (November 2019, eact date), she noticed the with urine and the whole				
	-The wound was back kept soiled.	because the resident was MA about the resident's				
	wound because that war-The MA should have					
	12/12/19 at 11:25am r	nift medication aide (MA) on evealed: CA had reported to her that				

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THE HERITAGE OF CEDAR ROCK

191 CRESTVIEW DRIVE

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	/VE\
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 137	D 273		
	Resident #3 had a bump or scar on his bottom, and he was soaked with urineThis had been reported to the Administrator, but nothing was done.			
	Interview with Resident #3's Primary Care Provider (PCP) on 12/06/19 at 12:30pm revealed: -On 05/13/19 she referred Resident #3 to home health due to a wound on the resident's right buttockShe did not know home health was not caring for			
	the wound as she orderedShe did not know the wound had gotten worseThe facility staff should have notified her the resident's wound was not being treated by home health.			
	-She expected the facility staff to inform her that the wound had gotten worse. -She will look at the wound today and order something accordingly.			
	Interview with the Administrator on 12/12/19 at 9:13am revealed: -She was not aware Resident #3 had a wound on his bottomIf staff were looking at the resident's bottom and knew about the wound, they should have made			
	the MA aware. -The MA should go and look at the wound. -The MA should call the resident's PCP to make the PCP aware. -With any skin concern staff should be alert and report any skin breakdown to her or the Supervisor.			
	Attempted interview with the home care agency on 12/06/19 at 4:32pm, 12/10/19 at 9:21am and 9:31am were unsuccessful.			
	3. Review of Resident #5's current FL2 dated			

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COME	PLETED	
1							
		HAL030007	B. WING		12	12/13/2019	
						71372019	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, S	,			
THE HERI	TAGE OF CEDAR ROCK		STVIEW DRIVE				
			/ILLE, NC 2702	8			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 273	Continued From page	138	D 273				
	10/04/19 revealed:						
		formations of halfs and he had a literature					
1	_	fracture of left ankle, bipolar,					
	_	lux disease (GERD), and					
	anemia.	م معالم المعالم					
	-Resident #5 was con-The resident had ina	•					
		erbally abusive at times.					
	wandered and was ve	abusive at times.					
	Review of Resident #	5's Care Plan dated					
	08/23/19 revealed:						
	-Resident #5 required	extensive assistance with					
	bathing, dressing and						
	-Resident #5 required	limited assistance with				1	
	eating, toileting, ambu	llation, and transfers.					
		ent #5's lower extremities on					
	12/05/19 at 8:53am re						
	-The resident had on s	socks that were anklets.					
	socks.	de (FCA) lemoved me					
		plus pitting edema when					
	touched by the PCA.	Piez Pirmig Casilla Illian					
	-Resident #5's feet we	ere white with grayish					
	patches of dry skin.						
		ces like a chalky substance					
		m both the resident's feet.					
		s on the first three toes					
	were black and thick.						
	Intoniou with Desider	of #E on 12/05/10 at 0:50					
	revealed:	nt #5 on 12/05/19 at 8:53am					
		, and they hurt when he					
	walked.	, and they halt when he					
		ollen for over one month.					
	-He had not seen the						
	(PCP) for almost a mo	•					
		PCP was aware his feet					
	were swollen.						
	-He believed the facilit	y staff knew his feet were				1	
	swollen because they						

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	:		COMPLETED	
		HAL030007	B. WING		12/13	/2019	
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, S' TVIEW DRIVE LLE, NC 2702		•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL -SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 273	Interview with Reside 12/05/19 at 11:56am -She was not aware to swollenShe wished someone to tell her the resident was unable to wear the She expected the fact regarding the resident Interview with the Sup 10:19am revealed: -When Resident #5 ca ankles was swollen be surgery on the ankleShe did not know the were currently swoller can be surgery on the ankleShe knew the resident due to the previous such expected the staresident had a change swollen legs. Interview with the facil Professional Support at 9:30am revealed: -She last saw Resider resident had slight edershe did not report the Interview with a first stare 12/06/19 at 10:18am resident legs and feetThe Administrator knew of the Administrator to continuous want to wear his stare to the surgery of the She did not report the swollen legs and feet.	nt #5's Guardian on revealed: he resident's feet were e from the facility had called 's feet were swollen, and he he shoes. idity staff to contact the PCP t's swollen feet. Dervisor on 12/05/19 at the secause he previously had resident's legs and ankles had an	D 273	DEFICIENCY)			
						I	

Division of Health Service Regulation

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL030007 B. WING 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 273 Continued From page 140 D 273 Interview with another MA on 12/12/19 at 11:37am revealed: -No one told her that Resident #5 had swollen feet and legs. -The PCA that was responsible for showers was supposed to report their assessment of the -The PCA should report if something was wrong. Interview with a first shift PCA on 12/12/19 at 10:15am revealed: -Resident #5 had complained about his shoes being too small because his feet were swelling. -The resident's feet had been that way for almost -She believed the MA had notified the resident's PCP and the Administrator. -The Administrator was aware that Resident #5's feet were swollen, and he was unable to wear his shoes. -It was the Administrator and the Supervisor's responsibility to notify Resident #5's Guardian. -They also were responsible for notifying the resident's PCP regarding the resident's swollen feet. Interview with Resident #5's PCP on 12/05/19 at 10:46am revealed: -Previously, she was in the facility twice a month. recently she increased her visits to weekly. -Last week, she was in the facility, but Resident #5 was not put on her list to be seen.

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-She was not aware the resident still had swollen

-If the resident still had swollen lower extremities,

-Her concern was the facility did not use lotion on

lower extremities (legs, ankles and feet). -Last month, she identified the resident had swollen lower extremities and she ordered

she expected facility staff to contact her.

furosemide for five days.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(,		(X3) DATE SURVE	
AND PLAN	JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	x	COMPLETED	
		UA1 020007	B. WING		101	1010010
		HAL030007			12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST. FVIEW DRIVE	ATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK		LLE, NC 27028	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
D 273	Continued From page	e 141	D 273			
	the residents.					
	Interview with the Adi 9:00am revealed: -She was not aware to swollenThe PCA assisting the MA if the resident had a regarding his swollen. 4. Review of Resident 05/19/19 revealed: -Diagnoses included and encephalopathy and service resident #18 was distributed to the resident #18 was sefunctional limitations of the rewas document personal care assistated feeding and verbal control of the rewas document personal care assistated in the reverse rever	det the resident's PCP feet. t #18's current FL2 dated dementia, acute schizoaffective disorder soriented intermittently. emi-ambulatory, with of hearing and sight. tation Resident #18 required nce with bathing, dressing, mmunication.				
	Review of Resident #18's Care Plan dated 01/22/19 revealed: -Resident #18 required limited assistance with eating, toileting, ambulation, dressing and					
	bathing and grooming					
	 Resident #18 had dis behaviors. 	sruptive inappropriate				
		nistory of mental illness and een by mental health.				
	10:00am to 6:30pm at -At 10:45am Resident with the vending mack	ling loud as if he was in an				

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HAL030007 B. WING NAME OF PROVIDER OR SUPPLIER THE HERITAGE OF CEDAR ROCK HAL030007 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
THE HERITAGE OF CEDAR ROCK 191 CRESTVIEW DRIVE			HAL030007	B. WING		12/1	13/2019
THE HERITAGE OF CEDAR ROCK	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	THE HED	TACE OF CEDAR BOCK	191 CRES	TVIEW DRIVE			
	I HE HEK	HAGE OF CEDAR ROCK		LLE, NC 27028			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETE DATE
D 273 Continued From page 142 The resident was hitting the tables with his hands and pushing the chairs with his hand. The resident did not respond when called by name but continued to fuss and yell (words could not be understood). No staff were observed near Resident #18 or in view of the resident to provide redirection. At 1:05pm Resident #18 was observed wheeling himself through the main hallway of the facility. There were other residents sitting in the hallway. Resident #18 did not touch any residents but he appeared to be angry. He yelled and fussed at everyone as he wheeled himself past the residents. No staff attempted to redirect or communicate with Resident #18. At 3:35pm Resident #18 was observed in the snack room with the vending machines. No staff were observed in view of the resident. Resident #18, was fussing and yelling out loud. The resident was beating hard on the tables; he used one hand to pick up and attempted to throw chairs around the room. Resident #18 wheeled his wheelchair over the vending machines and beat hard on the vending machines. Resident #18 wheeled himself to the wall outlet where the wall-mounted television was set-up. The resident started to jerk and pull the cord attached to the wall-mounted television cord from the outlet and again started to pull the cord. Facility staff removed Resident #18 from the room. At 5:10pm Resident #18 was agitated, angry and fussing at everyone in the hallway. Interviews with three residents sitting in the main hallway on 12/10/19 at 5:12pm revealed: Resident #18 was always acilated.	D 273	-The resident was hith hands and pushing the -The resident did not name but continued to not be understood)No staff were obserview of the resident to -At 1:05pm Resident in himself through the method of the resident to the resident #18 did not appeared to be angryed -He yelled and fussed himself past the resident with Resident #18At 3:35pm Resident in snack room with the veryed one hand to pick chairs around the roor -Resident #18 wheele vending machines around the roor -Resident #18 wheele vending machines and machinesResident #18 wheele where the wall-mount -The resident started to attached to the wall-mesident #18 unpluge the outlet and again seriality staff removed roomAt 5:10pm Resident in Interviews with three rehallway on 12/10/19 and resident #18 unpluged the outlet and again seriality staff removed room.	ting the tables with his te chairs with his hand. Trespond when called by to fuss and yell (words could ed near Resident #18 or in to provide redirection. #18 was observed wheeling the facility. T	D 273			

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 273 Continued From page 143 -He hit and beat the walls and pushed chairsResident #18 never attempted to hit or push residentsResident #18 yelled, fussed and even cursed at	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028 (X4) ID PREFIX TAGE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 143 -He hit and beat the walls and pushed chairsResident #18 never attempted to hit or push residentsResident #18 yelled, fussed and even cursed at	110	
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THE HERITAGE OF CEDAR ROCK MOCKSVILLE, NC 27028 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 143 -He hit and beat the walls and pushed chairsResident #18 never attempted to hit or push residentsResident #18 yelled, fussed and even cursed at		
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-He hit and beat the walls and pushed chairsResident #18 never attempted to hit or push residentsResident #18 yelled, fussed and even cursed at	(X5) DMPLETE DATE	
-Resident #18 never attempted to hit or push residentsResident #18 yelled, fussed and even cursed at		
residents, but that did not bother them. -They were annoyed with Resident #18 yelling and cursing, but they were not afraid of the resident. -No staff attempted to assist Resident #18 when he was yelling and hitting walls; they just let him do what he wanted to do. Interview with a personal care aide (PCA) on 12/10/19 at 5:20pm revealed: -Although, Resident #18 showers were scheduled for first shift she tried to give him a shower on the second shift. -Resident #18 did not cooperate when she tried to shave him. -When she attempted to shower Resident #18, he usually refused the shower, became combative and fought a lot. -She attempted three to four times to get Resident #18 to take a shower, then she left him alone. -She gave the resident a bed-bath if he allowed her. -Resident #18's agitation today was his normal level of agitation. -When Resident #18's was agitated he hit walls, and tables and threw chairs. -Dealing with Resident #18's agitation and combativeness were a daily issue. -She had heard the medication aide (MA) say as needed medications did not work for Resident #18. -She did not know if the resident's PCP was notified.		

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provider on 12/09/19, but did not contact the

-Her expectations were that staff contacted Resident #18's mental health provider to let the provider know when the resident was having

-Staff should let her know if they are having difficulty with anything especially if a resident is

provider on 12/10/19.

being combative.

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THE HERITAGE OF CEDAR ROCK

191 CRESTVIEW DRIVE

INE NEK	MOCKSV	ILLE, NC 2702	8	
(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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	-There was an order for fluconazole 100mg daily for 9 days for yeast dermatitisThe fluconazole 100mg daily ended on 11/11/19There was an order for nyamycin powder 100,000u/gm apply to affected area once daily as needed for redness. Review of Resident #1's Care Plan dated 01/22/19 revealed: -Resident #1 was able to groom herselfResident #1 required limited assistance with getting dressedResident #1 required extensive assistance for toileting and bathing. Review of Resident #1's progress notes revealed			

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12/06/19 at 8:50 am revealed:

"rash" under her breasts.

-She did not know how long Resident #1 had the

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-Resident #1 had problems with a rash off and on

Interview with a MA on 12/12/19 at 3:29 pm

-She expected the facility staff to keepher informed when there were changes with a

for a while, especially when she refused to bathe. -Resident #1 was treated for a rash in November

for resident #1 as she needed to be patted dry under her breast after her bath and each time she was washed and had requested a soft cloth of some sort be placed underneath Resident #1's breasts to prevent skin from touching skin. -She did not believe Resident #1 received

- 2019. -She had not informed the PCP of Resident #1
- having the rash under her breast again or of Resident #1 refusing a cloth under her breast

Interview with a second MA on 12/12/19 at 4:45 pm revealed:

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adequate care.

resident.

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	OF CORRECTION	IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		HAL030007	B. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK		STVIEW DRIVE			
			ILLE, NC 27028			
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D 273	Continued From page	e 148	D 273			
	few weeksStaff tried to keep clobreasts, but she remo- She had not informed having the rash under	d the PCP of Resident #1 her breast.				
	11:09 am revealed: -She did not help on t was more of an admir -She did not know Re her breasts.	he floor very often as she histrative assistant. sident #1 had a rash under found, the MAs would				
	6:55pm revealed: -She did not know how rash under her breast: -She was made aware 10/31/19 when she sa pillowcases under her from touchingShe expected the reswith each bath.	e of Resident #1's rash on w an order to use breasts to keep her skin ident's skin to be checked as to notify the PCP when				
	(GI) appointment to be-There was no docum GI appointment in the Interview with Resider 10:05am revealed: -She had not been to aphysician.	for a gastroenterologist e scheduled. entation of a referral for a residents' record.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COMF				
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***************************************		MOCKSVIL	LE, NC 27028	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	scheduled at 7:30am, -FSBS were not obtain in November with a de "missed dose"FSBS were not obtain in December with a de "missed dose"FSBS ranged from 83 -FSBS ranged from 83 -FSBS ranged from 85 -FSBS ranged from	14's November and ronic medication (eMAR) revealed: o check FSBS before meals 11:30am, and 4:30pm. ned for 7 of 90 opportunities ocumented reason of med for 4 of 12 opportunities ocumented reason of sto 495 in November 2019. The second revealed there ders, progress notes, or a cited pharmacy or a medical obtain a new glucometer 4/19. The second revealed there ders, progress notes, or a cited pharmacy or a medical obtain a new glucometer 4/19. The second revealed there ders, progress notes, or a cited pharmacy or a medical obtain a new glucometer 4/19. The second revealed there ders, progress notes, or a cited pharmacy or a medical obtain a new glucometer 4/19. The second revealed there ders, progress notes, or a cited pharmacy or a medical obtain a new glucometer 4/19. The second revealed there ders, progress notes, or a cited pharmacy or a medical obtain a new glucometer 4/19. The second revealed there ders, progress notes, or a cited pharmacy or a medical obtain a new glucometer 4/19. The second revealed there ders, progress notes, or a cited pharmacy or a medical obtain a new glucometer 4/19. The second revealed there ders, progress notes, or a cited pharmacy or a medical obtain a new glucometer 4/19. The second revealed there ders, progress notes, or a cited pharmacy or a medical obtain a new glucometer 4/19. The second revealed there ders, progress notes, or a cited pharmacy or a medical obtain a new glucometer 4/19. The second revealed there ders, progress notes, or a cited pharmacy or a medical obtain a new glucometer 4/19. The second revealed there ders, progress notes, or a cited pharmacy or a medical obtain a new glucometer 4/19.	D 273			
	9:30am revealed: -Resident #14's gluco	meter had not been working				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL030007	B. WING	B. WING		9
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, ST TVIEW DRIVE LLE, NC 2702		1	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COM	K5) PLETE ATE
	check Resident #14's -She had informed the Administrator that Res not working properly a quit working properly a quit working properly. Interview with the Sup 10:02am revealed: -She did not know Res not work properlyIf she had been told F did not work she woul one. Interview with the Adm 10:35am revealed: -She did not know tha did not work properlyShe had not tried to g glucometer for Reside -She expected the MA glucometers were brown Interview with Resider provider on 12/04/19 a -She did not know Res not been working prop -She would have writte glucometer if she had 7. Review of Resident revealed: -Diagnoses included d anemia, schizoaffectiv depression, and chron dermatitis.	Resident #2's glucometer to FSBS. E Supervisor and the sident #14's glucometer was about 3 weeks ago when it sident #14's glucometer did Resident #14's glucometer did Resident #14's glucometer did have ordered her a new ninistrator on 12/04/19 at t Resident #14's glucometer did t Resident #14's glucometer did have ordered her when the sident #14's glucometer get a replacement fint #14. The sident #14's glucometer had berly. In the sident #14's glucometer had berly.	D 273			

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK MOCKSVILLE, NC 27028 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 273 Continued From page 152 D 273 -Resident #9's skin condition was listed as chronic and fungal atopic dermatitis. -There was an order for nystatin 100,000u/gm apply to affected areas BID under bilateral breast and abdominal folds. Review of the signed physicians order dated 11/08/19 revealed there was an order for nystatin 100,000u/gm apply to affected areas BID under bilateral breast and abdominal folds. Review of Resident #9's progress notes revealed there were no documentation informing the primary care provider (PCP) of the red, inflamed rash underneath the resident's abdominal folds between 11/01/19 to 12/11/19 Observation of Resident #9 on 12/11/19 at 9:05am revealed: -The skin in her left abdominal/groin fold was red and inflamed with blister like bumps and extended from the most medial aspect of the abdominal fold to the most lateral aspect of the abdominal fold. -There was a scant amount of tacky yellowish powder in the crease of her left abdominal fold. -The skin in her right abdominal/groin skin fold as red and inflamed with blister like bumps with one open irregular shaped, 1/2 inch in diameter, area to the most lateral aspect of her right abdominal skin fold; the area extended to the most medial aspect of her right abdominal skin fold.

-There was a scant amount of tacky, yellowish

powder in the abdominal skin fold.

12/12/19 at 3:29 pm revealed: Resident #9's rash never went away. -The PCP was aware of the continual problem

with Resident #9's rash.

Interview with a medication aide (MA) on

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING. HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 273 D 273 Continued From page 153 Interview with a second MA on 12/12/19 at 4:45 pm revealed: -Resident #9 kept a rash off and on. -Resident #9 had an order for nystatin powder that was used. -She thought the PCP knew Resident #9 had a rash, so she did not report it. Interview with the Supervisor on 12/13/19 at 11:09 am revealed: -She did not help on the floor very often as she was more of an administrative assistant. -Resident #9 had dealt with a rash off an on a long time. -The PCP had increased the frequency of her nystatin powder (did not say when). -Usually, if a rash was found, the MAs would inform the PCP. Interview with the Administrator on 12/12/19 at 6:55pm revealed: -She knew Resident #9 had a rash off and on for a while. -The MA applied Resident #9's nystatin powder as ordered. -She expected the MAs to ensure skin was intact and apply medications to the rash as ordered. -She expected the MAs to notify the PCP when the rash did not clear up. Interview with Resident #9's PCP on 12/12/19 at 4:50 pm revealed -She did not know that Resident #9 currently had a rash. -Resident #9 was treated for a rash in early November 2019. -Resident #9 did not have an ongoing issue with a

-She expected the facility staff to keep her

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 273 Continued From page 154 D 273 informed when there were changes with a resident. Based on observation, interview, and record review, it was determined Resident #9 was not interviewable. The facility failed to assure referral and follow up for the acute health care needs of 7 of 11 sampled residents including a resident ordered a MRI and serve conduction study for muscle weakness that resulted in frequent falls (#12), a resident with a pressure ulcer ulcer that caused burning and stinging when sitting (#3), a resident with swelling in his lower extremities resulting pain when walking (#5), a resident with aggressive/agitated behaviors that yelled at other residents, beat on the walls and threw chairs (#18) a resident whose glucometer was not working properly which led to staff sharing glucometers (#14), two residents who had a rash that burned and caused pain (#1 and #9), and two residents with missed gastroenterologist appointments (#1 and #9). This facility's failure placed the residents at substantial risk of neglect and physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/06/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 12, 2020. D 285 10A NCAC 13F .0904(a)(4) Nutrition And Food D 285

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Service

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vitamin C fortified should be served at the

-A total of 31 residents residing in the facility requiring 124 ounces of fruit vitamin C juice for

breakfast meal daily.

one breakfast meal.

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING_ HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

191 CRESTVIEW DRIVE

THE HER	TAGE OF CEDAR ROCK	STVIEW DRIVE		
	MOCKSV	/ILLE, NC 2702	28	
(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 285	Continued From page 156	D 285		
	-There was a shortage of 44 ounces of juiceThere was not have enough fruit vitamin C juice for a three- or five-day supplyThere were no muffins in the facility.			
	Refer to interview with the cook on 12/03/19 at 1:07pm			
	Refer to interview with the Administrator on 12/04/19 at 1:10pm			
	2. Review of the dinner menu for regular diets dated 12/03/19 revealed the meal consisted of chicken fried rice, broccoli, dessert, white or wheat roll, milk and water.			
	Observation food storage areas including the pantry, refrigerator and freezer compared to the regular menu on 12/03/19 at 10:42am revealed: The facility had 3 gallons (384 ounces) of milk on hand. -Per the facility menu, milk should be served at breakfast and dinner. -For a census of 31 residents, a total of 496			
	ounces of milk was required to serve milk at the breakfast and dinner meals on 12/03/19. -There was a shortage of 112 ounces of milk for one day.			
	Refer to interview with the cook on 12/03/19 at 1:07pm			
	Refer to interview with the Administrator on 12/04/19 at 1:10pm			
	3. Review of the lunch menu for regular diets dated 12/03/19 revealed the meal was chef's choice entrée, starchy vegetable, seasonal fresh fruit, cook's choice bread, beverage/water.			

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revealed:

12/04/19 at 1:10pm

-She did not order the food.

Interview with the cook on 12/03/19 at 1:07pm

-The Administrator ordered all food for the facility. -She cooked the food that she had available.

-The food truck delivered on Thursday each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMPL		
		HAL030007	B. WING	_	12 <i>l</i>	13/2019
	NAME OF PROVIDER OR SUPPLIER THE HERITAGE OF CEDAR ROCK MOCKSV MOCKSV					
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 285	Interview with the Adr 1;10pm revealed: -The food truck delive -She felt the facility ha truck arrived.	ministrator on 12/04/19 at ered every Thursday. ad enough food until the	D 285			
D 286	enough to supply the days.	nat she needed to have menu for the three to five (b)(1) Nutrition and Food	D 286	THE DIGNINA CHED DESCRIPTIONS WERE	T. I.G	
	Service 10A NCAC 13F .0904 (b) Food Preparation a Homes: (1) Sufficient staff, spa provided for safe and preparation and service This Rule is not met a Based on observations	Nutrition and Food Service and Service in Adult Care ace and equipment shall be sanitary food storage, se. s evidenced by: s and interviews, the facility shwasher was in a safe and		THE DISHWASHER REFERENCED HER LEASED FROM, AND SERVIED BY AU'CHLOR ON A MONTHLY BASIS. IT IS TRESPONSIBILITY TO ENSURE THE MAIS MAINTAINED TO MEET THE STAND REQUIRED BY THE HEALTH DEPARTMIT IS THE COOK'S RESPONSIBILITY (S. ATTACHED JOB DESCRIPTION) TO "AS SANITATION STANDARDS" WERE BEIND THE RESPONSIBILITY OF THE ADMINSTRATOR TO SEE THAT ALTER MEANS OF SANITIZING, WERE BEING THROUGH USING THE 3 COMPARTME METHOD	TO- THEIR CHINE DARDS MENT. EE SSURE NG MET RNATE MET	
	at 4:04pm revealed: -There were dishes wadishwasherThe first cycle maximi was 92 degrees Fahre -The second cycle maximi reached was 98 degre -The third cycle maximi was 100 degrees F.	ximum temperature				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	COMP	PLETED
		HAL030007	B. WING		12/	/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK	191 CREST	VIEW DRIVE			
			LE, NC 2702	28		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 286	Continued From page	159	D 286			
	-The instructions on the minimum water temperature of the proper temperature of the machine interview we equipment technician of revealed: -The facility dishwasher was machine." -The water temperature of the machineThe water temperature of the water temper	ne machine advised a crature of 125 degrees F. cent sink was not being used. Id shift Dietary Aide on wealed: De ran 3 or 4 times to get machine was not reaching e. Viced once a month. In the food service In 12/05/19 at 9:17am For had been serviced every serviced on 11/22/19 with a low temperature The in the machine was the he hot water going into the ein the machine must be egrees F to sanitize the Victory on 12/05/19 at erature was 125 degrees F. The Inspector on 12/05/19 at erature was 110 degrees F	D 286			
	to hand wash and sani machine was repaired. Interview with a first sh at 9:07am revealed she	tize the dishes until the				

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STATEMENT OF DEFICIENCIES (X1) PR

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		HAL030007	B. WING		121	13/2019
	NAME OF PROVIDER OR SUPPLIER THE HERITAGE OF CEDAR ROCK MOCKS			TATE, ZIP CODE	121	13/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 286	the dishes in the three dishwasher was repail Interview with the Adr 9:21am revealed she dishwasher temperature.	e compartment sink until the red.	D 286			
D 287	Service 10A NCAC 13F .0904 (b) Food Preparation a Homes: (2) Table service shall	setting consisting of at least ate and beverage s may be made on an nall be based on	D 287	STAFF WERE ABLE TO ORDER FOOD SUPPLIES AS NEEDED THRU PEFORM FOOD SERVICE. ADMINISTRATOR WAS CONDUCT MONTHLY INVENTORY COAND ADJUST LEVELS AS NEEDED, TO GUIDELINES IDENTIFIED ON ATTACH INVENTORY CONTROL SHEET.	AS TO OUNTS O MEET	
	reviews, the facility fail were provided with a no	s, interviews and record ed to ensure residents on-disposable place setting osable bowl for breakfast				
		inistrator on 12/03/19 at sidents currently resided in				
	Observation of the lunc	ch meal service on				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED
		HAL030007	B. WING		1:	2/13/2019
	ROVIDER OR SUPPLIER	191 CRE	ADDRESS, CITY, STATE STVIEW DRIVE VILLE, NC 27028	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 287	12/03/19 from 12:15p -There was one dining with 4 to 5 residents such the residents such that the	m to 1:30pm revealed: g room with multiple tables bitting at one table. ents present for the meal. of chicken with white gravy, a hamburger bun, tea, water the peaches was served in ware. erved in disposable bowls. In service ware section on evealed: It service ware was stored itchen. It was there were eleven unce bowls, and eleven 20 eakfast meal on 12/05/19 In revealed: Ints present for the meal. If eggs, toast, and dry sived cereal in It bowls. It bowls. It was pre-packed in It was	D 287			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		SURVEY PLETED
	-	HAL030007	B. WING		12	/13/2019
	PROVIDER OR SUPPLIER	191 CR	ADDRESS, CITY, STATESTVIEW DRIVE	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	residents. -The residents' took the room. -The Administrator was have hard plastic bow the disposable bowls. -She thought the Administrator was the disposable bowls. -Interview with a person 12/04/19 at 12:03pm resident's non-disposable bowls. -For example, if five resident's non-disposable bowls. -For example, if five resident's non-disposable bowls. -For example, if five resident's non-disposable bowls. -Coreal was a plastic of the five resident's non-disposable bowls. -Cereal was with a resident during the lunch meal 12:15pm to 12:55pm resident during the lunch meal 12:15pm to	le enough bowls for all the me bowls from the dining as aware the facility did not all because she purchased inistrator had ordered more and care aide (PCA) on revealed: the told the Administrator the ard plastic bowls, eakfast, they rotated giving all bowls and disposable as idents got disposable en tomorrow she made to sable bowls. Idents got cereal that came disposable bowl. The dining room service on 12/03/19 from evealed: The always served in most every morning in all sand disposable bowels. The time the dining room service on 12/03/19 from every morning in all sand disposable bowels.	D 287			

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STATEMEN	T OF DEFICIENCIES	(X1) PROVIDERISHED LEDIOLIA	0.00			
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION		E SURVEY
			A. BUILDING:		COM	PLETED
		1				
		HAL030007	B. WING		41	2/13/2010
NAME OF F	ROVIDER OR SUPPLIER	1				10/2019
I WAINE OF F	NOVIDER OR SUPPLIER		ADDRESS, CITY, ST.			
THE HER	ITAGE OF CEDAR ROCK	\	STVIEW DRIVE			
		MOCKS	VILLE, NC 27028	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SH	IOULD BE	E SURVEY PLETED (X5) COMPLETE DATE
			TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE
D 287	Cantinua d Farm	400	_			
D 201	Continued From page	9 163	D 287			
	1:10pm revealed:					
		ey needed bowls she would				
	have ordered more be					
	-She believed the dis	posable bowls were already				
	at the facility.					
	-The residents' took b	owls from the dining room				
		hen to not have enough				
	bowls.	3				
D 316	10A NCAC 13F .0905	(c) Activities Program	D 316			
		-				
	10A NCAC 13F .0905	Activities Program				
	(c) The activity director	or, as required in Rule				
	.0404 of this Subchap					
		n the residents' interests				
	and capabilities as do	cumented upon admission				
	and updated as neede	ed to arrange for or provide				
	planned individual and	group activities for the	1			
		account the varied interests,				
		ole cultural differences of				
	the residents;	and and an element				
	(2) prepare a monthly	calendar of planned group				
		e easily readable with large		,		
		inent location by the first				1
	any changes;	d updated when there are				
	(3) involve community	u rooourooo a aabaa				
	recreational, volunteer	religious aging and				1
		led-associated agencies, to				
	enhance the activities	available to residents:				1
	(4) evaluate and docu					
		tivities program at least				
		nput from the residents to				
	determine what have b					
	activities and to elicit s					
	enhance the program;	aggostions of ways to			1	
	(5) encourage resider	its to participate in			l l	
	activities; and	no to participatelli				
	, with				l,	1

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12/03/19 and 12/12/19.

Observation on 12/06/19 between 3:00pm and 5:00pm revealed there was a local high school group in the facility singing to residents.

There were no other activities observed between

Interview with a first shift medication aide (MA) on

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I I I		(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		
		HALUSUUU7			12/13/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
THE HER	ITAGE OF CEDAR ROCK		TVIEW DRIV	_	
			LLE, NC 270	28	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 316	Continued From page	165	D 316		
	12/12/19 at 9:50am re-There was an activity activities, but she had -The residents had be director to do activities -If a staff member had activityShe saw the activities 2019, but there was no posted prior to or after Interview with a secondat 11:46am revealed: -The activity director wagoPreviously there had and no calendar of sch-She had only seen a carried out with resided: -When she had down to residents' nails or put a watchResidents had complete having activities and sl Administrator regarding not having activities. Interview with the Super 12:48pm revealed: -There was an activity doing activities with the There should be at learnore. Interview with 3 residence.	evealed: If director hired to do If only seen him twice, seen asking for the activity is. If time, they would lead an is calendar for November of an activities calendar. November 2019. If director hired to an involvember and activities calendar for November 2019. If director heduled activities, calendar for November en maybe one activity into in November 2019. It ime, she tried to paint a movie in for residents to sained to her about not he had talked to the gresidents' concerns with ervisor on 12/12/19 at director, but he was not eresidents. If an into the was not eresidents are not activity daily if not into on 12/12/19 at 6:00pm are at the facility.	D 316		
	a church.	p came to the facility from			

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE	SLIBVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		3:		LETED
		HAL030007	B. WING		12/	13/2019
NAME OF P	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	T10F 0F 0F0	191 CDES	TVIEW DRIVE			
I HE HERI	ITAGE OF CEDAR ROCK		ILLE, NC 2702	28		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD B		COMPLETE
			TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
D 316	Continued From page	166	D 316			
			20.0			
		owed movies and the library				
	truck came to the faci	Durs of activities offered at				
	the facility on a weekl					
	and lability on a wooli	y 50010.				
		ninistrator on 12/12/19at				
	6:20pm revealed:					
		director when she first no worked from January				
	2019 through May 201					
		director in October 2019,				
	but she did not think s					
	-"! think he quit."	•				
		vas responsible for creating				
	the monthly activities					
	activities weekly rathe	cided to offer 24 hours of				
		nay have completed 6-8				
		2019 and some of those				
	activities were comple					
	Interview with the Activ	vity Director on 12/13/19 at				
	2:18pm revealed:	vity Director on 12/13/19 at				
	-He was hired as an a	ctivity director a month and				
		passed medication a few				
	times.					
	 He had completed an He was hired to work 	activity director course.				
	-He did not have the n					
	complete activities with					
		vided by the facility and he				
	had to purchase them	with his own money.				
	-The Administrator sho	uld have put up a calendar				
	for December 2019.					
	-He purchased the app					
	calendar for November going to do it again.	2019 and ne was not				
		n the facility was 11/27/19.				
	Interview with a resider	nt on 12/03/19 at 7:50am				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
			A. BOILBING			
		HAL030007	B. WING		12	2/13/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
THE HER	ITAGE OF CEDAR ROCK	191 CRE	STVIEW DRIV	Ē		
			/ILLE, NC 270:	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 316	Continued From page	167	D 316			
	revealed: -Activities were very r -Sometimes someone three residents to chu -In October 2019, a m calendarThe male did not wor -She came to the facil never been on an outi -She would like to go something, she was n would be nice to go ou Interview with a reside revealed: -Activities "what's that -No activities were cor -They (residents') just television and sometim was nothing to do. Interview with a reside revealed: -No activities were offe -The only activities we the windowThere was nothing go tried to get out daily ar	are at the facility. c came and took two to prich on Sunday. hale put up an activity It at the facility. It in April 2019 and had hing. It in an outing and do not sure exactly what, but it it. In an outing and do ot sure exactly what, but it it. In an on 12/03/19 at 10:39am It in a count all day watching hes smoking because there In an on 12/05/19 at 9:03am It in an outing and looking out hing on at the facility, so she hing on at the facility, so she hing on somewhere.				
	 She liked doing things There was no nothing No one had asked he activity. 					
D 319	10A NCAC 13F .0905	•	D 319			
	10A NCAC 13F .0905	Activities Program				
	(f) Each resident shall participate in at least o	have the opportunity to ne outing every other				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE	SURVEY
AND FLAIN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G:	COMP	PLETED
			D MANO			
		HAL030007	B. WING		12/	13/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE HER	ITAGE OF CEDAR ROCK		TVIEW DRIV			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	LLE, NC 270			
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 319	Continued From page	168	D 319			
	month. Residents inte the community more f encouraged to do so.	rested in being involved in requently shall be				
	failed to assure each r	s evidenced by: s and interviews, the facility resident had the opportunity at one outing every other				
	The findings are:					
	-There was an activitie November 2019 hangi hallway of the facility. -There were 6 activities through Friday, 4 activ Saturdays, and 3 to 4 a Sundays in the month -There was no December 1000 hands	ng on the wall in the main s scheduled daily Monday ities scheduled on activities scheduled on of November. per 2019 calendar posted. ting" scheduled for 12/8/19				
	Observations at various through 12/12/19 reveal being conducted for res	aled there were no outings				
	revealed: -Activities were very rale-Sometimes someone of three residents to churd-She came to the facilit never been on an outin-She would like to go or	came and took two to ch on Sunday. y in April 2019 and had g.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY
			A. BUILDING	3:	COMI	PLETED
		HAL030007	B. WING		12	/13/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE HER	TAGE OF CEDAR ROCK		TVIEW DRIV			
(X4) ID	SHAMADVST		LLE, NC 270			
PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 319	Continued From page	169	D 319			
	would be nice to go or	ut.				
	12/12/19 at 9:50am re -There was an activity activities, but she had -If a staff member had activityThe residents went or since the activity directory -There had not been as she knew of. Interview with a secon at 11:46am revealed: -She had only seen are 2019 and had only seen carried out with resider -She had not seen any Interview with the Super 12:48pm revealed: -There was an activity doing activities with the -She did not know whe was"They sometimes have leave the floor." Interview with 3 resider revealed: -There were no outings -The residents had nev initiated by the facilityThey would like to go of offered by the facility.	director hired to do only seen him twice. Itime, they would lead an a shopping outing once for started. In previous outings that director shift MA on 12/12/19 calendar for November en maybe one activity ints. It resident outings. Pervisor on 12/12/19 at director, but he was not e residents. In the last resident outing e an outing when staff can ints on 12/12/19 at 6:00pm is scheduled for residents. The residents is en been on an outing interesidents.				
	6:20pm revealed: -There was an activity of					

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION S:	(X3) DATE SURVEY COMPLETED
		HAL030007	B. WING		12/13/2019
	PROVIDER OR SUPPLIER	404 CDEC		TATE, ZIP CODE	
THE HER	ITAGE OF CEDAR ROCK		TVIEW DRIVI LLE, NC 270:		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 319	Continued From page	170	D 319		
D 328	came to the facility whe 2019 through May 2019. She hired an activity but she did not think surely activities and the monthly activities are activity director to the monthly activities are activity director to shopping in November. The activity director to shopping in November. There had been no of residents. Interview with the active 2:18pm revealed: He was hired as an area half ago, but he also times. Supplies were not prohad to purchase them. The last time he was a started working at the slisted on the calendar.	no worked from January 19. director in October 2019, whe had one anymore. vas responsible for creating calendar. ook some residents r 2019. ther outings offered to vity director on 12/13/19 at ctivity director a month and passed medication a few evided by the facility and he with his own money. in the facility was 11/27/19.	D 328		
	and Services 10A NCAC 13F .0906 Services (f) Visiting:	Other Resident Care and	D 328		
	and there is reason to l safety, the person in ch immediately notify the i	e law enforcement agency			

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION B:	(X3) DATE COMP	SURVEY LETED
		HAL030007	B. WING		12/	13/2019
	PROVIDER OR SUPPLIER	191 CREST	DRESS, CITY, S IVIEW DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
	This Rule is not met a Based on interviews a facility failed to immed Department of Social incidents involving 1 of (Resident #5), regardi (#5). The findings are: 1. Review of Resident 10/04/19 revealed: -Diagnoses included fit gastroesophageal refluentianemiaResident #5 was consected to the resident and the disoriented to the plant of	s evidenced by: and record reviews, the liately notify the local county Services (DSS) for af 1 sampled residents ang a resident who eloped #5's current FL2 dated racture of left ankle, bipolar, ax disease (GERD), and stantly disoriented. ation the resident had ation the resident had ation the resident had ation the police ation by the police officers ation by the police officers ation by the police officers ation the facility. A resident was found was a the facility. A resident appeared police officers that he was at pains in his left arm, but all medical assistance for all. A sported back to the facility. A did not know the resident and being held open by a and the alarm to be a how Resident #5 left the	D 328	ANY EPISODE REGARDING A WANDER RESIDENT ARE FIRST, TO BE RECORTHE MED TECH SHIFT REPORT. THE ADMINISTRATOR'S JOB DESCRIPTION STATES SHE IS TO FILL OUT ACCIDENT/INCIDENT REPORT. (COPY ATTACHED) THESE ARE TO BE SENT DAVIE COUNTY D.S.S. IMMEDIATLEY ALL RESPONSIBLE PERSONS NOTFIEI AS OF 2/7/2020 ALL RESIDENTS HAVE MOVED TO APPROPRIATE LEVELS OF AND THE HOME HAS BEEN CLOSED.	DED IN TO AND D. BEEN	

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION S:	(X3) DATE SURVEY COMPLETED
			720.20		
		HAL030007	B. WING		12/13/2019
	PROVIDER OR SUPPLIER	404 CDEC		STATE, ZIP CODE	
THE HER	ITAGE OF CEDAR ROCK		TVIEW DRIV LLE, NC 270		
(X4) ID	1	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 328	Continued From page	172	D 328		
	Resident #5 left the fa	acility.			
D 338	10:42am revealed: -She worked part-time did paper work in the cashe previously worked aware that and incider completed for a resideThe facility did not do Interview with the local Specialist on 12/05/19The facility did not ser reportsShe previously had a Administrator regarding reports. Interview with the Administrator regarding reportsWhen a resident was staff were to do an accordance and month or more ago, start doing accident/incidented.	ed at other facility's and was int/accident report should be ent that eloped. I incident/accident reports. It county Adult Home I at 1:00pm revealed: Ind her accident/incident I conversation with the g her not getting incident I sent out to the hospital cident/incident report. I she had instructed staff to cident reports. I d any accident/incident I Resident Rights	D 338	ALL STAFF ARE PROVIDED A COPY OF RESIDENTS BILL OF RIGHTS UPON HIS VIOLATION OF THESE RIGHTS ARE CAFOR IMMEDIATE TERMINATION, ADMINISTRATOR SHOULD HAVE FILE	RE. .USE D A
	An adult care home shall residents guarantee	all assure that the rights of d under G.S. 131D-21, ts' Rights, are maintained without hindrance.		REPORT AND TERMINATED STAFF ME IMMEDIATELY. AS OF 2/7.2020, ALL RESIDENTS HAVE MOVED TO APPROPRIATE LEVELS OF AND THE HOME HAS BEEN CLOSED.	BEEN
	TYPE B VIOLATION				

AND PLAN OF CORRECTION INDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HAL030007 B. WING		12/1	3/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STAT	TE, ZIP CODE			
THE HERITAGE OF CEDAR ROCK 191 CRESTVIEW DRIVE				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE	
Based on record review and interviews the facility failed to assure 1 of 17 sampled residents (Resident #19) were free of abuse and neglect resulting in a resident (#19) being physically assaulted by a medication aide (Staff M). The findings are: Review of Resident #19's current FL2 dated 10/22/19 revealed: -Diagnoses included vascular dementia without behaviors, chronic diastolic congestive heart failure, depression/anxiety, hearing loss, heart disease, diabetes mellitus and neuropathyResident #19 was intermittently disoriented. Review of Resident #19's Care Plan dated 11/08/19 revealed: -Resident #9 required supervision with eating, toileting, ambulation, bathing, dressing, grooming and transferringThere was no documentation regarding the resident's mental health status or the agency to contact. Review of a police report dated 11/13/19 revealed: -There was an altercation at the facility between a staff (Staff M, medication aide (MA)) and a resident (#19)Staff M admitted she was"punching"Resident #19 in the face so the resident would stop assaulting herThe report noted the resident had blood on her lip. Interview with Resident #19 on 12/05/19 at 9:03am revealed: -She lived at the facility since the end of October				

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		John	
		HAL030007	B. WING		12	/13/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STAT	E, ZIP CODE		
THE HER	ITAGE OF CEDAR ROCK		STVIEW DRIVE			
(VA) IB	CUMMADVOT		VILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page	174	D 338			
	facility, she had an inc -One night it was cold roomWhen Staff M came it door openShe asked Staff M to because she was cold -Staff M said, "Wait a -Staff M proceeded to medication and did no -Staff M and her starte -Staff M and her strug -She pushed Staff M to faceStaff M pushed her ba	and Staff M came into her nto the room she left the close the room door d. minute." give her roommate some at close the door. ed yelling at each other. gled back and forth. because she was in her ack, she did not recall her coming to the facility or the				
	medicationsResident #19 had conbeing openResident #19 had ask close the doorStaff M left the door of Resident #19 got upsetThere was a struggle well. Interview with Resident provider (MHP) on 12/0-He last visited Residenter recommended the	vealed: e to her room to give her enplained about the door ed the MA (Staff M) to pen. et and got in Staff M's face. but she could not see very t #19's mental health 26/19 at 3:37pm revealed: ent #19 on 11/05/19. facility provide social en mood/anxiety cognition. t Resident #19 had an				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE COMPI	
		HAL030007	B. WING		12/	13/2019
	ROVIDER OR SUPPLIER	191 CREST	DRESS, CITY, S IVIEW DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	-He did not have any altercationsThe agency had a 24 be paged any time of with Resident #19. Interview with Staff M revealed: -On 11/13/19 she wento give 12:00pm media roommateShe left the door ope she usually did when smedicationsResident #19 said clow in a minuteResident #19 pushed then started hitting, bit -On 11/13/19, the hall #19 wanted the door to she tried to protect he #19 off her, so she pushed the Administration that Resident #1 -She called the Administration that Resident #1 -She called the Administration with the policeShe did not call Reside provider. Interview with the Administration with the Administration of the Staff M on the Staff M had informed here to she told Staff M to careportShe talked with Staff M resident because it was resident started the incommendation.	reports of Resident #19 in I-hour hotline, and he could day if there were problems on 12/06/19 at 10:20am In into Resident #19's room cation to Resident #19's In because that was what she administered In the using her body, and ting and scratching her. In way was cool, and Resident to be kept closed. It is resident, but she 19. It is resident was told to call the shed the resident, but she 19. It is resident was told to call the second shift because her of the incident. If the police and make a M, but did not interview the sher understanding the	D 338			

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY
		ISERTITION NOTIFICAL.	A. BUILDING	S:	COMPLETED
		HAL030007	B. WING		12/13/2019
NAME OF P	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	
THE HER	ITAGE OF CEDAR ROCK		STVIEW DRIVI		
O(A) ID	CHAMADYOT		/ILLE, NC 270		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 338	sampled residents (# regarding a resident (by a staff (Staff M). The rights of resident was health safety and well B violation. The facility provided a accordance with G.S. this violation. CORRECTION DATE VIOLATION SHALL N 2020.	19) from abuse and neglect #19) being pushed and hit he facility's failure to the detrimental to the residents are and constitutes a Type plan of protection in 131D-34 on 12/12/19 for FOR THE TYPE B OT EXCEED JANUARY 27,	D 338		
	(a) An adult care hom preparation and admin prescription and non-p by staff are in accorda (1) orders by a license which are maintained i (2) rules in this Section and procedures. This Rule is not met as TYPE A2 VIOLATION Based on observations interviews, the facility formedications as ordered practitioner for 6 of 6 si #3, #4, #5 and #12) rel (#3), an anti-coagulant reliever (#4), a rapid according to the prescription of the practitioner for for formedications as ordered practitioner for formedications as ordered practitioner for formedication and #12) reliever (#4), a rapid according to the prescription of the prescription and #12) reliever (#4), a rapid according to the prescription and #12) reliever (#4), a rapid according to the prescription and prescription and administration and prescription and administration and prescription and administration and prescription and administration and prescription and	Medication Administration e shall assure that the istration of medications, rescription, and treatments nce with: ed prescribing practitioner in the resident's record; and in and the facility's policies sevidenced by: for record reviews and called to administer d by a licensed practicing campled residents (#1, #2, cated to a topical antiseptic		FACILITY POLICIES (SEE ATTACHED) ALLOW CERTIFIED MED TECHS TO ADMINISTER MEDICATIONS & TREAT ACCORDING TO ORDERS BY DOCTOR: THE RESPONSIBILITY OF THE RCC AN ADMINISTRATOR TO ASSURE THAT A MEDS ARE BEING GIVEN PROPERLY. QUARTERLY, PHARMACIST WAS COM TO DO MED REVIEWS. AFTER SURVEY OWNER HAD PHARMACY NURSE COM DO DIABETIC TRAINING FOR MED TEC (SEE ATTACHED). A NURSE ALSO CAM ON 1/16/20 & 1/17/20, TO PROVIDE TRAI ON WOUND CARE AND MORE MEDICA TRAINING FOR STAFF. ON 2/7/2020, ALL RESIDENTS WERE MO TO APPROPRIATE LEVELS OF CARE AN HOME WAS CLOSED WITH THE ASSITA	MENTS, S. IT IS D THE LL ING IN TO CHS IE IN NING TION OVED

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/	13/2019	
	PROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, S' STVIEW DRIVE /ILLE, NC 2702	:	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
D 358	(#1). The findings are: 1. Review of Residen 10/02/19 revealed: -Diagnoses included preuroendocrine tumor chronic diastolic congresions and order for injection 30mg subcutt days to reduce the risk a. Review of a previous summary dated 09/25/lovenox injections (use a day for 30 days. Review of a physician' revealed resident was lovenox every 12 hours. Nurse (HHN) was to in Review of a physician's revealed continue love completed and then disk revealed and then disk revealed continue love completed and then disk revealed discontinue love completed and then disk revealed continue love completed and then disk revealed continue love completed and then disk revealed for Review of an emergence report dated 09/27/19 report dated 09/27/19 rems was called for Re-The chief complaint was injectionEMS assessed Reside	t #4's current FL2 dated orimary malignant of ileum, hyponatremia, estive heart failure, protein and mass of small intestine. or enoxaparin (lovenox) aneously twice a day for 30 of blood clotting. s hospital discharge 19 revealed an order for ed to treat blood clots) twice s order dated 10/04/19 able to self-administer s and a Home Health struct. s order dated 10/15/19 nox injections until scontinue. at physician's order dated ontinue lovenox injections. cy medical services (EMS) revealed:	D 358				

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(VO) BRUIL THE	OLE CONCERNATION								
	OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED						
			A. BUILDING	G:	COMI	PLETED						
		HAL030007	B. WING		12	/13/2019						
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\						12/13/2019						
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE								
THE HER	TAGE OF CEDAR ROCK	191 CRE	STVIEW DRIVI	E								
MOCKSVILLE, NC 27028												
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	iD	PROVIDER'S PLAN OF CORRI	ECTION	No.						
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SH								
TAG			TAG		CROSS-REFERENCED TO THE APPROPRIATE							
				DEFICIENCY)								
D 358	Continued From page	178	D 358									
	Review of Resident #4's electronic Treatment											
		d (eTAR) for September										
	2019 revealed:											
		or lovenox 30mg/0.3 ml										
	syringe inject 0.3ml (3	30mg) subcutaneously every										
	12 hours for 30 days a	at 9:00am and 9:00pm.										
-There was no documentati												
	administered to Resid	ent #4 from 09/25/19										
	through 09/30/19.											
		ation Resident #4 was in										
	the hospital on 09/30/	19 at 9:00pm.										
	Review of Resident #4 revealed:	4's eTAR for October 2019										
	-There were 3 entries	for lovenox 30mg/0.3 ml										
syringe inject 0.3ml (30mg) subcutaneously every 12 hours for 30 days at 9:00am and 9:00pm. -There was no documentation lovenox was												
	administered for 7 of 3											
	10/01/19 through 10/1											
	-There was no docume											
	administered on 10/03											
		s: Home Health (HH) will										
	administer.	or reality will										
	-There was no docume	entation lovenov was										
	administered on 10/04											
		s: not administered by staff.										
	-There was no docume											
	administered on 10/04											
	reason documented as	e nurse/MD										
	-There was no docume											
	administered on 10/07											
	reason documented as											
		ation Resident #4 was in										
	the hospital on 10/07/1 10/09/19 at 9:00am.	a at a nobin through										
	T0/09/19 at 9:00am. -There was no docume	entation levens										
		/19 at 9:00pm or 10/10/19										
	at 9:00am with no reas	on accumented.										
			II I	III.								

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(VA) DATE OUR (EV						
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		G:	(X3) DATE SURVEY COMPLETED						
			A. BOILDING								
		HAI 020007	B. WING								
HAL030007			D. WING_	B. WING		12/13/2019					
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE							
THE HERITAGE OF CEDAR ROCK 191 CRESTVIEW DRIVE											
MOCKSVILLE, NC 27028											
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION							
PREFIX TAG		/ MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD I		COMPLETE					
	The state of the s		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	JATE	DATE					
D 358	Continued From page	170	D.O.S.O.								
5330			D 358								
		ent #4's medications on									
	hand on 12/05/19 at 2	2:41pm revealed there was									
	no lovenox in the med	lication cart.									
	Today 1 10 S 11										
	Interview with Resident #4 on 12/03/19 at 10:56am revealed:										
	-She was admitted to the facility on 09/25/19 from the hospital.					1					
	-She remembered going back to the hospital not long after she was admitted to the facility										
because she could not catch her breath and she			10								
	had not been getting her lovenox injections.										
-She was told by staff they could not give her											
	lovenox injectionsWhen staff did get the lovenox injections in the		1								
	facilty, they were kept on the medication cart, but she self-administered the injection.										
	Interview with medication aide (MA) on 12/12/19 at 9:50am revealed: -She did not know why lovenox injections were not available in the facility for Resident #4Resident #4 was transported to the hospital by EMS for her lovenox injection and came back to										
	the facility on 09/27/19										
	-She ordered Resident										
	pharmacy on 09/28/19 Resident #4's HHN.	during a visit from									
		lovenox was not ordered				1					
		admitted from the hospital			1						
		in the facility on 09/27/19.									
	Interview with the Direct										
		alth agency on 12/12/19 at				- 1					
	11:23am revealed:										
	-Resident #4's start of o					- 1					
	-A home health nurse v										
	บษเZ//19 to provide edu	cation to Resident #4 on									
	the administration of the The home health nurse										
	THE HOME HEALTH HUISE	a loulid there were no									

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL030007	B. WING		12/13/2019	
	ROVIDER OR SUPPLIER	191 CRES	DDRESS, CITY, STATESTVIEW DRIVE	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
	lovenox injections in t -The home health nur previous primary care clarification and expla be started, but it was -Resident #4 was sen facility for a lovenox ir -The home health nur 09/28/19 to provide ed lovenox injectionsResident #4 was disc nursing services on 10/0 Interview with the Sup 12:48pm revealed: -She knew Resident # lovenox injections twic -"The hospital was sup lovenox injections but -She had told the hosp not be admitted to the injections because the administer themThe hospital staff was the (HH) agencyShe thought the (HH) for obtaining the loven would be the ones who -"It did not matter if the the facility or not becau administer them." -She thought Resident hospital by EMS on 09 breathing, she did not documented she was t for lovenox injectionsShe had talked to the	he facility. se contacted Resident #4's provider (PCP) for ined the need for lovenox to not available in the facility. It out to the hospital by the higection. se visited Resident #4 on ducation regarding the charged from home health 0/11/19 due to a 0/7/19. ervisor on 12/12/19 at 4 had physician's orders for se daily. Oposed to discontinue the they did not." Dital staff Resident #4 could facility with lovenox by were not able to a capposed to reach out to agency was responsible ox injections since they of administered them. In a lovenox injections were in the were could not a were could not a weather the management of the hospital staff Resident the hospital and the Hamiltonian was taken to the hospital and the Resident lovenox injections, but she	D 358			

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL030007	B. WING		12/13/2019
	PROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STATI STVIEW DRIVE VILLE, NC 27028	E, ZIP CODE	•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 358	-There was no docum Resident #4's PCP re to the facility with love injections not being a Interview with Reside 12/2/19 at 3:47pm rev -She did not know Re admitted to the facility injectionsShe received a call fr Resident #4 did not he in the facilityShe contacted a hose asked why Resident #4 facility with the lovenor -The hospital discharge reason Resident #4 we was because facility s would have HH in place discharge from the ho able to administer the -She expected the face provider and HH shou ensure a nurse was ave lovenox injections as of b. Review of Resident 10/02/19 revealed an of 2 tablet every 8 hours Review of a physician' revealed oxycodone 1 scheduled and 1 table pain. Review of Resident #4 Administration Record revealed:	nentation of contact with garding her being admitted enox injections and the dministered for 3 days. Int #4's previous PCP on realed: Isident #4 had been with an order for lovenox It was admitted to the axe any lovenox injections It was admitted to the axinjections. It is staff told her the only as discharged to the facility that had assured her they be upon Resident #4's spital and HH would be lovenox. It is to contact a HH lid have been in place to real was administer ordered for Resident #4. #4's current FL2 dated order for oxycodone 10mg	D 358		

		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA !DENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION :	(X:	3) DATE SURVEY COMPLETED
			HAL030007	B. WING			12/13/2019
NAN	IE OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATÉ, ZIP CODE		12/10/2013
	- Geni	T40F 0F 0FD4D D00//	191 CRES	TVIEW DRIVE			
IHE	HEKI	TAGE OF CEDAR ROCK		LLE, NC 2702	28		
(X	4) fD	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	0/5
PF	RÉFIX AG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ION SHOULD BE HE APPROPRIATI	(X5) COMPLETE E DATE
	358	Continued From page	182	D 358			
		½ tablet every 8 hours severe pain. -There were two entriet tablets ½ tablet every severe pain. -There were two entriet tablets 1 tablet every pain/shortness of breat pain/shortness of breat tablet four times a day was discontinued on 1. There was an entry for tablet four times a day was discontinued on 1. There was an entry for tablet every 4 hours for 10:00am, 2:00pm, 4:00. There was a second at tablet 1 tablet every 4 6:00am, 10:00am, 2:00 tablet 1 tablet every 4 6:00am, 10:00pm. -Oxycodone was docu administered for 27 of 10/16/19 through 10/3: -Oxycodone was docu administered 14 times documentation Reside on 10/28/19 at 2:00am Resident #4 was sleep -Oxycodone was documentation administered 7 times at -Oxycodone was documentation administered 1 time at -Oxycodone was documentation was documentation administered 2 times at -Oxycodone was documentation was documentation administered 2 times at -Oxycodone was documentation administered 2 times at -Oxycodone was documentation was documentation and time at -Oxycodone was documentation and -Oxycodone was documentation and -Oxycodone was documentation and -Oxycodone was documentation and -Oxycodone was documentation	es up to 7 days as needed for es for oxycodone 10mg 8 hours as needed for es for oxycodone 10mg I hour as needed for th. or oxycodone 5mg tablets 1 as needed for pain and 0/10/19. or oxycodone 10mg tablet 1 or pain at 2:00am, 6:00am, 0pm, and 10:00pm. entry for oxycodone 10mg hours for pain at 2:00am, 0pm, 4:00pm, and mented as not 1/19. mented as not at 2:00am; there was on #4 refused oxycodone it there was documentation ing on 10/29/19 at 2:00am. mented as not 16:00am. mented as not 10:00am. mented as not to 2:00pm; there was mented as not to 3:00pm; there was mented as not to 4:00pm; there was	D 358			
		documentation oxycod- administered at 12:42p					
		-Oxycodone was docur administered 3 times a	mented as not				
		Review of Resident #4' 2019 revealed: -There were two entries					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		COM	PLETED
		HAL030007	B. WING		12	2/13/2019
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE HER	TAGE OF CEDAR ROCK	191 CRE	STVIEW DRIVE			
		MOCKS	VILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 183	D 358			
	tablets 1 tablet every	1 hour as needed for				
	pain/shortness of brea					
		or oxycodone 10mg tablet 1				
		or pain at 2:00am, 6:00am,				
	10:00am, 2:00pm, 4:0					
	-Oxycodone was doci					
		f 180 opportunities from				
	11/01/19 through 11/3					
	-Oxycodone was docu administered 8 times					
	documentation Reside					
		here was documentation				
		ping soundly 11/11/22/19 at				
	2:00am.					
	-Oxycodone was docu					
	administered 5 times					
	-Oxycodone was docu					
	administered 1 time at					
	 Oxycodone was docu administered 1 time at 					
	-Oxycodone was docu					
	administered 1 time at	10:00pm				
		. толоории.				
	Observation of Reside hand on 12/05/19 at 2	ent #4's medications on :41pm revealed:				
		able on the medication cart.				
	-The label on the bubb					
		as dispensed on 11/30/19				
	with a quantity of 100					
		of oxycodone dispensed				
		he medication cart and 73				
	tablets were remaining	J.				
	Interview with Residen	it #4 on 12/03/19 at				
	10:56am revealed:					
	-She had physician's o	orders for oxycodone every				
	4 hours and as needed	d for pain.				I
	-She had gone "long s	tretches" without her pain				
	medication on numero					
	gone as long as 10 ho	urs.				

Division of Health Service Regulation

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12	/13/2019	
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		10/2010	
THE HEDI	ITAGE OF CEDAR ROCK	191 CBE	STVIEW DRIVE	, 0002			
THE HER	TIAGE OF CEDAR ROCK		ILLE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
	-The times she had to medication, she expershe sometimes went unbearable to ask for she did not want to get staffShe had been told by was in medication tote around to putting medicate from the totes yetMany times there were working to administer. Interview with hospice primary care provider's 11:10am revealed: -Resident #4 had told there was no staff in the was not able to get here. Resident #4 had physoxycodone every 4 hore every hour as needed. Interview with a third site interview with a third site interview with a third site interview with a third site. She administered medication multiple time. Resident #4 was some 2:00am administration. She thought she had convenient was not given.	go without her pain rienced severe pain. until her pain was pain medication because at a cold response from a staff her pain medication as and staff had not gotten ication on the medication. The no medication aides (MA) medication on third shift. In urse from Resident #4's a office on 12/03/19 at the there were times when the facility at night and she in coxycodone. In ician's orders for urs around the clock and for pain. Thiff MA on 12/05/19 at the dication to Resident #4 If there was no the the time. In the times as the pain is a staff the mot administered her son. In this pain was a staff had not administered her son. In this pain was a staff had not administered pharmacy on the court and the medication are contracted pharmacy on the cold staff.	D 358				
	12/11/19 at 12:51pm re						

Division of Health Service Regulation

HAL030007 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE HERITAGE OF CEDAR ROCK 191 CRESTVIEW DRIVE	l .	OF CORRECTION	IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE COMPI	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE HERITAGE OF CEDAR ROCK 191 CRESTVIEW DRIVE				A. BOILDING.			
THE HERITAGE OF CEDAR ROCK 191 CRESTVIEW DRIVE			HAL030007	B. WING		12/	13/2019
THE HERITAGE OF CEDAR ROCK	NAME OF P	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	FATE, ZIP CODE		
	THE HER	ITAGE OF CEDAR ROCK	191 CRES	TVIEW DRIVE			
MOCKSVILLE, NC 27028				LLE, NC 2702	8		
PREFIX (EACH CORRECTIVE ACTION SHOULD BE CON	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETE DATE
D 358 Continued From page 185 -There was an order dated 10/02/19 for oxycodone 10mg tablets ½ tablet every 8 hours as needed and was dispensed on 10/09/19 with a quantity of 30 ½ tabletsThere was an order dated 10/18/19 for oxycodone 10mg tablets 1 tablet every 4 hours and 1 tablet every 1 hour as needed and was dispensed on 10/18/19 with a quantity 240 tabletsThere was an order dated 11/29/19 for oxycodone 1 tablet every 4 hours and 1 tablet every 1 hour as needed and was dispenses on 11/30/19 with a quantity 240 tabletsThere was an order dated 11/29/19 for oxycodone 1 tablet every 4 hours and 1 tablet every 1 hour as needed and was dispenses on 11/30/19 with a quantity of 100 tablets. Interview with a first shift MA on 12/12/19 at 9:50am revealed: -Resident #4 had physician's orders for oxycodone every 4 hours and every hour as neededShe administered oxycodone to Resident #4 during her shift and did not remember any time when she did not administer oxycodoneIf a medication was not marked on the eMAR with an initial, then the medication was not administered to the resident. Interview with the Administrator on 12/12/19 at 6:20pm revealed: -She did not know there were multiple missed doses of oxycodone for Resident #4 in the months of October and November 2019 -The eMAR audits were completed once a month by MAsThe last eMAR audit was completed in November 2019 and staff did not inform her of any missed doses of medication for Resident #4She expected medication to be administered as prescribed by the physician and if there was a medication error to the physician and if there was a medication error, the MAS should have contacted		-There was an order of oxycodone 10mg table as needed and was diguantity of 30 ½ table. There was an order of oxycodone 10mg table and 1 tablet every 1 highers and 1 tablet every 1 highers and 1 tablet every 1 hour as needed 11/30/19 with a quantity of 10 hour as needed 11/30/19 with a quantity oxycodone 1 tablet every 1 hour as needed 11/30/19 with a quantity oxycodone every 4 hours and the self and the	dated 10/02/19 for lets ½ tablet every 8 hours ispensed on 10/09/19 with a lets. dated 10/18/19 for lets 1 tablet every 4 hours four as needed and was 9 with a quantity 240 dated 11/29/19 for lety 4 hours and 1 tablet led and was dispenses on lity of 100 tablets. This was and every hour as letter and every hour as letter and every hour as letter oxycodone. The letter oxycodone in the emals and every hour as letter oxycodone. In letter oxycodone in letter oxycodone. In letter oxycodone in letter oxycodone in letter oxycodone. In letter oxycodone in letter oxyco	D 358	DEFICIENCY		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION S:		(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/	13/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	Interview with the Hos #4's PCP's office on 1 revealed missed dose increased pain levels 2. Review of Resident 10/21/19 revealed: -Diagnoses included of disorder, and deep ve-There was an order for subcutaneously (a rap lower elevated blood subcutaneously for FS	spice Nurse from Resident 2/12/19 at 11:03am as of oxycodone could cause and increased anxiety. #12's current FL2 dated diabetes mellitus, psychotic in thrombosis. For humalog inject 14 units aid-acting insulin used to sugar levels) if fingerstick are greater than 250. Give SBS are greater than 400 m. Inscharge summary report ed: ated for hypoglycemia in mental status. It of follow-up with the form (PCP) to discuss insulin 2's September 2019 Administration Records are humalog sliding scale BS greater than 250 at 6:30am and 4:00pm.	D 358	DEFICIENCY)		
	administered 6 times fr 09/30/19 when the resi than 250 as follows: -On 09/03/19 at 6:30ar "246" units. -On 09/04/19 at 4:00pn units.	rom 09/01/19 through ident's FSBS were less				

A. BUILDING:	
D 14410	
HAL030007 B. WING 12/13/2	3/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE HERITAGE OF CEDAR ROCK 191 CRESTVIEW DRIVE	
MOCKSVILLE, NC 27028	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358 Continued From page 187 -On 09/26/19 at 4:00pm FSBS 383, received 28 units (more than the required 14 units)On 09/30/19 at 6:30am FSBS 157, received 14 unitsOn 09/30/19 at 4:00pm FSBS 199, received 14 units. Review of Resident #12's October 2019 eMARs revealed: -There was an entry for humalog sliding scale subcutaneously for FSBS greater than 250 scheduled twice daily at 6:30am and 4:00pmThere was documentation humalog was administered 14 times from 100/1/19 through 10/31/19 when the resident's FSBS were less than 250 as follows: -On 10/02/19 at 6:30am FSBS 221, received 14 unitsOn 10/10/19 at 6:30am FSBS 144, received 14 unitsOn 10/14/19 at 6:30am FSBS 185, received 14 unitsOn 10/14/19 at 6:30am FSBS 185, received 14 unitsOn 10/15/19 at 6:30am FSBS 185, received 14 unitsOn 10/15/19 at 6:30am FSBS 132, received 14 unitsOn 10/15/19 at 6:30am FSBS 143, received 14 unitsOn 10/15/19 at 4:00pm FSBS 143, received 14 unitsOn 10/16/19 at 6:00pm FSBS 143, received 14 unitsOn 10/15/19 at 4:00pm FSBS 181, received 14 units.	

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМР	LETED	
			D MANAGE				
		HAL030007	B. WING		12/	13/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE			
THE HERI	TAGE OF CEDAR ROCK	191 CRES	STVIEW DRIVE				
			ILLE, NC 2702	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
D 358	Continued From page	e 188	D 358				
	units.	om FSBS 195, received 14					
	Review of Resident # eMARs revealed: -There was an entry for subcutaneously for FS scheduled twice daily -There was document administered 8 times if 11/30/19 when the rest than 250 as follows: -On 11/02/19 at 4:00punitsOn 11/03/19 at 4:00punitsOn 11/04/19 at 6:30arunitsOn 11/11/19 at 6:30arunitsOn 11/11/19 at 6:30arunitsOn 11/14/19 at 6:30arunitsOn 11/15/19 at 6:30arunitsOn 11/15/19 at 6:30arunitsOn 11/18/19 at 6:30arunitsOn 11/16/19 at 6:30arunits.	or humalog sliding scale SBS greater than 250 at 6:30am and 4:00pm. ation humalog was from 11/01/19 through sident's FSBS were less m FSBS 160, received 14 m FSBS 166, received 14 m FSBS 152, received 14 m FSBS 188, received 14 m FSBS 173, received 14 m FSBS 129, received 14 m FSBS 128, received 14 and FSBS 128, received 14 m FSBS 128, received 14 and FSBS 128, received 14					
	administered 3 times fi 12/12/19 when the resithan 250 as follows:	rom 12/01/19 through					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		HAL030007	B. WING		12/	13/2019
1	PROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, ST. STVIEW DRIVE /ILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
	unitsOn 12/03/19 at 4:00p unitsOn 12/09/19 at 4:00p units. Review of a local Eme (EMS) report dated 07 -Staff informed EMS t acting like his normal -Resident #12 stated I self, he felt weakResident #12 was as transported to the hos Review of a local EMS revealed: -Resident #12's chief of mental statusThe resident was tran Review of Resident #1 were no discharge or related to the visits on Observation of Reside 11:04am revealed: -The resident was sittin -The resident was lear lying on the bedWhen the resident tall hold his head upThe resident appeared Interview with Residen 11:06am revealed:	ergency Medical Services 7/17/19 revealed: hat Resident #12 was "not self." he didn't feel like his normal sessed as being weak and pital. Freport dated 11/19/19 complain was altered sported to the hospital. 2's record revealed there eturn hospital visit notes 07/17/19 and 11/19/19. ht #12 on 12/04/19 at hig in a wheelchair. has facing the bed. hed forward with his head ked, he used his hands to d to tired and lethargic. ht #12 on 12/04/19 at he received medication to his hands to	D 358			

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/13/2019	
	PROVIDER OR SUPPLIER	191 CRES	DDRESS, CITY, S STVIEW DRIVI ILLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES . Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 358	ordered to control his -The medication aide sugars dailyThe MA did not share -He did received insul know the units of insu -Some days he felt we was related to his bloc Interview with the sec (MA) on 12/11/19 at 5 -She read the order for and she thought the o units each time she ch sugar, and if the bloco 250 give an additional -She did administer 14 Resident #12 when his 250On 09/26/19 at 4:00p units of insulin to Resi thought if the FSBS we had to give twice the a -She felt the order nee it was difficult for her to -She had not contacte Provider (PCP) to get -She thought the Supe PCP to clarify the orde Telephone interview w aide (MA) on 12/12/19 -She was aware Resid ordered when the resic greater than 250She did not recall adm the resident's blood su	diabetes. (MA) checked his blood at the FSBS results. in injections but did not lin administered. eak but did not know if it od sugar being low. ond shift medication aide (45pm revealed: ar Resident #12's humalog reder required humalog 14 hecked the resident's blood a sugar was greater than 14 units. If units of humalog to se blood sugar was less than make administered 28 dent #12 because she as greater than 250 she mount of insulin. Ided to be clarified because the order clarified. In third shift medication at 4:50pm revealed: ent #12's humalog was dent's blood sugar was less than 250. In the interest of the properties of the order clarified was dent's blood sugar was less than 250. In the make the properties of the order clarified was dent's blood sugar was dent's bl	D 358			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/	13/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	***		
THE HERI	TAGE OF CEDAR ROCK	191 CRE	STVIEW DRIVE				
			/ILLE, NC 27028	8			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
	pharmacy on 12/12/19 -When he did quarter! the blood sugars from printed from the eMAf -He mainly checked th they were being done -He did not look at the -He mainly focused or that were being used a -He also focused on re -He made recommend observed from the vita medications and refus -He did not know that to Resident #12 when were not within range Interview with Resider 4:30pm revealed: -She had previously ta about Resident #12's lidentified the medication when the resident's bla 250The Supervisor blame and said it would be ta -She felt some things, needed not wait when residentsResident #12 had bee times weakness and a -The resident getting th humalog could also co weakness and lethargi was experiencing.	macist at the contracted 9 at 3:36pm revealed: y drug reviews he looked at a "vital sign" report that he R system. The blood sugars to ensure of eMARs. The as needed medications as lot. The dissign report, as needed als. The sign report, as needed als. The resident's blood sugars for the medication. The side with the Supervisor humalog because she had be on was being administered bood sugars were less than and the problem on the MAs ken care of. The like insulin administration it comes to caring for the ent to the hospital several litered mental status.	D 358				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL030007	B. WING	· · · · · · · · · · · · · · · · · · ·	12/	13/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE HER	ITAGE OF CEDAR ROCK	191 CRES	TVIEW DRIV	E		
	OUR MARK OF		LLE, NC 270	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	192	D 358			
	eMARs and medication ensure the medication orderedShe was not aware the administering humalog #12's blood sugars was insulin.	on on hand at the facility to his were administered as the medication aide was g insulin when Resident has not within range for the				
	were administering ins #12's blood sugars that -She had an in-service week in November to to insulin for residents with blood sugars were less -She had contacted the #12's humalog order be sugars were often less -She did not have any communication with Re- -She did not have doct response from Resident 3. Review of Resident 06/28/19 revealed: -Diagnoses include closmuscle weakness, and	he had identified that MAs stulin incorrectly for Resident at were less than 250. It with the MAs the first ell them not to administer the orders for insulin when is than 250. It will be provided that 250. It will be provided that 250. It will be provided to the cause the resident's blood of than 250. It will be provided that 250. It				
	solution (used to treat statistics) daily for wound at 7:00. -There was documental started on 12/08/19.	's December 2019 administration record the eMAR for betadine skin infections) use twice				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
			A. BOILDING.			
	HAL030007 B. WING		12/	13/2019		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, ST	ATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK	191 CRE	STVIEW DRIVE			
			/ILLE, NC 2702	8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	Observation of Reside at 8:35am revealed: -The resident had a tonear the lower bottom. -The inner part of the area that was white at Observation of Reside hand at the facility on revealed: -The medication aide solution on the medication on the medication storage ar Interview with Resider Provider (PCP) on 12/1-Today (12/05/19), she wound and it was a stShe sent an order for wound on 12/05/19. -The medication should today, or at the latest she was going to ma resident's wound.	at 7:00pm, 12/09/19 at and 12/10/19 at 7:00am. ent #3's wound on 12/06/19 wo-inch diameter wound of his right buttock. wound had a pea-sized to the top of the wound. ent #3's medications on 12/10/19 at 10:12am was unable to find betadine ation cart. found the medication in the ea. ont #3's Primary Care (05/19 at 4:50pm revealed: e assessed Resident #3's age II. To betadine for Resident #3's ald be in the facility later early tomorrow morning. It is frequent checks on the dication aide (MA) on revealed: and betadine solution on the early to the part of the total solution on the early to the part of the total solution on the early to the part of the total solution on the early to the part of th	D 358	DEFICIENCY)		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED	
		HAL030007	B. WING		1:	2/13/2019
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, S' TVIEW DRIVE	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
	-She did not have an creamShe did not realize the use the cream on Restin addition, another regave Resident #3 here. The resident told the the PCA to put on Restin addition and the empty of the emp	at she needed an order to sident #3's wound. esident told her that she cream to use on his wound. MA she gave her cream to sident #3's wound. R for the betadine solution ee Betadine solution on the solution of the solution	D 358			

1	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7,142,123,44	S. SS	IDENTIFICATION NOWIDER.	A. BUILDING:		COMPLETED	
HAL030007		B. WING		12/13/2019		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK	191 CRES	TVIEW DRIVE	:		
			ILLE, NC 2702	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	E
D 358	Continued From page	e 195	D 358			
		d label showed the and dispensed on 07/11/19. t #5's current FL2 dated				
	10/04/19 revealed:	fracture of left ankle, bipolar,				
	gastroesophageal refl anemia.	lux disease (GERD), and				
	 -Resident #5 was con -There was document 	tation the resident had				
	inappropriate behavio verbally abusive at tin	r, wandered and was				
	Review of a physician Resident #5's record of furosemide 20mg dail					
	Review of Resident # electronic Medication (eMAR) revealed:					
	day for five days.	retention) one table every				
	administered at 9:00a 11/20/19.	ation furosemide 20mg was m from 11/16/19 through				
	-On 11/21/19 staff documented "Exp" on the eMAR. Observation of Resident #5's medications on hand at the facility on 12/05/19 at 11:28am revealed:					
	 -A bubble-packed con was available for adm -There were two table 	s of furosemide left in the				
	bubble-packed contain	ner.				
	Review of the pharma the medication was fill 11/15/19 for a quantity					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMPI	
HAL030007 B. WING		B. WING		12/	13/2019	
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, ST FVIEW DRIVE LLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Interview with the me on duty revealed: -"Exp" on the eMAR furosemide had expir medication was admir -She did not know wh was not administered -She observed the eMhad no reason why the administered. Observation of Reside 12/05/19 at 8:53am re-The resident had on -The personal care air socks. -Resident #5 had two touched by the PCAResident #5's feet we patches of dry skinThere were loose flal that fell to the floor from -The resident's toenait were black and thick. Interview on 12/05/19 revealed: -His feet were swollerd -His feet had been swollerd	meant the order for red, meaning all the nistered as ordered. by Resident #5's furosemide of the medication was not see medication was not see medication was not see medication was not see white with grayish sees like a chalky substance of the medication was not see white with grayish sees like a chalky substance of the medication was not see white with grayish sees like a chalky substance of the medications of the first three toes at 8:53am with Resident #5 of and they hurt badly. Follen for over one month the walked. In instered medications to ow the medications of the first three thad they have the medications of the first three thad they have the medications to ow the medications of the first three thad they have the medication thad they have the medication thad they have the medication thad they are sident had they are sident h	D 358			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007 B. WING			12/13/2019
NAME OF PROVIDER OR SUPPLIE THE HERITAGE OF CEDAR	ROCK 191 CRE	DDRESS, CITY, STAT STVIEW DRIVE VILLE, NC 27028	E, ZIP CODE	
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
medication as or lifthere was a predications she medications she medications she medications she medications she medications she medications at the medication of administered as a surfly and polyneuropal causing weakned pain of the legs. There was an or sugars (FSBS's) and supper. There was an oral rapid-acting insublood sugar leves subcutaneously if under 100. Review of Resided dated 11/08/19 results an oral sugar (FSBS) 2 to dinner. There was an oral sugar (FSBS) 2 to dinner. There was an oral sugar (FSBS) 2 to dinner.	acility staff to administered the redered. roblem administering the expected staff to notify her expected was ordered. The expected staff to notify her expected was ordered was ordered. The expected staff to notify her expected was ordered. The expected staff to notify	D 358		

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	TOWN DATE	OUD) (E)
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		S:	(X3) DATE SURVEY COMPLETED	
1			A. BOILDING			
1						
		HAL030007	B. WING		12	/13/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		101 CDES	TVIEW DRIV			
THE HER	TAGE OF CEDAR ROCK		ILLE, NC 270			
(X4) ID	SI IMMADV ST	ATEMENT OF DEFICIENCIES				-
PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5)
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
				DEFICIENCY)		
D 358	Continued From page	198	D 358			T
			D 330			
	Review of Resident #					
	electronic Medication	Administration record				
	(eMAR) revealed:					
	-There was an entry to	check finger stick blood				
	sugar (FSBS) 2 times	a day before breakfast and				
	dinner scheduled for 6					
		red at 6:30am on 09/04/19,				
		9/10/19, 09/11/19, 09/12/19,				
	09/14/19, 09/16/19, 09	/17/19, 09/19/19, 09/22/19,				
	09/24/19, 09/25/19, ar	nd 09/26/19 with a reason of				
		ented. It was unknown if				
		lovolog insulin at those				
	times.					
		or Novolog Insulin 100U/ML				
	inject 12 units subcuta	neously for FSBS over				
		l 8 units for FSBS over				
	400. Hold if FSBS und					
	-There was documenta					
	administered incorrect	ly 6 times from 09/01/19				
	through 09/30/19 as fo					
	-On 09/04/19 at 5:00pr	m, FSBS 40, received 12				
	units when should not					
		n, FSBS 468, received 12				
	units when should have					
		n, FSBS 559, received 12				
	units when should have					
	units when should have	n, FSBS 420, received 12				
	units when should have	n, FSBS 309, received 10				
	units when should not l	n, FSBS 167, received 12				
	dilits when should hot i	nave received insulin.				
	Review of Resident #2	s October 2019 eMARs				
	revealed:	S COLODE! 2019 GWARS				
		check finger stick blood			1	
	Sugar (FSRS) 2 times	a day before breakfast and				
	dinner scheduled for 6:	30am and 5:00pm				
		ed at 5:00pm on 10/04/19,				
	6:30am and 5:00pm on					
	o.ooani ana o.oopiii on	Toroor 18, 0.30am on				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G:	COMPLETED	
		HAL030007	B. WING		12/13/2019	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE HER	ITAGE OF CEDAR ROCK		TVIEW DRIV			
	C1111111 C1		ILLE, NC 270	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
	of "missed dose" docu Resident #2 needed N times. -There was an entry for inject 12 units subcutate 250. Give an additionate 400. Hold if FSBS unce -There was documented administered incorrect through 10/31/19 at 5:00punits when should have-On 10/18/19 at 5:00punits when should have-On 10/20/19 at 6:30au units when should have-On 10/21/19 at 5:00punits when should have-On 10/25/19 at 5:00punits when should h	10/24/19, 6:30am on a on 10/29/19 with a reason amented. It was unknown if Novolog insulin at those or Novolog Insulin 100U/ML aneously for FSBS over at 8 units for FSBS over der 100. ation Novolog was at 6 times from 10/01/19 oblows: m, FSBS 427, received 12 or received 20 units. m, FSBS 487, received 14 or received 20 units. m, FSBS 285, received 0 or received 12 units. m, FSBS 402, received 12 or received 20 units. m, FSBS 402, received 12 or received 20 units. m, FSBS 332, received 20 or received 12 units.	D 358			
-On 10/26/19 at 5:00pm, FSBS 358, received 8 units when should have received 12 units. Review of Resident #2's November 2019 eMARs revealed: -There was an entry to check finger stick blood sugar (FSBS) 2 times a day before breakfast and dinner scheduled for 6:30am and 5:00pm. -FSBS were not checked at 6:30am on 11/06/19, 11/07/19, 11/10/19, 11/12/19, 11/13/19, 11/18/19, 11/20/19, 11/21/19, 11/25/19, 11/26/19,11/27/19 and 11/30/19 with a reason of "missed dose" documented. It was unknown if Resident #2 needed Novolog insulin at those times. -There was an entry for Novolog Insulin 100U/ML inject 12 units subcutaneously for FSBS over 250. Give an additional 8 units for FSBS over 400. Hold if FSBS under 100.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X2) MULTIPLE CONSTRUCTION			
		A. BOILDING.		COMP		
	HAL030007	B. WING		12/	13/2019	
NAME OF PROVIDER OR SUPPLIE	R STREET	ADDRESS, CITY, STA	TE, ZIP CODE			
THE HERITAGE OF CEDAR	ROCK	ESTVIEW DRIVE				
0100		VILLE, NC 27028				
PRÉFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL BY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
administered ince through 10/31/19 -On 11/02/19 at a units when shou -On 11/06/19 at a units when shoul -On 11/11/19 at a units when shoul -On 11/20/19 at a units when shoul -On 11/26/19 at a units when shoul -On 11/26/19 at a units when shoul -On 11/28/19 at a units when shoul -On 11/26/19 at a	amentation Novolog was orrectly 7 times from 10/01/19 as follows: 5:00pm, FSBS 249, received 12 d not have received insulin. 5:30am, FSBS 169, received 12 d not have received insulin. 5:00pm, FSBS 434, received 12 d have received 20 units. 5:30am, FSBS 201, received 12 d not have received insulin. 5:00pm, FSBS 415, received 18 d have received 20 units. 5:00pm, FSBS 290, received 20 d have received 12 units. 5:00pm, FSBS 290, received 20 d have received 12 units. 5:00pm, FSBS 212, received 12 d not have received insulin. 5:00pm, FSBS 212, received 12 d not have received insulin. 5:00pm, FSBS 212, received 12 d not have received insulin. 5:00pm, FSBS 212, received 12 d not have received insulin. 5:00pm, FSBS 212, received 12 d not have received insulin. 5:00pm, FSBS 212, received 12 d not have received insulin. 5:00pm, FSBS 212, received 12 d not have received insulin. 5:00pm, FSBS 212, received 12 d not have received insulin. 5:00pm, FSBS 212, received 12 d not have received insulin. 5:00pm, FSBS 212, received 12 d not have received insulin. 5:00pm, FSBS 212, received 12 d not have received insulin. 5:00pm, FSBS 212, received 12 d not have received 12 units. 5:00pm, FSBS 212, received 12 d not have received 12 units. 5:00pm, FSBS 212, received 12 d not have received 20 units. 5:00pm, FSBS 212, received 12 d not have received 20 units. 5:00pm, FSBS 212, received 12 d not have received 20 units. 5:00pm, FSBS 212, received 12 d not have received 20 units. 5:00pm, FSBS 212, received 12 d not have received 20 units. 5:00pm, FSBS 212, received 12 d not have received 20 units. 5:00pm, FSBS 212, received 12 d not have received 20 units. 5:00pm, FSBS 212, received 12 d not have received 20 units. 5:00pm, FSBS 212, received 12 d not have received 12 units. 5:00pm, FSBS 212, received 12 d not have received 12 units. 5:00pm, FSBS 212, received 12 d not have received 12 units. 5:00pm, FSBS 212, received 12 d not have received 12 units. 5:00pm, FSBS 212, received 12 d not have received 12 units. 5:00pm, FSBS 212, received 12	D 358				

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HAL030007		B. WING		12/	13/2019		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•		
THE HER	ITAGE OF CEDAR ROCK		ILLE, NC 270				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
D 358	would administer the less than 100. -She must have read -The Administrator tal regarding reading instadministering the corn November 2019. Interview with a MA or revealed: -Some FSBS were no because there was noted and the stay unting the shiftShe thought the first swhen they were not coat 6:30amShe did not know she dosages of insulin to Foshe did not audit the anyone reviewed them Interview with Resident physician's (PCP) nurs at 4:55 pm revealed: -She did not know Resincorrect dosages of in the eMARsTo much or to little instand hyperglycemia and resident's diabetes. Interview with the Superscriptions or complete in the superscription of the emaled: -At times there were not medications or complete in the emaled: -At times there were not medications or complete in the emaled: -At times there were not medications or complete in the emaled: -At times there were not medications or complete in the emaled: -At times there were not medications or complete in the emaled: -At times there were not contained in the emaled: -At times there were not contained in the emaled in t	the order incorrectly. ked with each of the MAs alin orders correctly and ect dose sometime in 12/12/19 at 4:45pm t completed at 6:30am MA on duty. s aware that sometimes 17:00am when she worked shift MA would do the FSBS ompleted by night shift MAs had administered incorrect Resident #2. eMARS and did not know if the trace of the practitioner on 12/12/19 sident #2 had received sulin leads to hypoglycemia and poorly controls the ervisor on 12/13/19 at the MAs on duty to pass the FSBS checks. and assist with personal caused the MAs to get	D 358				

AND PLAN OF CORRECTION Complete Construction Complete Complet	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE 12/13/2019 STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028 (X5) PREFIX (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE 12/13/2019 STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028 (X5) PREFIX (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE	
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIED TO THE APPROPRIATE DATE OF CROSS-REFERENCED TO THE OF CROSS-REFERENC	
MOCKSVILLE, NC 27028 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIATED PROVIDER'S PLAN OF CORRECTION (X5) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE O(AC) COMPANY TAG CROSS-REFERENCED TO THE APPROPRIATE	
DEFICIENCY)	PLETE
D 358 Continued From page 202 -The Administrator knew that medications had been missed. Interview with the Administrator on 12/13/19 at 1:55pm revealed: -She knew there were some medications that had been missedShe knew there had been an issue with administering incorrect dosages of insulin, so she held a brief in-service for the MA's sometime in November 2019Sometimes there was not an MA on duty at 8:30am for various reasons one of which was staffing issuesFirst shift should administer medications not passed at 6:30amShe was responsible for auditing eMARs but had not done them lately as she had depended on the pharmacy reviews to let her know if there was a problemShe expected medications to be administered as ordered and in a timely manner to the right resident. Based on observation, interview, and record review, it was determined Resident #2 was not interviewable. 6. Review of Resident #1's FL2 dated 10/04/19 revealed: - Diagnoses included cerebral palsy, seizures, hypothyroldism, arthritis, gastroesophageal reflux disorder, and hypomagnesemiaThere was an order for omeprazole (used to treat gastroesophageal reflux) 20mg 2 times a day at 6:30 am and 4:30 pm. Review of Resident #1's September 2019 electronic Medication Administration record	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION		E SURVEY PLETED
			A. BUILDING	3:		
	HAL030007		B. WING		12	2/13/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE HER	ITAGE OF CEDAR ROCK		TVIEW DRIV			
OVA IB	CLIMANA DV OT		LLE, NC 270			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	203	D 358			
	-There was an entry for capsule 2 times daily at 6:30am and 4:30pm -Omeprazole 20mg wardministered on 09/10/6:30am, 09/12/19 at 6 and 4:30pm, 09/17/19 6:30am, 09/24/19 at 6:30am, 09/27/19 at 6:30am, 09/27/19 at 4:30pm, at a documented reason Review of Resident #1 revealed: -There was an entry for capsule 2 times daily stated 6:30am and 4:30pm, 10/06/19 at 6:30am, 10/09/19 at 6:30am, 10/09/19 at 6:30am, 10/09/19 at 6:30am, 10/02/19 at 6:30am,	or omeprazole 20mg 1 scheduled for administration in daily. as not documented as i/19 at 6:30am, 09/11/19 at i:30am, 09/16/19 at 6:30am at 6:30am, 09/18/19 at i:30am and 4:30pm, i/26/19 at 6:30am, ind 09/28/19 at 6:30am with of missed dose. 's October 2019 eMAR or omeprazole 20mg 1 icheduled for administration idaily. is not documented as i/19 at 4:30pm, i/07/19 at 6:30am, i/10/19 at 6:30am, i/10/19 at 6:30am, i/10/19 at 6:30am, i/25/19 at 6:30am, i/25/19 at 6:30am, i/26/19 at 4:30pm, i/27/19 at 6:30am, i/27/19 at 6:30	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION S:	(X3) DATE SURVEY COMPLETED
		HAL030007	B. WING		12/13/2019
	PROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, S TVIEW DRIVI LLE, NC 270:		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
	Review of Resident # revealed: -There was an entry for capsule 2 times daily at 6:30am and 4:30pm - Omeprazole 20mg wardministered on 12/01 documented reason of the composition of Reside hand on 12/05/19 at 4 - There was 1 partially omeprazole 20mg captake 1 capsule (20mg) and 4:30pm - The omeprazole had 05/03/19The omeprazole had remaining. Interview with Resident revealed: -She did not know whate - The staff brought here - Sometimes she had composite the hospital but it was she had composite to Resident #1 that wate - Sometimes there was and sometimes Resident medications.	ary of the second of the secon	D 358		
	Interview with third shif 4:45pm revealed: 				

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIE	PLE CONSTRUCTION	(V2) DAT	ECHDWEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		G:	1 ' '	E SURVEY PLETED
			A. BOILDING	2.		
		HAL030007	B. WING		1 40	14010040
NAME OF 5					12	/13/2019
NAME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK		STVIEW DRIV			
		MOCKS	/ILLE, NC 270	28		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR		COMPLETE
			1/1/0	DEFICIENCY)	OFRIATE	DATE
D 358	Continued From page	205	D 050			
	_		D 358			
	-She did not recall no	t administering omeprazole				
		as scheduled for 6:30 am.				
	-Sometimes there was	s no MA on duty at 6:30am.		T.		
	-Sometimes she was					
		nistrator k new she would				
1	not be able to work the	The state of the s				
[]		medication was missed at				
	6:30 am then the next					
	administer the medica	ition.				
	Interview with a secon	nd MA on 12/12/19 at				
	12:10pm revealed:	Id ND (OII 12/12/19 at				
-Third shift was responsible for		nsible for administering				
	medications schedule	d for 6:30am.				
		at might have happened to				
		t to receive her omeprazole				
	at 6:30am.	•				
		e Nurse Practitioner (NP)				1
	knew that multiple dos					
	Resident #1 had not be					1
		cation had a missed dose				
	did not mean it was du	e to not having an MA on				
	duty; sometimes the th	nird shift MA just did not				1
	administer the medical					
		e eMARs as the computer				
	would only let her go b -She did not know who					
	auditing the eMARs to					
	received medications a					
		ao ordered.				
	Interview with Residen	t #1's primary care				
		e practitioner on 12/12/19				
III.	at 4:50 pm revealed:					
	-She did not know Res					
	receiving her omepraze					
	-Resident #1 had reflux					
	hospital a few months a	ago due to chest pain				
	caused by the reflux.					- 1
-	-Resident #1 continued	d to have problems with				- 1
	retlux and could experie	ence increased episodes				- 1

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPL	.ETED
			1	:		
		HAL030007	B. WING		12/1	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		191 CRES	TVIEW DRIVE	· •		
THE HERI	TAGE OF CEDAR ROCK		ILLE, NC 2702			
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	206	D 358			
	of chest pain due to n as ordered.	ot receiving her medication ations to be administer as				
	1:55pm revealed: -She knew some med at times but could not received their medications are staffing issuesFirst shift should admipassed at 6:30amShe was responsible not done them lately a pharmacy reviews to leproblemShe expected medicatordered and in a timely resident. The facility failed to adordered to 6 of 6 sampresident not administer which resulted in the retransported to the hospinjection and placed the clotting (#4); a residen narcotic pain medicatic experiencing severe particularly failed to addinate the control of time (#4); two resident not administer wound for 3 days placifurther skin breakdown resident not administer wound for 3 days placifurther skin breakdown resident not administer	sion. Is not an MA on duty at asons one of which was sinister medications not for auditing eMARs but had as she had depended on the let her know if there was a stions to be administered as a manner to the right selded residents resulting in a red Lovenox for 3 days esident having to be loital for a Lovenox e resident at risk for blood at not administered a lon resulting in the resident at ain for extended amounts ents administered incorrect ling the residents at risk for erglycemia (#2 and #12); a red a topical antiseptic to a long the resident at risk for and infection (#3); a red a diuretic placing the		THERE WERE NUMEROUS POLICIES AND PROCEDURES CONCERNING MEDICATION MANAGEMENT AND FOLLOW-UP WITH DO ADMINISTRATOR, BY HER OWN ADMISSIC INTERVIEW WITH STATE, ACKNOLEDGED COPIE OF PROCEDURES ATTACHED. HOME WAS CLOSED ON 2/7/20 AND WITH TASSISTANCE OF DAVIE COUNTY D.S.S., ALRESIDENTS WERE RELOCATED TO APPROLEVELS OF CARE.	OCTORS. DN IN SUCH.	
	resident not administer					

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 358 Continued From page 207 D 358 (#5); and a resident with multiple missed doses of a gastric acid reducer placing the resident at risk for having chest pain and increased acid reflux (#1). This failure placed residents at substantial risk for serious physical harm and neglect which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/04/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 12. 2020. D 371 10A NCAC 13F .1004(n) Medication D 371 Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents . FACILITY POLICY STATES THAT ALL STAFF This Rule is not met as evidenced by: ARE TO RECEIVE OSHA TRAINING UPON Based on observations, interviews and record HIRE. AFTER SURVEY, STAFF RECEIVED reviews, the facility failed to ensure medications ANOTHER OSHA INFECTION CONTROL were administered in accordance with infection

Division of Health Service Regulation

dropped on the floor.

The findings are:

control measures for 1 of 8 sampled medication

aides (Staff M) not using appropriate infection control measures when medications were

TRAINING CLASS PROVIDED BY EXPRESS

AS OF 2/7/2020, ALL RESIDENTS HAVE BEEM

MOVED TO AN APPROPRIATE LEVEL OF CARE WITH ASSISTANCE FROM DAVIE COUNTY D.S.S. AND THE HOME IS NOW

CARE PHARMACY. (SEE ATTACHED)

CLOSED.

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ' '	CONSTRUCTION	(X3) DATE : COMPL	
		HAL030007	B, WING		12 <i>i</i> -	13/2019
	ROVIDER OR SUPPLIER	191 CREST	RESS, CITY, STA VIEW DRIVE LLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 371	Observation on 12/05 -There was a small, we floor in a resident's rotate and the floor in his room by hit is room by hit is resident until he swall observation on 12/05 -Staff M went into the state at the floor in his room by hit is resident until he swall observation on 12/05 -Staff M went into and dropped a tablet on the staff M picked the tate attempted to give the estaff M was prompted the tablet according to another tablet to give estaff M gave the resident until he swall observation on 12/05 -Staff M went into and dropped a tablet on the staff M was prompted the tablet according to another tablet to give estaff M gave the resident of the floor with revealed she did not included to be disposed interview with Reside 4:27pm revealed MAs medications to him be the floor. Interview with a second 4:44pm revealed if a staffoor, it was documen "thrown away or flush interview with the Sup 4:37pm revealed: -Facility policy for a deto pick the tablet up a staffoor in the floor.	white, round tablet on the som by his wheelchair. MA), Staff M, on first shift resident had a tablet on the swheelchair. resident's room, picked up a floor and proceeded to resident and watched the lowed the tablet. Material and watched the lowed the floor and proceeded: Material and watched the lowed the tablet. Material and watched the floor and tablet to the other resident. Material and get to the other resident. Material another tablet. Material another tablet. Material another tablet another floor and tablet to the other resident. Material another tablet. Material another tablet another floor and tablet was dropped on the tablet was dropped and then ed."	D 371			

Division of Health Service Regulation

STATE FORM

STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/13/2019	•
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, ST. TVIEW DRIVE LLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMP	.5) PLETE .TE
D 371	the facility's contracted 10:34am revealed: -If medications were of another pill." -The MA should docushould be contacted. Interview with the Add 4:51pm revealed: -Facility policy for a dwaste the medication-The dropped tablet vontainer or flushed. Telephone interview vontainer or flushed.	with a representative from ad pharmacy on 12/10/19 at dropped, staff "punched ment and the pharmacy ministrator on 12/06/19 at ropped medication was to was thrown away in a sharps with Resident #12's Primary /10/19 at 11:07am revealed: ave a process in place for	D 371			
	10A NCAC 13F .1008 (a) An adult care homeotrievable record of a documenting the recordisposition of controller records shall be main	Controlled Substances be shall assure a readily controlled substances by sipt, administration and ed substances. These tained with the resident's order that there can be n.				

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 392 Continued From page 210 D 392 POLICIES (SEE ATTACHED) WERE IN PLACE Based on observations, interviews, and record TO PROPERLY ADMINISTER CONTROLLED reviews, the facility failed to assure records of the SUBSTANCES. ANY INCONSISTENCIES WERE administration of controlled substances were TO BE REPORTED TO ADMINISTRATOR OR maintained, accurate and reconciled for 5 of 8 RCC IMMEDIATELY. sampled residents (Residents #4, #5, #15, #17 and #18) who were prescribed Oxycodone (#4 AS OF 2/7/2020, ALL RESIDENTS HAVE BEEN and #17), lyrica (#4), zolpidem tartrate (#4), MOVED TO AN APPROPRIATE LEVEL OF hydrocodone (#15), and lorazepam (#5 and #18). CARE WITH THE ASSISTANCE OF DAVIE COUNTY D.S.S. AND THE HOME IS NOW CLOSED. The findings are: Review of the facility's Medication Administration Policy for Controlled Drugs revealed: -Individual controlled drug records shall be maintained for each resident; one medication per record with the following information: name of resident, name of medication, dosage administered, date of administration, initial and ending count. -All controlled drugs shall be counted each shift by two persons (not from the same shift, one from the preceding shift and one from the incoming shift). -Documentation of the count shall be maintained on individual controlled drug sheets, on the active medication administration record, signed by two persons. -If all drugs were not accounted for, the Resident care Director, Executive Director and vendor pharmacy must be notified. -Return of controlled substances from the

the community.

community to vendor pharmacy required documentation of such drugs on the Return to Pharmacy Form and placed in a sealed tote for return to the vendor via the delivery driver. The vendor pharmacy would confirm the returned medications and return the confirmed receipt to Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		HAL030007	B. WING		12/1	3/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
			VIEW DRIVE			
THE HERI	TAGE OF CEDAR ROCK		LE, NC 27028			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIAIE	DATE
				,		
D 392	Continued From page	211	D 392			
	1. Review of Residen	t #17's FL2 dated 07/29/19				
	revealed:					
	-Diagnoses included	scoliosis, restrictive lung				
	disease, chronic pain					
	-Admission date was					
		for oxycodone (a narcotic				
		te to severe pain) 20mg one				
	tablet every 6 hours a	is needed for pain.				
	Review of Resident #17's physician's orders revealed: -There was a copy of a prescription dated 07/26/19 for oxycodone 20mg take 1 tablet every					
	6 hours as needed for	r pain with a dispensed				
	quantity of 120 tablets					
		copy of a prescription dated				
	-	ne 20mg take 1 tablet every				
	quantity of 120 tablets	r pain with a dispensed				
		py of a prescription dated				
		ne 20mg take 1 tablet every				
		r pain with a dispensed				
	quantity of 120 tablets	S.				
	Review of Resident #	17's progress notes				
	revealed:	nt #17 was admitted and				
	had 110 oxycodone 2					
	-	nce Count Sheet (CSCS)				
	was created for Resid	, .				
		codone 20mg tablets were				
	wasted with a witness	_				
	-On 08/05/19 at 1:59					
		not match the quantity on				
		blets not accounted for and				
	the Supervisor inform					
		noted that the Administrator				
		found that the medication				
	was "on point" so the	count was leπ. cond page for the CSCS				
	-On corear 19, the sec	ond page for the CSCS				

Division of Health Service Regulation

STATE FORM KGC311 If continuation sheet 212 of 327

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		HAL030007	B. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, ST	ATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK		VIEW DRIVE .LE, NC 27028	2		
240.45	CHMMADY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	212	D 392			
D 392	sheets started on 08/c count of 90 and 7 table count. On 08/18/19, the CS Resident #17 count we tablets. On 08/18/19, it was nand the Administrator oxycodone 20mg counts. Review of Resident #10 compared to the July Administration Records. There was not an entablet every 6 hours and the empared to the July Administration Records. There was not an entablet every 6 hours and the empared to t	208/19 at 1:30pm with a lets were left out of the CS for oxycodone 20mg for vas noted to be off by 3 moted that the Supervisor were informed of the nt being off by 3 tablets. 17's CSCS for oxycodone 2019 electronic Medication of (eMAR) revealed: try for oxycodone 20mg 1 is needed on the eMAR. Hone 20mg tablets instered in the medication available for review for codone signed out for 31/19. (Resident #17 was with 110 oxycodone 20mg the July 2019 eMAR and codone available for vere 105 tablets of ted for. 17's CSCS for oxycodone ust 2019 eMAR revealed: or oxycodone 20mg 1 tablet ded on the eMAR. as documented as a from 08/01/19 through available for review for ninistration for 08/01/19	D 392			
		esident #17 was admitted				
		gh 08/27/19 a total of 28				

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ B. WING ___ HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK

SUMMARY STATEMENT OF DEFICIENCIES D PROVIDERS PLAN OF CORRECTION PREFIX TAG (READ-DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
oxycodone 20mg tablets were unaccounted forOxycodone 20mg (120 tablets) were dispensed on 08/26/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 08/27/19 to 08/31/19There were 20 tablets signed out as compared to the eMAR from 08/27/19 through 08/31/19 and 19 tablets were documented as administered on the eMARThe CSCS count started at 120 tablets on 08/37/19 and ended at 100 tablets on 08/37/19 for a total of 1 tablet not accounted for. Review of Resident #17's CSCS for oxycodone 20 mg compared to the September 2019eMAR revealed: -There was an entry for oxycodone 20mg 1 tablet every 6 hours as needed on the eMAROxycodone 20mg (120 tablets) were dispensed on 08/26/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 09/01/19 to 09/27/19 with 93 tablets signed out as compared to the eMAR from 09/01/19 through 09/27/19 102 tablets were documented as administered on the eMARThe CSCS count started at 100 tablets and ended at 0 tablets on 09/27/19 at 12:20am for a total of 7 tablets not accounted forOxycodone 20mg (120 tablets) were dispensed on 09/27/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 09/27/19 and 3 tablets signed on the eMAR from 09/01/19 through 09/27/19 and 3 tablets signed on the eMAR from 09/01/19 through 09/27/19 and 5 tablets on 09
on 08/26/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 08/27/19 to 08/31/19. -There were 20 tablets signed out as compared to the eMAR from 08/27/19 through 08/31/19 and 19 tablets were documented as administered on the eMAR. -The CSCS count started at 120 tablets on 08/31/19 for a total of 1 tablet not accounted for. Review of Resident #17's CSCS for oxycodone 20 mg compared to the September 2019eMAR revealed: -There was an entry for oxycodone 20mg 1 tablet every 6 hours as needed on 08/26/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 09/01/19 to 09/27/19 with 93 tablets signed out as compared to the eMAR. -Oxycodone 20mg (120 tablets) were dispensed on 08/26/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 09/01/19 to 09/27/19 with 93 tablets signed out as compared to the eMAR from 09/01/19 through 09/27/19 102 tablets were documented as administered on the eMAR. -The CSCS count started at 100 tablets and ended at 0 tablets on 09/27/19 at 12:20am for a total of 7 tablets not accounted for. -Oxycodone 20mg (120 tablets) were dispensed on 09/27/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 09/27/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 09/27/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 09/27/19 and documented on the CSCS for administration 1 tablet every 6 hours as needed from 09/27/19 to 09/30/19 with 11 tablets signed
out as compared to the eMAR from 09/28/19 through 09/30/19 at 6:36am and 11 tablets were documented as administered on the eMARThe CSCS count started at 120 and ended at 88 on 09/30/19 for a total of 21 tablets not accounted for.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(,	CONSTRUCTION	(X3) DATE S	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
	1				
	HAL030007	B. WING		12/1	3/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	ATE, ZIP CODE		
THE HERITAGE OF CEDAR ROCK	191 CREST	VIEW DRIVE			
MOCKSVILLE, NC 27028 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)					
PREFIX (EACH DEFICIENCY MUS		ID PREFIX TAG		BE	(X5) COMPLETE DATE
D 392 Continued From page 214	4	D 392			
compared to the October -There was an entry for o every 6 hours as needed -Oxycodone 20mg (120 to on 09/27/19 and document administration 1 tablet ever from 10/01/19 to 10/25/19 tablets signed out as com 10/01/19 through 10/25/19 tablets were documented eMARThe CSCS count started 09/27/19 at 12:20am for a accounted forThere was a CSCS with Resident #17's name, dru and instructions for use. The prescription number on it. beginning count on it. The was 10/25/19 at 12:00 pm counted down to 0Oxycodone 20mg was do handwritten label CSCS fr 10/29/19 at 6:00pm with 1 compared to the eMAR fr 10/29/19 at 6:00pm and 1 documented as administer -Oxycodone 20mg (120 to on 10/28/19 and document administration 1 tablet eve 10/30/19 to 10/31/19 with compared to the eMAR fr 10/31/19 and 8 tablets we administered on the eMAI -The CSCS count started 111 on 10/31/19 for a total accounted for. Review of Resident #17's	r 2019 eMAR revealed: bxycodone 20mg 1 tablet I on the eMAR. tablets) were dispensed ented on the CSCS for very 6 hours as needed 9 at 12:00am with 88 inpared to the eMAR from 19 at 12:00am and 89 Id as administered on the If at 88 and ended at 0 on it a total of 1 tablet not a handwritten label with ing name and strength, There was no if It did not have a it is first time signed out in beside number 17 and is locumented on the from 10/25/19 to 17 tablets signed out as from 10/25/19 through 13 tablets were it is locumented on the CSCS for very 6 hours from in 9 tablets signed out as from 10/30/19 through ere documented as ir. if at 120 and ended at al of 1 tablet not	D 392			

Division of Health Service Regulation

STATE FORM

AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDING			
		HAL030007	B. WING		12/	13/2019
NAME OF PRO	VIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	FATE, ZIP CODE		
THE HERITA	GE OF CEDAR ROCK	191 CREST	VIEW DRIVE	:		
			LE, NC 2702	8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392 C	Continued From page	215	D 392			
-T ev -C or ac from tax arrival from tax	There was an entry for very 6 hours on the expectage of t	or oxycodone 20mg 1 tablet aMAR. 10 tablets) were dispensed mented on the CSCS for every 6 hours as needed 7/19 at 6:00pm with 107 ocumented as dropped and ted as wasted but not as compared to the eMAR 11/27/19 at 6:00pm and mented as administered on ted at 111 tablets and 11/27/19 at 6:00pm for a scounted for. 10 tablets) were dispensed mented on the CSCS for every 6 hours from with 12 tablets signed out as 8 from 11/28/19 through 18 were documented as MAR. 11 tablet not 19 tablet not 19 cSCS for oxycodone 19 cDecember 2019 eMAR	D 392			

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	B. WING		12/13/2019
NAME OF PROVIDER OR SUPPLIER THE HERITAGE OF CEDAR ROO	191 CRE	ADDRESS, CITY, STATESTVIEW DRIVE VILLE, NC 27028	E, ZIP CODE	
PRÉFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
accounted for. Observation of Resist hand on 12/06/19 at 85 oxycodone 20mg Interview with a MA revealed: -Resident #17's oxy a bottle instead of a -When Resident #17 110 tablets of oxycotherA CSCS was create oxycodone 20mg. Interview with a PCA revealed she had cowith a MA a few time oxycodone, because the building. Interview with the Ac 5:25pm revealed: -She had been told a count was offThe count for Resid questioned in Octobowhen she looked at staff errorShe did not recall R oxycodone in in July Resident #17 was ac -She could not find the 2019 for Resident #17 -She would double coxycodone that migh missing.	dent #17's medications on 1:30pm revealed there were available for administration. on 12/03/19 at 4:40pm codone 20mg were initially in blister pack. Was admitted, she brought done 20mg to the facility with ed for Resident #17's 110 on 12/04/19 at 7:25am unted controlled substances as, including Resident #17's at there was not another MA in element #17's oxycodone ent #17's oxycodone was er and November 2019, but the CSCS there had been a lesident #17 missing or August 2019 after limitted. ne CSCS for July and August	D 392		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		TE SURVEY MPLETED
		HAL030007	B. WING			2/13/2019
	ROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STA STVIEW DRIVE /ILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 392	to be reported to DSS pharmacyShe had no proof of a linterview with a MA or revealed: -She knew Resident administered oxycodo she had been admitteted oxycodone 20mg for a line CSCS indicating the CSCS in	any diversion of oxycodone. In 12/06/19 at 5:45 pm If 17 had an order and was one 20mg for her pain since d in July 2019. Ining out on the CSCS the Resident #17. Circle around the number on that was the actual number or other MAs to sign for done when the CSCS had ew Resident #17's off because staff had told dinstructed the MAs to ad count was off. In ocumenting the beginning ontrolled substances in the order on the count was off. In our MAs to sign for done when the CSCS had ew Resident #17's off because staff had told dinstructed the MAs to ad count was off. In ocumenting the beginning ontrolled substances in the order on oncoming MA and the apposed to count all together. In times in which she had to on on oncoming MA when or on oncoming MA when of the tablets 2 times. In the pharmacy in the paint of the tablets 2 times. In the pharmacy in the paint of the tablets 2 times. In the pharmacy in the paint of the tablets 2 times. In the police, and the vendon was an and the paint of the tablets 2 times.	D 392			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION	COMPI		
		HAL030007	B. WING		12/	13/2019
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, ST TVIEW DRIVE LLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	-The pharmacy disperoxycodone 20mg to the dispense quantity of 1 -The pharmacy disperoxycodone 20mg to the dispense quantity of 1 -The pharmacy disperoxycodone 20mg to the dispense quantity of 1 -The pharmacy sent at each dispensed date 1 -The procedure for redestruction to the pharmacy. The facility form with documentate were to be sent back 1 -The pharmacy courier nightly at the facility. There were no return Resident #17The pharmacy represany discrepancies with oxycodone. Interview with a MA or revealed: -There had been time and there were no MA count controlled drugs -She did not want to loshe would have a PCA witness only as a last -The Administrator was	nsed Resident #17's ne facility on 09/27/19 with a 120 tablets. nsed Resident #17's ne facility on 10/28/19 with a 20 tablets. nsed Resident #17's ne facility on 11/27/19 with a 20 tablets. n CSCS to the facility with for the oxycodone 20mg. turning narcotics for rmacy was as follows: nere discontinued or the charged the facility was ng narcotics to the restaff were to fill out a return ion of how many tablets and include a signature. rewould pick up the narcotics ned oxycodone 20mg for sentative was not aware of the Resident #17's n 12/12/19 at 12:10pm s when she came to work as on duty, so she had to a by herself. See her MA certification so A count with her as a resort. Is aware of the PCA being I controlled medications.	D 392			

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		HAL030007	B. WING		12/	3/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK		VIEW DRIVE			
THE HERI	TAGE OF GEDAR ROOK		LE, NC 27028	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	2 Continued From page 219		D 392			
D 392	Interview with Reside 1:00pm revealed: -She knew that she h missing after she was then a few in October because she ran shor -The Administrator ha oxycodoneThe MA that was sus oxycodone was still e -Sometimes the MA w on night shift and she medicationShe had some difficu- especially on night sh show up for workHer physician sched- the clock so she woul periods for her pain m Interview with a MA o revealed: -The Administrator ha oxycodone were miss 2 months agoShe did not know hor investigatedWhen the oxycodone	and at least 10 oxycodone admitted to the facility and 2019 were missing rt. ad investigated the missing appected of taking her amployed at the facility. Would not show up for work had to go without her pain alty getting her oxycodone around do not have to wait extended nedication. In 12/12/19 at 4:45pm and told her that some sing for Resident #17 about we the situation was a went missing, they had to	D 392			
	start documenting beg	ginning and end counts in				
	the shift report book in CSCS.	addition to using the				
	-She did not know Re some oxycodone. -Resident #17 had be 20mg by another med -She never reviewed	19 at 4:50pm revealed: esident #17 was missing en prescribed oxycodone				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	_ETED
		HAL030007	B. WING		12/	13/2019
NAME OF PR	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
		191 CREST	VIEW DRIVE			
THE HERIT	AGE OF CEDAR ROCK		LE, NC 27028	8		
040.15	CUMMADV CT			T	,	T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	392 Continued From page 220		D 392			
	Continued From page 220					
	20mg.					
	Interview with the Sup 11:09am revealed: -She knew Resident: administered oxycodo she was admitted in J-She remembered sig oxycodone 20mg for I-The CSCS required a controlled substance -Resident #17 had 11 she was admitted on I-The MAs were not do supposed to do (filing logs for July and Augu-The Administrator kn missing some oxycod told her in August 201-After the first time Rewent missing, the Admeach MA to document count on a sheet of passign stating she receivalent of the beginning a substances were to be report notebookThe first time some owent missing, the invedown to 3 MAs, then come the missing oxycodo-The second time Reswent missing, the sambut the police were notedoneSometimes the MAs second in the second	Ining out on the CSCS for Resident #17. In a signature each time a was signed out. In o oxycodone 20mg when or				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) P.

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPL	LETED	
			1				
		HAL030007	B. WING	——————————————————————————————————————	12/	13/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
THE HERI	TAGE OF CEDAR ROCK	191 CRES	TVIEW DRIVE	<u>:</u>			
THE THERE	TAGE OF GEDAR ROOM		LLE, NC 2702	28			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORT OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE	
			-				
D 392	Continued From page 221		D 392				
	-When the off-going N	//As counted by themselves					
		ing the keys were placed in					
		o that the oncoming MA					
	knew where they were	e at.					
	-She knew sometimes	s the MAs would utilize a					
		ed substances when no					
	other MA was in the b						
	-The Administrator kn						
		a witness to the controlled					
	substance count.						
	Interview with a MA o	n 12/13/10 at 1:34 nm					
	revealed:	11 12/13/19 at 1.34 pm					
		er MA for 2 days on the					
	cart.	ion with tot 2 days on the					
		missing before he worked					
	on the cart.						
	-He told the Superviso	or and the Administrator					
		done count was off just by					
	looking at the CSCS.						
	-Nothing was put in pl						
	oxycodone from being	unaccounted for.					
	Interview with the Adn	ninistrator on 12/12/19 at					
	6:55pm revealed:						
	-	time during September and					
	October 2019 when th						
	building and residents	may have not gotten their					
		on as they requested it.					
		v shifts during November					
		no MA on duty, especially					
	on third shift.						
		had any on call staff for the					
		e in and give medications					
	as needed.	t the gentually desired as a					
		t the controlled substances				1	
		s due to the oncoming MA					
	running late.	rived, they would also count				I	
	the controlled substan						
	une controlled substan	UES.					

DIVIDION	or rioditir octatoc recyd	iduon				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	LETED
			1			
			B MING			
		HAL030007	D. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	191 CRES			•		
THE HERI	TAGE OF CEDAR ROCK		ILLE, NC 2702			
			TEEE, NC 2702	7		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 000	0	222	5.000			
D 392	Continued From page	222	D 392			
	Interview with the Adı	ministrator on 12/13/19 at				
	1:55pm revealed:					
		0 oxycodone when she was				
	admitted to the facility					
	•	#17 had an order and was				
		one 20mg for her pain since				
	she was admitted in J					
		ning out on the CSCS for				
	oxycodone 20mg for					
		a signature each time a				
	controlled substance	•				
		#17 had some oxycodone				
	unaccounted for.	FIT flad some oxycodone				
		esident #17's CSCS and				
	compared it to the oxy					
	-	ally 5 oxycodone went				
	missing.					
		f and residents and found				
		odone had been wasted.				
		n, the information led her to				
	2 individuals who wer					
		either of the suspected	1			
		sing oxycodone to the police				
	(when asked why she					
		dent when 1 or 2 went				I
		w system in place requiring				I
	•	ating she had gotten her				
	medications.					I
		the suspected staff or notify				
	the police after the se					
		done went missing (when				
	asked why she did no					
		er why she did not report the				
	missing oxycodone to					
		resentative for the local				
	Department of Social	Services face to face when				
	she came in to monito	or the facility.				
						1
	2. Review of Resident	t #15's FL2 dated 04/18/19				1

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL030007	B. WING		12/13/2019
	PROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STAT STVIEW DRIVE VILLE, NC 27028	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
	revealed: -Diagnoses included of hypothyroidism -Admission date was revealed: -There was a copy of 07/12/19 for hydrocod 5/325mg take one-half as needed for pain, are day with a dispensed tablets. Review of Resident #* count sheet (CSCS) fo 07/12/19 for hydrocod 5/325mg take one-half as needed for pain, are day with a dispensed tablets on one line of the tablets on one line of the tablets on one line of the tablets on one-half tablets (expanding tablets) and one 30 one-half tablets (expanding tablets)There was documentated tabletsThere was documentated tablets.	dementia, insomnia, 09/14/06. 15's record revealed: a prescription dated lone/acetaminophen f(1/2) tablet 4 times a day nd one-half tablet 4 times a quantity of 150 whole 15's controlled substance or the prescription dated one/acetaminophen f(1/2) tablet 4 times a day nd one-half tablet 4 times a quantity of 150 whole he form revealed: tracking sheets generated aminophen 5/325mg with e-half tablets (equaling 135 e CSCS tracking sheet for qualing 15 whole tablets) for blets totaling 300 one-half ation nophen dispensed on e-half tablets was signed lets from 07/13/19 to ith a representative forthe on 12/13/19 at 2:12pm ed a physician's order esident #15's primary care	D 392		

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION	COMPL	
		HAL030007	B. WING		12 <i>l</i> ·	13/2019
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, STA TVIEW DRIVE LLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	used to treat moderat tablet 4 times a day a one-half tablet 4 times dispensed quantity of 300 half tablets. -The pharmacy receive physician's order date #15's primary care pro 5/325mg take one table needed for pain, and pain with a dispensed -The pharmacy discordone-half tablet every one-half tablet 4 times. The pharmacy routing substance count sheet controlled medication. The CSCS were to be administration and/or Review of the facility's revealed: -There was a pharma "prescription returned for 258 one-half tablets of one-half tablets of one-half tablets on	e pain) take one-half(1/2) is needed for pain, and is a day for pain with a 150 whole tablets equal to red a subsequent and 08/09/19 from Resident ovider's NP for hydrocodone alter every 4 hours as one tablet 4 times a day for quantity of 150 tablets. Intinued the order for 4 hours as needed and is a day. The sent to the facility. The used by the facility to track return of the medication. The pharmacy return credits by form completed for to pharmacy on 8/10/19 to one line of the form; 90 one line of the form; 90 one line of the form, and 30 of the line of the form. The for the staff completing macy signature'. The pain of the form is the pharmacist at the on 12/12/19 at 12:14pm and the documentation of the line of of line of the line of the line of the line of the line of line o	D 392			

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: _ HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 392 Continued From page 225 D 392 delivered. -The facility should complete a "prescription returned to pharmacy" form, retain a copy, and send two copies of the multiple copy form in the sealed medication return tote to the pharmacy with the delivery driver on the next delivery. -The form had a place for the pharmacy to sign and return to the pharmacy once the returns had been processed for disposition of the controlled substance (medication). -The facility should keep the signed return sheet along with a copy of the CSCS for tracking administration and/or disposition of medications. Interview with the Administrator on 12/12/19 at 1:10pm revealed: -She did not have any medications returned to the pharmacy. -Staff should use the CSCS to document administration of medications and place in the residents' record when the CSCS were completed. Confidential interview with a staff member revealed: -The keys to the medication cart were not always handed off from one medication aide (MA) to another MA. -Sometimes the MA left before the next MA came into the facility and the keys were hidden for the next MA.

Division of Health Service Regulation

-The staff had not reported to the Administrator regarding the keys being left unattended.

Telephone interview with the facility's contracted primary care physician's Nurse Practitioner (NP)

-The NP was not aware of Resident #15 missing

-The NP had changed Resident #15's pain

on 12/12/19 at 4:45pm revealed:

any medications for pain.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

HALO30007

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE HERI	TAGE OF CEDAR ROCK	191 CRESTVIEW DRIV MOCKSVILLE, NC 270		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMATION OF LABBORIES OF LSC IDENTIFYING INFORMATION OF LABBORIES OF LSC IDENTIFYING INFORMATION OF LSC IDENTIFYING INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMA	ULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 226	D 392		
	medication a couple of times but always wro new orders for the pain medication. -The resident had not reported being out of medication or missing any medication doses when she saw the resident during routine vi	S		
	-Interview with a medication aide on 12/12/15:40pm revealed: -She completed a "prescription returned to pharmacy" form for all controlled substances sent back to the contracted pharmacyThe controlled substances were placed in a going back to the pharmacy, sealed with a reseal, and picked up by the delivery driverThe facility signed for totes received but the not have the driver sign for returns sent back the pharmacy.	s she atote eturn		
	Interview with the Administrator on 12/12/19 6:30pm revealed: -When she did pharmacy returns, the pharm returns were written on a return sheet and the medication and the forms were placed in the sealed tote for the pharmacy delivery driver pick upShe did not keep a copy of the returnsShe did not know if the pharmacy sent a ref document for receipt of the returned controll substances or if staff tracked the disposition controls.	acy ne e tto		
	Interview with the pharmacist at the contract pharmacy on 12/12/19 at 12:14pm revealed: -He was not able to locate any papers to document receipt of the return for 258 of one tablets of hydrocodone/acetaminophen 5/32 since 08/10/19 for Resident #15The pharmacist had checked the processed CSCS returned sheets, the "prescription retuto pharmacy" form for all controlled substants of Service Regulation	e-half 5mg f urned		

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	COMPLETED
		HAL030007	B. WING		12/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE	
THE HERI	TAGE OF CEDAR ROCK		TVIEW DRIVE LLE, NC 2702		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 392	returned around 08/12 pharmacy staff workin substance return area documentation of des the contracted pharmacy documentation for dis -He could not find any received the returned pharmacy" form for Reference of the return sheet for Reference of	1/19, checked with the g in the controlled and even looked for truction of the medication by ction company used by the and was unable to locate position of the medication. The record the pharmacy prescription returned to resident #15. With the MA who prepared resident #15's prophen 5/325mg on revealed: Friday, Saturday, and the controlled substances for d pharmacy, she iption returned to poy, placed the form in a lithe tote with pharmacy zip trurns in the locked return or Resident #15's	D 392	DEFICIENCY)	
	were picked up on Mo -She did not know if th credit or documentatio medication. Telephone interview w contracted pharmacy w	nday. e facility had received a n for returning the			
	at 1:16pm revealed:	101 the lability on 12/10/19			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	COMPLETED	
		HAL030007	B. WING		12/13/2019	
	PROVIDER OR SUPPLIER	191 CRES	DDRESS, CITY, ST. STVIEW DRIVE ILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLET	ľΕ
D 392	-There was no docum returned 258 one-half hydrocodone/acetamin Resident #15The staff would conting medication. Telephone interview with 12/13/19 at 1:27pm reshe could not locate return of Resident #15 hydrocodone/acetamin one-half tablets writte. No staff had reported processed for return reshe had not been trathe processed "prescripharmacy" for controll but would start now. Based on observation reviews it was determinterviewable. Based on review of document interviewable. Based on review of document interviewable.	nentation for receipt of the fablets of inophen 5/325mg for nue to look in returns for the with the Administrator on evealed: documentation for the 5's nophen 5/325mg 258 in up on 08/10/19. It to her that medications had been missing. It is clearly be a continuously in the credit or return of ciption returned to led substances previously in the contracted pharmacy in of mophen 5/325mg for tions on hand for ledications awaiting return to leave for Resident #15, there leach all tablet of 300 doses of mised on 07/12/19 not in the current FL2 dated	D 392			

Division of Health Service Regulation

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 392 Continued From page 229 D 392 calorie malnutrition, and mass of small intestine. -There was a physician's order for oxycodone 10 mg tablets 1/2 tablet every 8 hours as needed for pain. Review of a hospital discharge summary dated 09/25/19 revealed an order for oxycodone 5mg every 8 hours as needed. Review of Resident #4's physician's orders dated 10/15/19 revealed oxycodone 10mg every 4 hours scheduled and 1 tablet every 1 hour as Review of Resident #4's electronic Medication Administration Record (eMAR) for September 2019 revealed: -There was an entry for oxycodone 10mg ½ tablet every 8 hours up to 7 days as needed for severe pain. -There was a second entry for oxycodone 10mg ½ tablet every 8 hours up to 7 days as needed for severe pain. -There was documentation of 4 oxycodone 10mg ½ tablets administered from 09/25/19 through 09/30/19. Review of Resident #4's controlled substance count sheet (CSCS) revealed there was documentation 4 oxycodone 10mg ½ tablet were signed out from 09/25/19 through 09/30/19. Review of Resident #4's eMAR for October 2019

revealed:

every 4 hours for pain.

tablet every 4 hours for pain.

-There was an entry for oxycodone 10mg 1 tablet

-There was a second entry for oxycodone 10mg 1

-There were 3 entries for oxycodone 10mg ½ tablet every 8 hours as needed for severe pain.

6899

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	ETED
		HAL030007	B. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
			VIEW DRIVE	,		
THE HERI	TAGE OF CEDAR ROCK					
			LE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATÉ
D 392	Continued From page	230	D 392			
	There were 2 entries	for averagence 10mg 1				
		for oxycodone 10mg 1				
	of breath.	s needed for pain/shortness				
		to for avusadona Ema 1				
		try for oxycodone 5mg 1				
		s needed for severe pain. tation 70 oxycodone 10mg				
		ered from 10/01/19 through				
	10/31/19.	ered from 10/0 i/ 19 tillough				
		tation 16 oxycodone 10mg				
	½ tablets were admin					
	through 10/14/19.					
	_	tation 11 oxycodone 10mg				
	tablets as needed wer					
	10/15/19 through 10/3	31/19.				
	-There was document	ation 1 oxycodone 5 mg				
	tablet was administered	ed from 10/01/19 through				
	10/31/19.					
		17 oxycodone 10mg ½				
	tablets documented a					
	10/01/19 through 10/3					
		31 oxycodone 10mg tablets				
	documented as admir	nistered from 10/01/19				
	through 10/31/19.					
	Review of Resident #4	4's CSCS revealed:				
		alf tablets of oxycodone				
	10mg received by the	*				
		73 oxycodone 10mg ½				
		s signed out from 10/01/19				
	through 10/20/19.					
	-There were 23 oxyco	done 10mg ½ tablets				
	returned to the pharm					
	-There were 240 oxyc	odone 10mg tablets				
	received by the facility					
		56 oxycodone 10mg tablets				
	_	d out from 10/01/19 through				
	10/31/19.					
		25 tablets documented as				I
		MAR, but not signed out on				
	the CSCS.					

Division of Health Service Regulation

STATE FORM

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING. HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE DATE **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 392 Continued From page 231 D 392 Review of Resident #4's eMAR for November 2019 revealed: -There was a total an entry for oxycodone 10mg 1 tablet every 4 hours for pain. -There was a second entry for oxycodone 10mg 1 tablet every 1 hour as needed for severe pain. -There was documentation 190 tablets of oxycodone 10mg were administered from 11/01/19 to 11/30/19. Review of Resident 4's CSCS revealed: -There were 100 tablets of oxycodone 10mg dispensed to the facility on 11/30/19. -There was a total of 179 oxycodone 10mg tablets documented as signed out from 11/01/19 through 11/30/19. -There was a total of 11 tablets documented as administered on the eMAR, but not signed out on the CSCS. Review of Resident #4's eMAR for December 2019 revealed: -There was an entry for oxycodone 10mg 1 tablet every 4 hours for pain. -There was a second entry for oxycodone 10mg 1 tablet every 1 hour as needed for severe pain. -There was documentation 29 tablets of oxycodone 10mg were administered from 12/01/19 through 12/05/19 at 2:00pm. Review of Resident #4's CSCS revealed: -There were a total of 27 oxycodone 10mg tablets documented as signed out from 12/01/19 at 10:00am through 12/05/19 at 2:00pm. -There were a total of 2 tablets documented as administered on the eMAR, but not signed out on

Division of Health Service Regulation

the CSCS.

Observation of Resident #4's oxycodone on hand

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	COMPL	
		HAL030007	B. WING		12/	13/2019
	PROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, STA IVIEW DRIVE LLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	on 12/05/19 at 2:41pr -There was a bubble- oxycodone 10mg tabl for pain and 1 tablet of pain/shortness of bree -There were 90 tablet were a total of 100 tal tablets in one bubble other bubble pack) dis on 11/30/19The first bubble pack had already been adm -There were 73 tablet remaining in the secon According to review of and December 2019 of and medications on hoxycodone tablets und Interview with Residen 10:56am revealed: -She had physician's of 4 hours and as needed -She had gone "long of medication on numero gone as long as 10 ho -The times she had to medication, she expension -She sometimes went unbearable to ask for she did not want to ge staffShe had been told by was in medication total around to putting medication total	packed container of ets 1 tablet every 4 hours every 1 hours as needed for ath. Is in a bubble pack, but there blets (2 bubble packs: 90 pack and 10 tablets in the spensed by the pharmacy of 10 oxycodone tablets in the spensed by the pharmacy of 10 oxycodone tablets in the spensed to Resident #4. Is of 90 tablets of oxycodone and bubble pack. If the October, November eMARS, dispensing records and, there were 38 accounted for. Int #4 on 12/03/19 at orders for oxycodone every of for pain. Is stretches without her pain ours occasions and had ours. In go without her pain rienced severe pain. In until her pain was pain medication because at a cold response from the staff her pain medication on the medication on the medication	D 392			

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 392 Continued From page 233 D 392 Interview with a third shift medication aide (MA) on 12/05/19 at 8:12am revealed: -She administered medication to Resident #4 including controlled substances. -When she administered controlled substances, she popped the pill and then she would document that the pill was signed out on the CSCS. -She did not know if anyone reviewed the CSCS for accuracy. -There were two omissions of oxycodone on the CSCS that occurred during her shift on 10/21/19. -Resident #4's physician's order for oxycodone changed from 1/2 tablets to whole tablet, but she did not remember when. -She thought she purposefully skipped signing

Division of Health Service Regulation STATE FORM

out two 1/2 tablet on 10/21/19 because she was using the 1/2 tablets to make a whole tablet to

-She did not realize the 1/2 tablets of oxycodone were returned to the pharmacy on 10/20/19.

Interview with the Supervisor on 12/05/19 at

-The pharmacy reviewed the CSCS once a

-There was no facility staff who reviewed the CSCS for accuracy on a regular basis. -She had been told by MAs the count on the CSCS did not match the number of controlled medication on the medication cart and she

-There was a shift to shift notebook where MAs noted how many controlled substance tablets they started with and how many tablets they

-She did not know what happened to the shift to shift notebook, but it was at the MAs work station

administer to Resident #4.

informed the Administrator.

at the beginning of the week.

Interview with a representative from the

4:37pm revealed:

quarter.

administered.

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12	2/13/2019
	PROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, ST STVIEW DRIVE VILLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 392	contracted pharmacy revealed: -There was a physicia 10mg ½ tablet every was dispensed to the quantity of 30 tablets. -There was a physicia oxycodone 10mg 1 tatablet every 1 hours a dispensed to the facili quantity of 240 tablets. -On 11/29/19, 100 tabletsOn 11/29/19, 23 tablet ablet every 4 hours a as needed was disperOn 10/22/19, 23 tablet tablets were keyed intreturned to the pharmal linterview with a first at 12/12/19 at 9:50am rescheded the control Resident #4's oxycodo started her shiftShe notified a Supernament of the number of the number of the number of the control	on 12/11/19 at 12:51pm an's order for oxycodone 3 hours as needed which facility on 10/09/19 with a an's order dated 10/15/19 for blet every 4 hours and 1 s needed and was ty on 10/18/19 with a blets of oxycodone 10mg 1 and 1 tablet every one hour ased to the facility. ets of oxycodone 10mg ½ to the system as being acy. and second shift MA on acycodone "many times" when she arisor and the Administrator antrolled medication count aber of controlled dication cart. chift notebook at the MA's as recorded the beginning and not seen the notebook ary entrance date). and controlled medication, administration on the CSCS. and sign out was abrough the eMAR to see arrow the names of the	D 392			

Division of Health Service Regulation

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMPI	
		HAL030007	B. WING		12/	13/2019
	ROVIDER OR SUPPLIER	191 CRES	DDRESS, CITY, ST. STVIEW DRIVE ILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	11:46am revealed: -She had talked to the missing controlled metaled: -The supervisor tried contact law enforcem controlled medication not. Interview with the Sup 12:48pm revealed: -She had informed the missing controlled medication: -Law enforcement she suspected MA(s) show and suspended until a completed. Interview with the Adr 6:20pm revealed she with residents' control not know there was an controlled medication: b. Review of Resident 10/02/19 revealed an 25mg 1 tablet twice dissubstance used to treabuse). Review of Resident #Administration Record revealed:	chift MA on 12/12/19 at chift MA on 12/12/19 at chications. To get the Administrator to ent to report the missing so, but the Administrator did chervisor on 12/12/19 at ch	D 392			

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

HALO30007

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

191 CRESTVIEW DRIVE

FORM APPROVED

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:
A. BUILDING:
B. WING
12/13/2019

NAME OF P	ROVIDER OR SUPPLIER STREE	T ADDRESS, CITY, STATE	E, ZIP CODE	
THE HERI	TAGE OF CEDAR ROCK	RESTVIEW DRIVE		
		KSVILLE, NC 27028		
(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 392	Continued From page 236 capsule twice a day for pain -There was a second entry for pregabalin 25mg 1 capsule twice a day for pain. -There was documentation 52 pregabalin (lyrica) capsules were administered from 10/03/19 through 10/31/19. Review of Resident #4's controlled substance count sheet (CSCS) revealed: -There was documentation 48 pregabalin (lyrica) were signed out from 10/03/19 through 10/31/19. -There was a total of 4 pregabalin (lyrica) documented as administered on the eMAR, but not signed out on the CSCS. Review of Resident #4's eMAR for November 2019 revealed: -There was an entry for lyrica 25mg 1 capsule twice a day for pain. -There was documentation 59 lyrica capsules	D 392	DELIVIENCE!)	
	were administered from 11/01/19 through 11/30/19 Review of Resident #4's CSCS reveled: -There was documentation 58 lyrica capsules were signed out from 11/01/19 through 11/30/19There was a total of 1 lyrica capsule documented as administered on the eMAR, but not signed out on the CSCS. Review of Resident #4's eMAR for December 2019 revealed: -There was an entry for lyrica 25mg 1 capsule twice a day for painThere was documentation 7 lyrica capsules were administered from 12/01/19 through 12/31/19. Review of Resident #4's CSCS revealed there was documentation 7 lyrica capsules were signed			
	was documentation 7 lyrica capsules were signed out from 12/01/19 through 12/04/19.			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPI	
		HAL030007	B. WING		12/	13/2019
	PROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, ST TVIEW DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	237	D 392			
	12/05/19 at 2:41pm re-There was a bubble-25mg 1 capsule twice -There were 56 capsupharmacy on 10/18/19 -There was a second lyrica 25mg 1 capsule -There were 60 capsupack dispensed by the According to review of and December 2019 eand medications on hunaccounted for. Interview with Resider 10:56am revealed: -She was on several processed and second and	packed container of lyrica a day for pain. Iles dispensed by the 9 with 5 capsules remaining. bubble-packed container of a twice a day for pain. Iles in the second bubble be pharmacy on 11/08/19. If the October, November be MARS, dispensing records and, there 5 lyrica tablets Int #4 on 12/03/19 at Doain medications. Stretches" without her pain bus occasions and had burs. If go without her pain rienced severe pain. Intil her pain was pain medication because at a cold response from It staff her pain medication be and staff had not gotten lication on the medication In revealed: dication to Resident #4				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/1	13/2019
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, ST. FVIEW DRIVE LLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	the pill was administerable did not know if a for accuracy. Interview with the Sup 4:37pm revealed: -The pharmacy review substance logs once a substance logs once a substance regular basisShe had been told by CSCS did not match to medication on the medication	red on the CSCS. Inyone reviewed the CSCS Dervisor on 12/05/19 at ved the controlled a quarter. Istaff who reviewed the logs for accuracy on a v MAs the count on the the number of controlled dication cart and she trator. Ishift notebook where MAs rolled pills they started with they administered. at happened to the "shift to twas at the MAs work station to week. Sentative from the facility on 12/11/19 at 12:51pm order for Lyrica 25mg 1 or Resident #4 and was tracy on 10/02/19 with a tes, on 11/18/19 with a tes, and on 12/02/19 with a tes.	D 392			
	12/12/19 at 9:50am re- -She found the count					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	SURVEY
			A. BOILDING			
		HAL030007	B. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK		TVIEW DRIVE			
			LLE, NC 2702	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
	when she found the codid not match the conmedication cart. -There was a shift to swork station where Mand ending count of considering the since 12/03/19 (survey-When she administer she documented the Administer she had administer she saw missing CSCS or if a deduction through the eMAR to swrote the names of the and gave it to the Administer she had talked to the missing controlled medications not. Interview with the Supplemental she had informed the missing controlled medications not. Interview with the Supplemental she had informed the missing controlled medications not. Law enforcement sho suspected MA(s) shou and suspended until arcompleted.	ervisor and the Administrator controlled medication count trolled medication on the shift notebook at the MA's As recorded the beginning controlled medications for had not seen the notebook of entrance date). The controlled medication, administration on the CSCS. The deductions from the mass not signed, she went see who was working and the MAs on a sheet of paper ministrator. The controlled medications from the mass not signed, she went see who was working and the MAs on a sheet of paper ministrator. The controlled medications from the massing signed from the missing signed from the missing signed from the Administrator did for the Administrator did for the Administrator about dications, but nothing was all the did have been drug tested in investigation was	D 392			
	6:20pm revealed she k with residents' controlle	inistrator on 12/12/19 at snew there had been issues ed medications, but she did issue with Resident #4's				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE	3/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE	
MOCKSVILLE, NC 27028	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Continued From page 240 controlled medications. c. Review of Resident #4's physician's orders revealed an order dated 10/15/19 for Zolpidem Tartrate (Ambien) 5mg 1 tablet at bedtime for linsomnia (a schedule IV controlled substance which can be abused and can lead to dependence), may repeat in 1 hour if not effective. Review of Resident #4's electronic Medication Administration Record (eMAR) for October 2019 revealed: -There was an entry for zolpidem tartrate 5mg 1 tablet at bedtime for insomniaThere was a second entry for zolpidem tartrate 5mg 1 tablet at bedtime for insomniaThere was documentation 15 tablets of zolpidem tartrate were administered from 10/16/19 through 10/31/19. Review of Resident #4's controlled substance count sheet (CSCS) revealed: -There was documentation 13 tablets of zolpidem tartrate signed out from 10/03/19 through 10/31/19. -There was a total of 2 tablets of zolpidem tartrate documented as administered on the eMAR, but not signed out on the CSCS. Review of Resident #4's eMAR for November 2019 revealed: -There was an entry for zolpidem tartrate documented as administered from the eMAR, but not signed out on the CSCS. Review of Resident #4's eMAR for November 2019 revealed: -There was an entry for zolpidem tartrate 5mg 1 tablet at bedtime for insomniaThere was documentation 25 tablets of zolpidem tartrate were administered from 11/01/19through 11/30/19. Review of Resident #4's CSCS revealed: -There was documentation 25 tablets of zolpidem	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY
			D MANAGE	*		
		HAL030007	B. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK		TVIEW DRIVE			
0.0.15	CLIMMANDY OT		LLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	241	D 392			
	tartrate were signed of 11/30/19. -There was no docum was signed out on the through 11/22/19, but on the eMAR zolpider 11/15/19 through 11/2. There was a total of 3 administered on the ethe CSCS. Review of Resident #4 2019 revealed: -There was an entry for tablet at bedtime for in -There was document tartrate 5mg were admithrough 12/03/19. Review of Resident #4 documentation 3 table signed out from 12/01/10. Observation of Reside hand at the facility on revealed: -There was a bubble-pzolpidem tartrate 5mg insomnia with a quanti were 15 tablets remain -There was a bubble-pzolpidem tartrate 5mg additional to scheduled.	entation zolpidem tartrate c CSCS from 11/15/19 there was documentation in tartrate was administered 20/19. 3 tablets of zolpidem tartrate MAR , but not signed out on 4's eMAR for December or zolpidem tartrate 5mg 1 isomnia. ation 3 tablets of zolpidem inistered from 12/01/19 4's CSCS revealed ts of zolpidem tartrate were 1'19 through 12/03/19. int #4's zolpidem tartrate on 12/05/19 at 2:41pm eacked container of 1 tablet at bedtime for ty of 15 tablets and there hing. eacked container of	D 392			
		the October, November MARS, dispensing records nd, there 5 zolpidem				

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE HERITAGE OF CEDAR ROCK MOCKSVILLE, NC 27028 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE	
THE HERITAGE OF CEDAR ROCK 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028 (A4) ID PREFIX TAG CONTINUED FOR ISOLOPHIP IN BEFORE PROCESS OF FULL REGULATORY OR ISOLOPHIP IN BEFORE PROCESS OF FULL REGULATORY OR ISOLOPHIP IN BEFORE PROCESS OF FULL TAG CONTINUED FOR ISOLOPHIP IN BEFORE PROCESS OF FULL REGULATORY OR ISOLOPHIP IN BEFORE PROCESS OF FULL TAG CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) D PREFIX TAG CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) D 392 Continued From page 242 Interview with a third shift medication aide (MA) on 12/05/19 at 5:12 am revealed: -She administered medication to Resident #4 including controlled substances, she popped the pill and then she would write that the pill was administered controlled substances, she popped the pill and then she would write that the pill was administered on ECSCS -She did not know if anyone reviewed the CSCS for accuracy. Interview with the Supervisor on 12/05/19 at 4.37pm revealed: -The pharmacy reviewed the controlled substance logs once a quarter, -There was no facility staff who reviewed the controlled substance logs for accuracy on a regular basisShe had been told by MAs the count on the CSCS did not match the number of controlled medication on the medication cart and she informed the AdministratorThere was a shift to shift notebook where MAs noted how many controlled pills they started with and how many pills they administratedShe did not know what happened to the shift to shift notebook, but It was at the MAS work station at the beginning of the week. Interview with a representative from the facility contracted pharmacy on 12/11/19 at 12:51pm revealed: -There was an active order for Resident #4 for Zolpidem Tartrate 5mg 1 tablet at bedtime, may repeat 1 dose if medication was not effective in 1 hour.		0. 00	DENTI TOATTON NOWBER.	A. BUILDING		COMP	LETED
THE HERITAGE OF CEDAR ROCK 191 CRESTVIEW DRIVE MOCKSVILLE, NO. 27028 (A4) ID PREFEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 392 Continued From page 242 Interview with a third shift medication aide (MA) on 12/05/19 at 8:12am revealed: -She administered medication to Resident #4 including controlled substancesWhen she administered medication to RCSCShe did not know if anyone reviewed the CSCS for accuracy. Interview with the Supervisor on 12/05/19 at 4:37pm revealed: -The pharmacy reviewed the controlled substance substance substance so a quarterThere was no facility staff who reviewed the controlled substance logs for accuracy on a regular basisShe had been told by MAs the count on the CSCS did not match the number of controlled medication on the medication cart and she informed the AdministratorThere was a shift to shift notebook where MAs noted how many controlled pills they started with and how many pills they administeredShe did not know what happened to the shift to shift notebook but it was at the MAS work station at the beginning of the week. Interview with a representative from the facility contracted pharmacy on 12/11/19 at 12:51 pm revealed: -There was an active order for Resident #4 for Zolpidem Tartrate 5mg 1 tablet at bedtime, may repeat 1 dose if medication was not effective in 1 hour.			HAL030007	B. WING		12/	13/2019
(X4) ID SUMMARY STATEMENT OF DEFICIENCES TAG (X4) ID (RACH DEFICIENCY MUST BE PRECEDED BY FULL RESOLUTION OF CRISCOMPLET IN AGE CROSS-REFERENCED TO THE APPROPRIATE D 392 Continued From page 242 Interview with a third shift medication aide (MA) on 12/05/19 at 8:12am revealed: -She administered medication to Resident #4 including controlled substancesWhen she administered on the CSCSShe did not know if anyone reviewed the CSCS for accuracy Interview with the Supervisor on 12/05/19 at 4:37pm revealed: -The pharmacy reviewed the controlled substances as the popped the pill and then she would write that the pill was administered on the CSCSShe did not know if anyone reviewed the CSCS for accuracy on a regular basisShe had been told by MAs the count on the CSCS did not match the number of controlled medication on the medication cart and she informed the AdministratorThere was a shift to shift notebook where MAs noted how many controlled pills they started with and how many pills they administeredShe did not know what happened to the shift to shift notebook, but it was at the MAs work station at the beginning of the week. Interview with a representative from the facility contracted pharmacy on 12/11/19 at 12:51pm revealed: -There was an active order for Resident #4 for Zolpidem Tartrate 5mg 1 tablet at bedtime, may repeat 1 dose if medication was not effective in 1 hour.	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE	***************************************	
(C4) ID SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MIST BE PRECEDED BY FULL RECOLATORY OR LISC IDENTIFYING INFORMATION) D PREFIX REGULATORY OR LISC IDENTIFYING INFORMATION) D PREFIX RECOLATORY OR LISC IDENTIFYING INFORMATION) D 392 Continued From page 242 Interview with a third shift medication aide (MA) on 12/05/19 at 8:12am revealed: -She administered medication to Resident #4 including controlled substances, she popped the pill and then she would write that the pill was administered on the CSCSShe did not know if anyone reviewed the CSCS for accuracy. Interview with the Supervisor on 12/05/19 at 4:37pm revealed: -The pharmacy reviewed the controlled substance logs once a quarterThere was no facility staff who reviewed the controlled substance logs once a quarterThere was no facility staff who reviewed the controlled substance logs for accuracy on a regular basisShe had been told by MAs the count on the CSCS did not match the number of controlled medication on the medication cart and she informed the AdministratorThere was a shift to shift notebook where MAs noted how many controlled pills they started with and how many pills they administeredShe did not know what happened to the shift to shift notebook, but it was at the MAs work station at the beginning of the week. Interview with a representative from the facility contracted pharmacy on 12/11/19 at 12:51pm revealed: -There was an active order for Resident #4 for Zolpidem Tartrate 5mg 1 tablet at bedtime, may repeat 1 dose if medication was not effective in 1 hour.	THE HERI	TAGE OF CEDAR ROCK	191 CREST	VIEW DRIVE	i .		
PREFIX TAG TAG CONTINUED FROM INSTITUTION INFORMATION) D 392 Continued From page 242 Interview with a third shift medication aide (MA) on 12/05/19 at 8:12am revealed: -She administered controlled substances, she popped the pill and then she would write that the pill was administered on the CSCSShe did not know if anyone reviewed the CSCS for accuracy. Interview with the Supervisor on 12/05/19 at 4:37pm revealed: -The pharmacy reviewed the controlled substance logs for accuracy on a regular basisShe had been told by MAs the count on the CSCS did not match the number of controlled medication on the medication cart and she informed the Administrator. -There was a shift to shift notebook where MAs noted how many controlled pills they started with and how many pills they administeredShe did not know what happened to the shift to shift notebook, but it was at the MAs work station at the beginning of the week. Interview with a representative from the facility contracted pharmacy on 12/11/19 at 12/51pm revealed: -There was an active order for Resident #4 for Zolpidem Tartrate 5mg 1 tablet at beditime, may repeat 1 dose if medication was not effective in 1 hour.		TAGE OF GEDAN NOON		LE, NC 2702	28		
Interview with a third shift medication aide (MA) on 12/05/19 at 8:12am revealed: -She administered medication to Resident #4 including controlled substances. -When she administered controlled substances, she popped the pill and then she would write that the pill was administered on the CSCS. -She did not know if anyone reviewed the CSCS for accuracy. Interview with the Supervisor on 12/05/19 at 4:37pm revealed: -The pharmacy reviewed the controlled substance logs once a quarter. -There was no facility staff who reviewed the controlled substance logs once a quarter. -There was no facility staff who reviewed the controlled substance logs for accuracy on a regular basis. -She had been told by MAs the count on the CSCS did not match the number of controlled medication on the medication cart and she informed the Administrator. -There was a shift to shift notebook where MAs noted how many controlled pills they started with and how many pills they administered. -She did not know what happened to the shift to shift notebook, but it was at the MAs work station at the beginning of the week. Interview with a representative from the facility contracted pharmacy on 12/11/19 at 12.51pm revealed: -There was an active order for Resident #4 for Zolpidem Tartrate 5mg 1 tablet at bedtime, may repeat 1 dose if medication was not effective in 1 hour.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
on 12/05/19 at 8:12am revealed: -She administered medication to Resident #4 including controlled substancesWhen she administered controlled substances, she popped the pill and then she would write that the pill was administered on the CSCSShe did not know if anyone reviewed the CSCS for accuracy. Interview with the Supervisor on 12/05/19 at 4:37pm revealed: -The pharmacy reviewed the controlled substance logs once a quarterThere was no facility staff who reviewed the controlled substance logs for accuracy on a regular basisShe had been told by MAs the count on the CSCS did not match the number of controlled medication on the medication cart and she informed the AdministratorThere was a shift to shift notebook where MAs noted how many controlled pills they started with and how many pills they administeredShe did not know what happened to the shift to shift notebook, but it was at the MAs work station at the beginning of the week. Interview with a representative from the facility contracted pharmacy on 12/11/19 at 12:51pm revealed: -There was an active order for Resident #4 for Zolpidem Tartrate 5mg 1 tablet at bedtime, may repeat 1 dose if medication was not effective in 1 hour.	D 392	Continued From page	242	D 392			
pharmacy on 10/18/19 with a quantity of 30 tabs and on 11/22/19 with a quantity of 30 tablets.		Interview with a third son 12/05/19 at 8:12an-She administered me including controlled su-When she administer she popped the pill and the pill was administer -She did not know if all for accuracy. Interview with the Sup 4:37pm revealed: -The pharmacy review substance logs once a -There was no facility controlled substance logs once a -There was no facility controlled substance logs once a -There was no facility controlled substance logs once a -There was a shift to she had been told by CSCS did not match the medication on the medinformed the Administration -There was a shift to she noted how many pills the -She did not know what shift notebook, but it was the beginning of the Interview with a repress contracted pharmacy or revealed: -There was an active of Zolpidem Tartrate 5mg repeat 1 dose if medical hourZolpidem Tartrate 5mg pharmacy on 10/18/19	shift medication aide (MA) In revealed: Idication to Resident #4 Ibstances. Ired controlled substances, Ired on the CSCS. Inyone reviewed the CSCS	D 392			

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED
		HAL030007	B. WING		1	2/13/2019
	PROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, S' TVIEW DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 392	pharmacy. Interview with a first at 12/12/19 at 9:50am re-She found the count controlled medications started her shift. -She notified the Superwhen she found the commedication cart. -There was a shift to swork station where Mand ending count of controlled medication cart. -There was a shift to swork station where Mand ending count of controlled medication cart. -When she administer she documented the atwice 12/03/19 (survey) -When she saw missing CSCS or if a deduction through the eMAR to sworde the names of the and gave it to the Administer she documented the atwice with a first shall she at the same she will be a sworde the names of the and gave it to the Administer with a first shall she at the contact law enforcement she controlled medications not. Interview with the Sup 12:48pm revealed: -She had informed the missing controlled medications not. Interview with the Sup 12:48pm revealed: -She had informed the missing controlled medications not.	and second shift MA on evealed: off for Resident #4's sometimes when she envisor and the Administrator controlled medication count trolled medication on the shift notebook at the MA's As recorded the beginning controlled medications for mad not seen the notebook at the medication, administration on the CSCS. In deductions from the medication was not signed, she went see who was working and the MAs on a sheet of paper ninistrator. In MA on 12/12/19 at Administrator about dications. To get the Administrator to cent to report the missing so, but the Administrator did ervisor on 12/12/19 at	D 392			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	
HAL		HAL030007	B. WING		12/13/2019	
THE HERITAGE OF CEDAR ROCK 191 CREST			DRESS, CITY, ST TVIEW DRIVE LLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	and suspended until a completed. Interview with the Adi 6:20pm revealed she with residents' control not know there was a controlled medication 4. Review of Resider 05/19/19 revealed: -Diagnoses included encephalopathy, and -There was a medical 1mg every eight hours anxiety/agitation (use Review of physician's record revealed: -There was an order of lorazepam from 1mg needed for anxiety/agitation (use Neview of Resident # electronic Medication (eMAR) revealed: -There was an entry for day as needed for anxiety for any and for any as needed for anxiety for an	ministrator on 12/12/19 at knew there had been issues led medications, but she did n issue with Resident #4's s. In #18's current FL2 dated dementia, acute schizoaffective disorder. ion order for lorazepam is as needed for d to treat anxiety disorder). Orders in Resident #18's dated 07/01/19 that changed to 0.5mg twice daily as itation. dated 12/10/19 that changed g to 1mg every eight hours //agitation. 18's September 2019 Administration Record or lorazepam 0.5mg twice a kiety/agitation. ation lorazepam 0.5mg was from 09/01/19 through	D 392			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL030007	B. WING		12/13/2019
	ROVIDER OR SUPPLIER	191 CRES	DDRESS, CITY, STA STVIEW DRIVE ILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO: (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 392	-There was document administered 9 times 09/30/19There was document lorazepam 0.5mg table. Review of Resident # revealed: -There was no entry for needed for anxiety/agThere was no documented of the revealed: -There was no documented of the revealed: -There was document tablets of 1mg lorazepThere was document tablets of 1mg lorazepThere was document signed out 7 times on 09/10/19 at 9:00am, 009/12/19 at 8:58am, 009/28/19 at 8:49am, aThere was document lorazepam 1mg were revealed: -There was an entry for day as needed for anximistered 10 times 10/31/19. Review of Resident #1 revealed: -There was documentated administered 10 times 10/31/19.	tation lorazepam 0.5mg was from 09/01/19 through tation Resident #18 had 27 ets remaining. 18's September 2019 eMAR or lorazepam 1mg as itation. entation lorazepam 1mg on the eMAR. 18's September 2019 CSCS ation Resident #18 had 37 oam. ation lorazepam 1mg was 09/07/19 at 2:00pm, 9/11/19 at 10:05am, 10:015am, 10:	D 392		

Division of Health Service Regulation

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
HAL030007		B. WING		12/13/	2019	
THE HERITAGE OF CEDAR ROCK 191 CRES		DDRESS, CITY, S' STVIEW DRIVE (ILLE, NC 2702				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Review of Resident # revealed: -There was no entry fineeded for anxiety/ag-There was no docum was administered. Review of Resident # revealed: -There was document signed out 11 times or 10/11/19 at 9:30pm, 1 10/18/19 at 7:00pm, 1 10/19/19 at 7:00pm, 1 10/22/19 at 9:00am, 1 10/27/19 at 4:12pm ar specified)There was document lorazepam 1mg was revealed: -There was an entry for day as needed for anximite administered 6 times for 11/30/19. Review of Resident #1 revealed: -There was documentated for a signed out 1 time from 11 times from 11 ti	18's October 2019 eMAR or lorazepam 1mg as itation. itentation Lorazepam 1mg 18's October 2019 CSCS ation lorazepam 1mg was in 10/08/19 at 1:40pm, 0/12/19 at 8:55pm, 0/19/19 at 9:00am, 0/20/19 at 8:00am, 0/24/19 (no time specified), ind 10/27/19 (no time ation 11 tablets of emaining. 18's November 2019 eMAR or lorazepam 0.5mg twice a diety/agitation. ation lorazepam 0.5mg was from 11/01/19 through 8's November 2019 CSCS ation lorazepam 0.5mg was in 11/01/19 through 11/30/19. ation Resident #18 had 19	D 392	DEFICIENCY)		
	-There was no entry for needed for anxiety/agi					

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PR

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SUR	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	ED .
		HAL030007	B. WING		12/13/2	2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	TATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK	191 CRES	TVIEW DRIVE			
			LLE, NC 2702	8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE 0	(X5) COMPLETE DATE
D 392	Continued From page	247	D 392			
		entation Lorazepam 1mg				
	Review of Resident # revealed:	18's November 2019 CSCS				
	-There was document signed out 7 times on	ation lorazepam 1mg was 11/01/19 at 6:39pm.				
	11/02/19 at 9:00am, 1	1/02/19 at 8:46pm, 11/18/19 at 11:23pm, 11/23/19 at				
	11:22am and 11/24/19 at 11:21amThere was documentation 4 tablets of lorazepam 1mg was remaining. Review of Resident #18's December 2019 eMAR revealed:					
		or lorazepam 0.5mg twice a				
	day as needed for anxiety/agitationThere was documentation lorazepam 0.5mg was administered 1 time from 12/01/19 through 12/12/19.					
	Review of Resident #1 revealed:	8's December 2019 CSCS				
	-There was documentation lorazepam 0.5mg was signed out 2 times from 12/01/19 through 12/12/19.					
	-There was documental lorazepam 0.5mg table	ation Resident #18 had 17 ets remaining.				
	Review of Resident #1 revealed:	8's December 2019 eMAR				
	-There was no entry for needed for anxiety/agi	tation.				
	was administered on the	entation Lorazepam 1mg he eMAR.				
	Review of Resident #18's CSCS revealed lorazepam 1mg was not signed out from 12/01/19 through 12/12/19.					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
		HAL030007	B. WiNG		12/	13/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE			
THE HEBI	TAGE OF CEDAR ROCK	191 CRES	VIEW DRIVE	i .			
I THE HERI	TAGE OF CEDAR ROCK	MOCKSVII	LE, NC 2702	28			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON	(VE)	
PREFIX TAG	The state of the s	/ MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
D 392	Continued From page	248	D 392				
D 392	Observation of Reside hand at the facility on revealed: -There was one bubble lorazepam 1mg tabletThe were no lorazepa containerThere were 75 tables containerThere was document filled on 12/10/19There was no other to cart for Resident #18. According to review of November and Decembre dispensing records and there were 12 tablets tablets unaccounted for tablets of the 05mg lower unaccounted for. Interview with Resider provider (MHP) on 12/10-During his visit to the verbally informed ResignitationReview of Resident #facility staff did not util for the increased anxied-The facility did not call #18's increased agitationThe staff requested the for the as needed loration in the staff requested the for the as needed loration.	ent #18's lorazepam on 12/12/19 at 11:50am de-packed container of is. am tablets missing from the is of 1mg lorazepam in the ration the medication was brazepam in the medication was brazepam in the medication of the September, October, of the 1mg lorazepam or, and there were 33 razepam tablets at #18's mental health (06/19 at 3:37pm revealed: facility on 12/03/19 he was ident #18 had increased in the medication. If him regarding Resident ion, the write another order zepam.	D 392				
	documentation there s -He requested to view medication cart.	hould be medication left. the lorazepam on the					
	-He identified there wa	s a card of lorazepam					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		HAL030007	B. WING		12/	13/2019
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, ST TVIEW DRIVE LLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE	(X5) COMPLETE DATE
D 392	0.5mg with tablets left -There was also a car tablets leftHe informed that faci write an order becaus availableHe also informed fac 1mg was discontinued was no current order in medicationHe suggested the me pharmacy. Second interview with 12/11/19 at 3:13pm re -On 12/09/19 he recei facilityThe complaint was R problemsHe asked had she trie 0.5mgThe staff the resident lorazepamHe changed the loraz daily as needed to 1m needed. Interview with a pharm pharmacy on 12/12/19 -Resident #18's 1mg a initially filled and dispendent quantity of thirty whole -Resident #18's 0.5mg last filled and dispendent quantity of sixty tablets -The pharmacy receiv for lorazepam 1mg as for anxietyThe lorazepam 1mg to	t. It dof lorazepam 1mg with lity staff that he would not the there was medications lility staff that lorazepam d in June 2019 and there to administer the ledication be sent back to the Resident #18's MHP on evealed: leved a call from a staff at the lesident #18 had behavior led to give the lorazepam let was out of the 0.5mg lepam from 05mg twice ling every eight hours as leacist at the contracted leas needed lorazepam was lensed on 06/27/19 for a let tablets. If as needed lorazepam was lead on 07/01/19 for a let dan order dated 12/10/19 leneeded every eight hours lablet was filled and 75	D 392			
	tablets were dispense	d on 12/10/19.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
			The Bolizanto.			
		HAL030007	B. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK		VIEW DRIVE			
240.15	OUR MADY OT		LE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	250	D 392			
	records department at on 12/13/19 at 2:36ph records showed no lot had been returned to in linterview with the Adm 11:13am revealed: -She sent Resident #1 0.5mg tablets and 1mg pharmacy on the morrorate she did not document of the pharmacyShe had never document of the pharmacyShe pharmacyShe had never document of the pharmacyShe pharmacy	8's unused lorazepam g tablets back to the ning of 12/10/19. ment the number of d 1mg) tablets she sent nented medications that armacy. w, observations, interviews				
	0.5mg as needed for a					
	Review of the physicia Resident #5's record re lorazepam 0.5mg 1 tak needed for agitation/ar	olet every 8 hours as				
	Review of Resident #5's August 2019 electronic Medication Administration Record (MAR) revealed: -There was an entry for lorazepam 0.5mg every 8 hours as needed for anxiety/agitation.					

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL030007	B. WING		12/	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK		TVIEW DRIVE LLE, NC 2702			
(VA) ID	SLIMMADY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	251	D 392			
	-There was documentation lorazepam 0.5mg was administered 5 times from 08/01/19 through 08/31/19. Review of Resident #5's August 2019 Controlled Substance Count Sheet (CSCS) revealed: -There was documentation lorazepam 0.5mg was signed out 7 times from 12/01/19 through 12/12/19There was documentation on 08/28/19 at					
	8:00pm and 08/31/19 at 8:11pm that was not documented on the eMAR.					
	-There was documentation Resident #5 had 83 lorazepam 0.5mg tablets remaining.					
	Review of Resident #5's September 2019 electronic Medication Administration Record (MAR) revealed: -There was an entry for lorazepam 0.5mg every 8 hours as needed for anxiety/agitationThere was documentation lorazepam 0.5mg was administered 8 times from 09/01/19 through 09/30/19. Review of Resident #5's September 2019 CSCS revealed: -There was documentation lorazepam 0.5mg was signed out 12 times from 09/01/19 through 09/30/19There was documentation lorazepam 0.5mg was					
	signed out on 09/02/19 at 8:38pm, 09/06/19 at 8:44pm, 09/07/19 at 7:35pm, 09/08/19 at 9:30am, 09/09/19 at 8:00pm, 09/13/19 at 8:58am, 09/14/19 at 9:00am, 09/27/19 at 8:00pm, and 09/27/19 at 8:00pm but not documented on the eMAR. -There was documentation Resident #5 had 71					
	lorazepam 0.5mg table	ets remaining.				
	Review of Resident #5	5's October 2019 eMAR				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING	B. WING		13/2019
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, ST. TVIEW DRIVE LLE, NC 27028	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	hours as needed for a -There was document administered 0 times 10/31/19. Review of Resident # revealed: -There was document signed out 3 times fro 10/31/19There was document 10:00pm, 10/12/19 at 9:00pm that were not -There was document lorazepam 0.5mg tab Review of Resident # revealed: -There was an entry f hours as needed for a -There was document administered 2 times 11/30/19. Review of Resident #4 revealed: -There was document signed out 2 times fro 11/30/19There was document lorazepam 0.5mg tab Review of Resident #4 revealed: -There was document signed out 2 times fro 11/30/19There was document lorazepam 0.5mg tab Review of Resident #4 revealed:	for lorazepam 0.5mg every 8 anxiety/agitation. tation lorazepam 0.5mg was from 10/01/19 through 5's October 2019 CSCS tation lorazepam 0.5mg was om 10/01/19 through tation on 10/11/19 at 4:30pm and 10/29/19 at 4:documented on the eMAR. tation Resident #5 had 69 lets left. 5's November 2019 eMAR for lorazepam 0.5mg every 8 anxiety/agitation. tation lorazepam 0.5mg was from 11/01/19 through 5's November 2019 CSCS tation lorazepam 0.5mg was om 11/01/19 through tation Resident #5 had 66 lets left. 5's December 2019 eMAR for lorazepam 0.5mg every 8 anxiety/agitation. tentation that showed	D 392			

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/13/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	FATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK		TVIEW DRIVE			
	0.11.54.57.4.57		LLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	ETE
D 392	Continued From page	253	D 392			
	12/01/19 through 12/1	11/19.				
	record revealed: -There was document had 63 tablets of loraz	5's December 2019 CSCS tation the resident currently zepam .05mg tablets with no why the medication was				
	Observation of Resident #5's medications on hand at the facility on 12/06/19 at 11:58am revealed: -Resident #5 had lorazepam 0.5mg as needed for anxiety on hand at the facilityThere was documentation 63 tablets were left in the bubble-packed containerThere was documentation the medication was filled on 08/26/19 for a quantity of 90 tablets. According to review of the August, September, October, November and December 2019 eMARs, CSCS, dispensing records and medications on hand, there were 3 tablets of the 05mg lorazepam tablets unaccounted for.					
	revealed: -His medications were staffHe did not know the thimHe did not know if he for agitation and anxie Interview with the phapharmacy on 12/10/19 -On 08/2619 the pharm	urmacist at the contracted at 12:30pm revealed: macy dispensed a 90-day				
	supply of lorazepam 0 -They had not dispens August 2019.	.5mg for Resident #5. ed the medication since				

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL030007 B. WING 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 392 Continued From page 254 D 392 Interview with the Administrator on 12/11/19 at 11:13am revealed: -The MAs should be counting off the controlled drugs. -A month or more ago she realized the controlled drugs were incorrect. -She informed staff to remember to document when they administered Resident #5's lorazepam. -Currently, she did not have a system of checking behind the MAs to ensure the controlled drug count was correct. The facility failed to assure 5 of 8 residents had a THERE WERE SEVERAL WRITTEN POLOCIES IN readily retrievable record of controlled substances PLACE (SEE ATTACHED) THAT ADMINISTRATOR by documenting the disposition of Resident #17's OR RCC WERE NOT FOLLOWING. ADMINSTRATOR STATES IT WAS HER RESPONSIBILITY TO DO SO. oxycodone with 324 tablets unaccounted for. RCC IS ALSO RESPONSIBLE. Resident #15's hydrocodone/acetaminophen 5/325mg with 42 tablets unaccounted for, Resident #4's oxycodone, 38 tablets unaccounted HOME WAS CLOSED ON 2/7/2020 WITH THE for, lyrica, 5 tablets unaccounted for, zolpidem ASSISTANCE OF DAVIE COUNTY D.S.S. AND tartrate, 5 tablets unaccounted for, Resident #18 RESIDENTS WERE RELOCATED TO APPROPRIATE lorazepam 1mg, 12 tablets unaccounted for, LEVELS OF CARE lorazepam 0.5mg 33 tablets unaccounted for and Resident #5 Iorazepam 0.5mg 3 tablets unaccounted for. The failure of the facility to locate the Controlled Substance Count Sheets or documentation that controlled drugs were returned to the pharmacy was detrimental to the safety, health, and welfare of the residents and

Division of Health Service Regulation

this violation.

constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/06/19 for

CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020.

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING. HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 399 Continued From page 255 D 399 D 399 10A NCAC 13F .1008 (h) Controlled Substance D 399 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the

This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to report suspected drug diversion of controlled substances to the pharmacy, local law enforcement, and the Health Care Personnel Registry for 1 of 5 sampled residents (#17) who was prescribed Oxycodone.

The findings are:

contact and action taken.

Refer to Tag 392, 10A NCAC 13F .1008(a) Controlled Substances.

Based on observations, interviews, and record reviews, the facility failed to report suspected drug diversions of controlled substances to the pharmacy, local law enforcement, and the Health Care Personnel Registry for 1 of 5 sampled residents (#17) who were prescribed Oxycodone.

The findings are:

Review of Resident #17's FL2 dated 07/29/19 revealed diagnoses included scoliosis, restrictive lung disease, chronic pain, and fibromyalgia.

OWNER'S HAD NEVER BEEN MADE AWARE OF ANY DRUG DIVERSIONS. THE ADMINISTRATOR HAD STATE GUIDELINES (SEE ATTACHED) ON HOW TO REPORT ANY ISSUE. THE ADMINISTRATOR FAILED TO DO

AS OF 2/7/2020, ALL RESIDENTS HAVE BEEN PLACED IN AN APPROPRIATE LEVEL OF CARE WITH ASSISTANCE OF DAVIE COUNTY D.S.S. AND THE HOME IS NOW CLOSED. ALL REMAINING MEDICATIONS HAVE BEEN RETURNED TO EXPRESS CARE PHARMACY.

Division of Health Service Regulation STATE FORM

	3/2019	
HAL030007 B. WING 12/13	12/13/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG DEFICIENCY)	(X5) COMPLETE DATE	
D 399 Continued From page 256 -Admission date was 07/29/19. -There was an order for oxycodone (a narcotic used to treat moderate to severe pain) 20mg one tablet every 6 hours as needed for pain. Review of Resident #17's physician's orders dated 11/08/19 revealed there was an order oxycodone 20mg one tablet every 6 hours. Observation of Resident #1's medications on hand on 12/06/19 at 1:30pm revealed there were 85 oxycodone 20mg available for administration. Review of Resident #17's record revealed: -Resident #17 110 oxycodone 20mg upon admissionThere were no controlled substance count sheets (CSCS's) available for the 110 oxycodone 20mg tablets Resident #17 had 410 oxycodone 20mg unaccounted for on the CSCS's. Interview with the Administrator on 12/06/19 at 5:25pm revealed: -She had been told Resident #17's oxycodone ocount was offThe count for Resident #17's oxycodone was questioned in October and November 2019, but when she looked at the CSCS there had been a staff errorShe could not find the CSCS for July and August 2019 for Resident #17'She knew any suspected diversion was required to be reported to Department of Social Services (DSS), the police, and the vendor pharmacyShe had no proof of any diversion of oxycodone. Interview with a MA on 12/06/19 at 5:45 pm revealed: -She knew Resident #17 had an order and was		

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 399 Continued From page 257 administered oxycodone 20mg for her pain since she had been admitted in July 2019She had left notes for other MAs to sign for	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE REGULATORY OR LSC IDENTIFYING INFORMATION) D 399 Continued From page 257 administered oxycodone 20mg for her pain since she had been admitted in July 2019. -She had left notes for other MAs to sign for	A. BUILDING.	
THE HERITAGE OF CEDAR ROCK 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 399 Continued From page 257 administered oxycodone 20mg for her pain since she had been admitted in July 2019She had left notes for other MAs to sign for	HAL030007 B. WING	12/13/2019
THE HERITAGE OF CEDAR ROCK MOCKSVILLE, NC 27028 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 399 Continued From page 257 administered oxycodone 20mg for her pain since she had been admitted in July 2019. -She had left notes for other MAs to sign for	STREET ADDRESS, CITY, STATE, ZIP CODE	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 399 Continued From page 257 administered oxycodone 20mg for her pain since she had been admitted in July 2019She had left notes for other MAs to sign for	CK	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 399 Continued From page 257 administered oxycodone 20mg for her pain since she had been admitted in July 2019She had left notes for other MAs to sign for		
administered oxycodone 20mg for her pain since she had been admitted in July 2019She had left notes for other MAs to sign for	NCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AIR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
Resident #17's oxycodone when the CSCS had been left blank. -The Administrator knew Resident #17's oxycodone count was off because staff had told her. -The Administrator had instructed the MAs to notify her when a controlled count was off. -The MAs had been documenting the beginning and ending count of controlled substances in the shift report notebook. -At shift change, the off going MAand the oncoming MA were supposed to count all controlled substances together. -There had been a few times in which she had to count by herself due to no oncoming MA when her shift was over. -When she counted by herself, she reviewed the controlled substance label and the medication label and then counted the tablets 2 times. Interview with a MA on 12/12/19 at 12:10pm revealed: -There had been times when she came to work and there were no MAs on duty, so she had to count controlled drugs by herself. -She did not want to lose her MA certification so she would have a PCA count with her as a witness only as a last resort. Interview with Resident #17 on 12/12/19 at 1:00pm revealed: -She knew that she had at least 10 oxycodone missing after she was admitted to the facility and then a few in October 2019 were missing because she ran short. -The Administrator had investigated the missing	odone 20mg for her pain since tted in July 2019. for other MAs to sign for codone when the CSCS had knew Resident #17's as off because staff had told had instructed the MAs to controlled count was off. In documenting the beginning of controlled substances in the k. In decimal was off. In documenting the beginning of controlled substances in the k. In documenting the beginning of controlled substances in the beginning to the beginning to the substances in the beginning to the beginning to the beginning tof	

	NT OF DEFICIENCIES OF CORRECTION	(1.2)			(X3) DATE SURVEY COMPLETED
		HAL030007	B. WING		12/13/2019
	PROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, S' TVIEW DRIVE		M
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 399	-The MA that was sus oxycodone was still e Interview with a MA orevealed: -The Administrator had oxycodone were miss 2 months agoShe did not know how investigatedWhen the oxycodone to start documenting is the shift report book. Interview with the Sup 11:09am revealed: -She knew Resident administered oxycodo she was admitted in Jack -The CSCS required a controlled substance was admitted on 0The MAs were not do supposed to do (filing logs for July and Auguanthe Administrator known issing some oxycodo had told herAfter the first time Rewent missing, the Admeach MA to document count on a sheet of pasign stating she receivalso, the beginning an substances were to be report notebookThe first time some of	ipected of taking her imployed at the facility. In 12/12/19 at 4:45pm Id told her that some ing for Resident #17 about in the situation was went missing, the MAs had beginning and end counts in intervisor on 12/13/19 at inte	D 399		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING:		
		HAL030007	B. WING		12/13/2019
	PROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STAT STVIEW DRIVE /ILLE, NC 27028	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
D 399	-She asked the Admin of the missing oxycodo-The second time Reswent missing, the sambut the police were not a staff were drug to missing oxycodone. -Sometimes the MAs themselves as there woulding. -When the off-going Mand then left the building and then left the building and unidentified area sknew where they were linterview with a MA or revealed: -He trained with anoth cart. -The oxycodone was son the cart. -The oxycodone was on the cart. -He told the Supervisor Resident #17's oxycoolooking at the CSCS. -Nothing was put in plooxycodone from being linterview with the Admin 6:55pm revealed: -The MAs had to cour by themselves at time running late. -When the next MA are the controlled substant linterview with the Admin 1:55pm revealed: -Resident #17 had 11 admitted to the facility	nistrator to notify the police one in August 2019. Sident #17's oxycodone ne 2 MAs were suspected, of notified. Sted as a result of the would have to count by was no other MA in the MAs counted by themselves ing the keys were placed in that the oncoming MA et at. In 12/13/19 at 1:34 pm Item MA for 2 days on the missing before he worked for and the Administrator done count was off just by acce to prevent the junaccounted for. In inistrator on 12/12/19 at the controlled substances is due to the oncoming MA rived, they would also count ces. In inistrator on 12/13/19 at 12/13/19 at 12/13/19 at 12/13/19 at 12/13/19 at 12/13/19 at 13/13/19 at 13/13/13/19 at 13/13/13/13/13/13/13/13/13/13/13/13/13/1	D 399		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
		HAL030007	B. WING		12/1	3/2019	
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, STA STVIEW DRIVE ILLE, NC 27028	TE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 399	unaccounted forShe had looked at Recompared it to the oxyShe thought that initimissingShe interviewed staff that some of the oxycAfter her investigation 2 individuals who wereShe did not drug test staff or report the missipoliceAfter the second incides missing, she put a new the resident to sign stamedicationsShe did not drug test the police after the sere Resident #17's oxycocShe "could not answer missing oxycodone to -She informed the rep Department of Social she came in to monito.	was signed out. #17 had some oxycodone esident #17's CSCS and ycodone on hand. ally 5 oxycodone went #18 and residents and found odone had been wasted. In, the information led her to be MAs. #19 either of the suspected #19 sing oxycodone to the #19 dent when 1 or 2 went #19 w system in place requiring #19 ating she had gotten her #10 the suspected staff or notify #11 cond incident when #11 done went missing. #12 er why she did not report the #13 the police". #19 resentative for the local #10 Services face to face when	D 399				
	Registry The facility shall comp	lly with G.S. 131E-256 and NCAC 13O .0101 and					

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 438 | Continued From page 261 D 438 This Rule is not met as evidenced by: TYPE B VIOLATION OWNER'S WERE NEVER MADE AWARE OF ANY RESIDENT ABUSE, Based on record reviews and interviews, the FACILITY POLICY STATES THAT RESIDENT facility failed to report allegations of physical ABUSE OF ANY KIND IS CAUSE FOR abuse of a resident (Resident #19) by a IMMEDIATE TERMINATION. medication aide (Staff F), to the Health Care ADMINISTRATOR FAILED TO FOLLOW Personnel Registry (HCPR). POLICY AND FAILED TO FOLLOW STATE GUIDELINES FOR REPORTING STAFF TO HCPR. The findings are: ON 2/7/2020, ALL RESIDENTS HAVE BEEN Review of Resident #19's current FL2 dated PLACED IN AN APPROPRIATE LEVEL OF 10/22/19 revealed: CARE WITH THE ASSISTANCE OF DAVIE -Diagnoses included vascular dementia without COUNTY D.S.S. AND THE HOME HAS BEEN behaviors, chronic diastolic congestive heart CLOSED. failure, depression/anxiety, hearing loss, heart disease, diabetes mellitus and neuropathy. -Resident #19 was intermittently disoriented. Review of Resident #19's Care Plan dated 11/08/19 revealed there was no documentation regarding the resident's mental health status or the agency to contact. Review of a police report dated 11/13/19 revealed: -There was an altercation at the facility between a staff and a resident. -Staff F, medication aide (MA) admitted "punching" Resident #19 in the face so the resident would stop assaulting her. -The report noted the resident had blood on her lip. Interview with Resident #19 on 12/05/19 at 9:03am revealed: -She lived at the facility since the end of October

-A couple of weeks after she moved into the

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/	13/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE			
THE HERI	TAGE OF CEDAR ROCK	(STVIEW DRIVE				
		MOCKSV	ILLE, NC 27028	8			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 438	roomWhen Staff F came is door openShe asked Staff F to because she was colStaff F said, "Wait a -Staff F proceeded to medication and did not staff F and her starterStaff F and her starterStaff F and her strugterShe pushed the MA faceStaff F pushed her because with the she did not recall the facilityShe did not recall the	cident with Staff F. d and Staff F came into her into the room she left the close the room door, d. minute." give her roommate some ot close the door. ed yelling at each other. gled back and forth. because she was in her ack. er lip bleeding. e police coming to the e Administrator talking with dent. int #19's roommate on evealed: le to her room to give her ing into the room another le room. emplained about the door liked Staff F to close the	D 438				
	-She was aware of ar #19 and Staff F on the	n incident between Resident e second shift.					

Division	of Health Service Regu	ılation			FOR	RM APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION		E SURVEY
		DEIVINIONTON NOMBER.	A. BUILDING:		COM	IPLETED
		HAL030007	B. WING		12	2/13/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	,	-
THE HER	ITAGE OF CEDAR ROCK	191 CRE	STVIEW DRIVE			
		MOCKS	VILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 438	Continued From page	e 263	D 438			
	-She did not interview her understanding the incidentShe did not contact to incident because she supposed report the incident staff Forevealed: -On 11/13/19 she were to give 12:00pm medion roommateShe left the door operal resident #19 pushed started hitting, biting a started hitting, biting a started hitting, biting a remission of all started to proper to her coming in member had come in openOn 11/13/19, the hall #19 wanted the door to she tried to protect her #19 off her, so she pudid not hit Resident #1 she did not call Resident #1 she did not call Resident #19 by Staff Fon 11/12 in Staff Foontinuing to was unprotected from failure was detrimental welfare of the resident	the resident because it was e resident started the he HCPR regarding the did not know that she was neident. on 12/06/19 at 10:20am In tinto Resident #19's room cation to Resident #19's n. I her body on the her and and scratching her. Into the room another staff the room and left the door way was cool, and Resident to be kept closed. erself by pushing Resident shed the resident, but she 19. Ident #19's mental health	D 436			
	The facility provided a accordance with G.S. this violation.	131D-34 on 12/05/19 for				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING	B. WING		12/2010
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE	121	13/2019
THE HER	ITAGE OF CEDAR ROCK	191 CDE6	TVIEW DRIVI			
		MOCKSVI	LLE, NC 270	28		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	264	D 438			
	VIOLATION SHALL N 27, 2020	OT EXCEED, JANUARY				
D 453	10A NCAC 13F .1212 and Incidents	(d) Reporting of Accidents	D 453			
	Incidents (d) The facility shall im department of social s G.S. 108A-102 and th	Reporting of Accidents and immediately notify the county services in accordance with a local law enforcement by law of any mental or ct or exploitation of a				
	Department of Social Sincidents involving 1 or	nd record reviews, the iately notify the local county Services (DSS) for		THERE ARE FACILITY POLICIES IN PLATE THAT REQUIRE ADMINISTRATOR TO ACCIDENTS/INCIDENTS TO DAVIE COD.S.S. ADMINISTRATOR FAILED TO FOTHESE POLICIES.	REPORT UNTY DLLOW	
	behaviors, chronic dias	ascular dementia without stolic congestive heart iety, hearing loss, heart		AS OF 2/7/2020, ALL RESIDENTS HAVE PLACED IN AN APPROPRIATE LEVEL (CARE WITH THE ASSISTANCE OF DAV COUNTY D.S.S. AND THE HOME HAS B CLOSED.	OF IE	
	staff member and a res -The staff admitted she	ion at the facility between a				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION :		(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/	/13/2019
	ROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, S STVIEW DRIVI VILLE, NC 270:	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D914	herThe report noted the lip. Interview with the local Specialist on 12/05/19The facility did not sereportsA few months ago, shifthe Administrator regardincident reports. Interview with the Supholical Policy and revealed: -She worked part-time did paper work in the Grand-She previously worked aware that accident/indicompletedThe facility did not do Interview with the Administrator did not do Interview with the Administrator was incident reportShe had instructed stareportsShe was unable to fin G.S. 131D-21(4) Declared.	resident had blood on her all county Adult Home at 1:00pm revealed: and her accident/incident are had a conversation with arding her not getting ervisor on 12/04/19 at at the facility and mostly office. d at other facility's and was cident reports needed to be incident/accident reports. aninistrator on 12/06/19 at sent out staff were to do an aff to start doing incident d incident reports. aration of Residents' Rights are the following rights: and physical abuse,	D 453			
ivision of Hospital	This Rule is not met as	evidenced by:				

					(X3) DATE SURVEY COMPLETED
		HAL030007	B. WING		12/13/2019
	PROVIDER OR SUPPLIER	191 CREST	DRESS, CITY, S' FVIEW DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D914	Based on observation interviews, the facility were free from abuse personal care and oth background checks, to diabetic resident, train resuscitation, staffing supervisor, ACH infect requirements, ACH mecompetency, examinated care, personal care and residents, and implementally for the findings are: 1. Based on record resinterviews the facility for care and mental health health care providers fresidents (Residents fresidents (Residents fresidents (Residents fresidents (Residents fresidents	is, record reviews and failed to assure all residents and neglect related to ser staffing, criminal raining on the care of sing on cardio-pulmonary of personal care aide tion prevention edication aide; training and tion and screening, health and supervision, Residents' tation. Eviews, observations and sailed to contact the health in providers and specialist for 7 of 11 sampled et 1, #3, #5, #9, #12, #14, resident with a pressure with extreme muscle falls who missed a nerve two MRI appointments swollen lower extremities in walking (#5), a resident ed behaviors that yelled at an the walls and threw ents with rashes which comfortable (#1 and #9) the did not work properly et 3 10A NCAC 13F Type A2 Violation)]. Tons, record reviews and failed to administer did by a licensed practicing ampled residents (#1, #2, ated to a topical antiseptic	D914	THE POLICIES AND PROCEDURES TO THAT THESE ITEMS WERE BEING AD TO, WERE IN PLACE AT ALL TIMES IN HOME. THE ADMINISTRATOR AND REFAILED TO FOLLOW THESE POLICIES AS OF 2/7/2020, ALL RESIDNETS HAVE PLACED IN AN APPROPRIATE LEVEL CARE WITH THE ASSISTANCE OF DAY COUNTY D.S.S. AND THE HOME IS NO CLOSED.	HERED I THE CC, . BEEN OF VIE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	AND PLAN OF CORRECTION (X1) PROVIDER/SOPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL030007	B. WING		12/13/2019
	ROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STAT STVIEW DRIVE VILLE, NC 27028	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
	reliever (#4), a rapid a #12), a diuretic (#5), a (#1). [Refer to Tag D3 Medication Administra 3. Based on interview Administrator failed to operations, and policic implemented and rule infection prevention readministration, control supervision, physical chousekeeping and furn background check, he check, nutrition and for rights, health care persaccident reports, activ health care, ACH medicompetency requirementarining on cardio-puln examination and screen substances, personal competency validation professional support taining on care of dial personal care aide sup implementation. [Refer Implementation (Type 4. Based on interview observations, the facilitiexit doors accessible for alarm that activated for sampled residents (Reconstantly disorientate	acting insulin (#2, #3 and and a gastric acid reducer 158 10A NCAC 13F .1004(a) ation (Type A2 Violation)]. Is and record reviews, the assure the management, as of the facility were as were maintained for ACH equirements, medication alled substances, environment, personal care, nishings, criminal alth care personnel registry and services, residents' connel registry, incident and aties, tuberculosis test, ication aides; training and ents, test for tuberculosis, nonary resuscitation, and for icensed health asks, personal care training agement of resident funds, bettic residents, staffing of the to Tag 980 G.S. 131D-25 A2 Violation)]. Is, record reviews, and the safety for 1 of 5 are residents' use had an of the safety for 1 of 5 asident #5) who was defined and had wandering from the facility without the to Tag D067 10A	D914		

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ HAL030007 B. WING 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)**PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D914 Continued From page 268 D914 5. Based on record reviews and interviews, the facility failed to assure 9 of 12 sampled staff (Staff A, B, C, E, F, G, I, J, and K) were tested for Tuberculosis (TB) disease upon hire. [Refer to Tag D131 10A NCAC 13F .0406(a) Test for Tuberculosis (Type B Violation)]. 6. Based on observations, interviews and record reviews, the facility failed to assure 7 of 12 sampled staff (Staff B, E, F, G, I, J, and K) had a criminal background check completed prior to hire. [Refer to Tag D139 10A NCAC 13F .0407(a) (7) Criminal Background Check (Type B Violation)]. 7. Based on record reviews and interviews, the facility failed to assure 4 of 11 sampled staff (Staff C, D, I, and J) who provided personal care to residents had documentation of successful completion of an 80 hour personal care training and competency evaluation program. [Refer to Tag D150 10A NCAC 13F .0501 Personal Care Training (Type B Violation)]. 8. Based on observations, record reviews and interviews, the facility failed to assure 2 of 7 staff sampled (Staff F) and the Administrator who administered insulin and obtained finger stick blood sugars for residents completed training on

Division of Health Service Regulation

care of the diabetic resident prior to the

Residents (Type B Violation)].

administration of insulin. [Refer to Tag D164 10A NCAC 13F .0505 Training on Care of Diabetic

9. Based on observations, record reviews and interviews, the facility failed to assure at least one staff was always on the premises who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) for 27 of 69

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		SURVEY
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(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	045
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D914	Continued From page	269	D914			
	October 2019, and No	days in September 2019, ovember 2019. [Refer to 13F .0507 Training on suscitation (Type B				
	10. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing at the facility for 8 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019. [Refer to Tag D188 10ANCAC 13F .0604(e) Personal Care and Other Staffing (Type B Violation)].					
	facility failed to assure were staffed with a mir including 16 hours of phours of supervision w toward personal care has staffed with 16 hours of supervisor hours when within 500 feet of the fashifts when there was an unsprinkled facility. NCAC 13F .0605(c) Staide Supervisor (Type 12. Based on observative reviews, the facility failed was provided to 8 of 11 #5, #7, #8, #11, #12, #12 care to three residents residents having to wait	nimum of 20 hours personal care staff and 8 ith up to 4 hours counted nours, and third shift was if personal care aide and 8 there was not a supervisor acility for 5 of 69 sampled a census of 31 residents in [Refer to Tag D214 10A affing of Personal Care B Violation)]. ons, interviews and record ed to assure personal care I sampled residents (#1, 18, and #20) including foot				
	and #11). [Refer to Tag	D269 10A NCAC 13F and Supervision (Type B				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

(X3) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL030007	B. WING	12/13/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADD	PRESS, CITY, STATE, ZIP CODE	

NAME OF F	ROVIDER OR SUPPLIER	STREET ADDRESS	S, CITY, STA	ATE, ZIP CODE	
THE HERITAGE OF CEDAR ROCK		191 CRESTVIE	N DRIVE		
***************************************	MOCKSVILLE,	NC 27028			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED B' REGULATORY OR LSC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 270 13. Based on record reviews, observation interviews the facility failed to provide supto meet the needs of 2 of 5 sampled reside (Residents #5 and #12) who had muscle weakness causing him to repeatedly fall (and a resident who eloped without staff's knowledge (#5). [Refer to Tag D270 10A M13F .0902(b) Personal Care and Supervision (Type B Violation)]. 14. Based on record review and interview facility failed to assure 1 of 17 sampled resident #19) were free of abuse and ne resulting a resident (#19) being physically assaulted by a medication aide (Staff M). to Tag D338 10A NCAC 13F .0909 Reside Rights (Type B Violation)]. 15. Based on observations, interviews, arrecord reviews, the facility failed to assure records of the administration of controlled substances were maintained, accurate and reconciled for 5 of 8 sampled residents (Residents #4, #5, #15, #17 and #18) who prescribed Oxycodone (#4 and #17), lyrical zolpidem tartrate (#4), hydrocodone (#15), lorazepam (#5 and #18). [Refer to Tag D38 NCAC 13F .1008(a) Controlled Substance B Violation)]. 16. Based on record reviews and interview facility failed to report allegations of physical abuse of a resident (Resident #19) by a medication aide (Staff F), to the Health Care Personnel Registry (HCPR). [Refer to Tag 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)].	n and ervision lents #12) NCAC ion styles the sidents glect [Referent and	914		

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL030007	B. WING		12/	13/2019
	PROVIDER OR SUPPLIER	191 CRES	DDRESS, CITY, STAT STVIEW DRIVE VILLE, NC 27028	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
	written infection contrifederal Centers for Di Prevention guidelines control procedures for 2 of 3 sampled reside with diabetes, resultin between residents. [R 131D-4.4 ACH Infection Requirements (Type E 18. Based on record facility failed to assure (MAs) sampled (Staff Administrator had commandatory annual inference [Refer to Tag D934 G. Infection Prevention R Violation)]. 19. Based on observation record reviews, the fact sampled staff (Staff C, administered medication administration or completed verification or completed Administration Skills V K), and passed the state exam (Staff E) prior to the Refer to Tag D935 G. Medication Aide Training Violation)]. 20. Based on interview facility failed to assure screening for the prese substances was complistaff (Staff B, C, E, F, I Administrator prior to the state of the prese substances was complistaff (Staff B, C, E, F, I Administrator prior to the state of the prese substances was complistaff (Staff B, C, E, F, I Administrator prior to the prese substances was complistaff (Staff B, C, E, F, I Administrator prior to the prese substances was complistance to the prese substance of the present of the	ol policy consistent with the sease Control (CDC) and to assure proper infection the use of glucometers for ints (Residents #2, and #14) g in sharing glucometers efer to Tag D932 G.S. on Prevention 3 Violation)]. Teviews and interviews, the roof 7 medication aides C. E. F. I. J., and K.) and the inpleted the state approved action control training. S. 131D-4.5B(a) ACH equirements (Type B attions, interviews and bility failed to assure 6 of 7 E. F. I. J., and K.) who cons, had employment end the 5, 10, or 15-hour ion courses (Staff C, E, F., and the written medication aide administering medications. S. 131D-4.B(b) ACH and Competency (Type and Competency (Type we and record reviews, the an examination and ence of controlled eted for 8 of 12 sampled at J. K.) and the	D914			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDING	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED		
	HAL030007		B. WING		12/13/2019	
NAME OF F	PROVIDER OR SUPPLIER	OTDEST AS	22500 0174		12/13/2019	
10		404 CDE0	DRESS, CITY, S TVIEW DRIV	STATE, ZIP CODE		
THE HER	ITAGE OF CEDAR ROCK		ILLE, NC 270			
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D914	Continued From page	272	D914			
	Controlled Substance	s (Type B Violation)].				
D916	G.S. 131D-21(6) Decl	aration of Resident's Rights	D916			
	Every resident shall had 6. To have his or her precords kept confident without the written conguardian, which conset the disclosure may be by applicable state or for by third party contrasection to prohibit accet the treating physician cobjects in writing. Recidisclosed with the writt individual to agencies, which are providing ento the individual. Disclosed	ial and not disclosed isent of the individual or ent shall specify to whom made, except as required federal statute or regulation ct. It is not the intent of this less to medical records by except when the individual cords may also be				
	This Rule is not met as Based on observations reviews, the facility fail personal information in	s, interviews, and record ed to maintainresidents'		COMPANY DOLLOW CERTICAL V. DR CAMPA		
	The findings are:			COMPANY POLICY STRICTLY PROHIBI SHARING OF ANY/ALL RESIDENT/EMP INFORMATION OUSTIDE OF THE BUSIN	LOYEE	
	Review of Resident #19 -Diagnoses included de -There was documenta intermittently disoriente	tion Resident #15 was		OFFICE. ALL RESIDENT MEDICAL INFORMATION NORMALLY STAYS IN A LOCKED ROOM AT THE MED ROOM, IN PRIVATE NOTEBOOK.	A N A	
	Review of an information Personal Health Inform residents upon admissi was required by law to	ation (PHI) provided to		AS OF 2/7/2020, THE HOME IS CLOSED A ALL RESIDENT FILES ARE LOCKED IN FILE CABINTES IN THE BUSINESS OFFI THE FACILITY OWNER IS THE ONLY PE WITH A KEY TO THIS OFFICE AND THE CABINETS.	TWO CE. ERSON	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/13/2019
	PROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, S' TVIEW DRIVE	:	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D916	resident's PHI. Observation of Reside times on 12/03/19 bet revealed: -Resident #15's room throughout the dayThere were 8 stacks bedThere were 4 stacks dresser. Observation Resident times on 12/04/19 bet revealed: -Resident #15's room throughout the dayThere were 8 stacks bedThere were 8 stacks bedThere were 4 stacks dresser. Review of the stacks dresser. Review of the stacks dresser. Review of the resident social security number numbers, diagnoses, and medications. Interview with Resider 5:20pm revealed: -Resident #15 stated, on." -He did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the document in the did not know when from or what the did	ent #15's room at various tween 9:45am and 5:45pm door remained opened of paper on Resident #15's of paper on Resident #15's #15's room at various ween 8:00am and 5:30pm door remained opened of paper on Resident #15's of paper on Resident #15's of paper on Resident #15's room at various ween 8:00am and 5:30pm door remained opened of paper on Resident #15's room at various ween 8:00am and 5:30pm door remained opened of paper on Resident #15's room at various ween 8:00am and 5:30pm door remained opened remained opened was esheets of paper which ats' names, dates of birth, rs, Medicaid identification bank account information, at #15 on 12/04/19 at "They gave me this to work re the documents came ments were. Iong the documents had	D916		

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D916 Continued From page 274 D916 Interview with medication aide (MA) on 12/04/19 at 5:23pm revealed: -Resident #15 had documents in his room spread across his bed since she was hired 3 months ago. -If papers were laying on the MA station desk at night, Resident #15 would pick them up and take them to his room to mark on. -"He's not picking up anything other than blank paper." -There was no other residents' personal information on the documents in Resident #15's room that she knew of. Interview with a personal care aide (PCA) on 12/04/19 at 5:27pm revealed: -She saw the documents in Resident #15's room, but she had never looked at them. -Resident #15 had documents in his room on his bed since she was hired 4 to 5 months ago. -She just thought they were blank papers. Interview with a second PCA on 12/04/19 at 5:31pm revealed: -She had seen the documents in Resident #15's room, but she had never looked at any of them. -"I thought they were his." Observation of Resident #15's room on 12/04/19 at 5:32pm revealed the Administrator had gathered the stacks of documents from Resident #15's bed and dresser into her arms and she was headed out of Resident #15's room.

5:32pm revealed:

Interview with the Administrator on 12/04/19 at

-She and the MAs were responsible for keeping residents' personal information in a secured

-She did not know where Resident #15 got the

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9:43am revealed:

-He had to "finish his work."

his room with a stack of documents which contained other residents' personal information.

Interview with Resident #15 on 12/06/19 at

-He had gotten the stack of documents from a

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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D916	box in his closet"They took the rest of the contained an old, empartment of the boxIt could not be determined additional resident were additional resident work were well as a second with the personal information resident was a second with the comparison of the comparison was a second with the comparison was a second with the comparison was a second was a se	f them." ent #15's room on 12/06/19 Resident #15's closet which only resident record binder. It is and other items in the ent documents in the box. Ininistrator on 12/06/19 at removed all the documents formation on 12/05/19. was at the end of the hall Administrator. ident #15 currently resided	D916			
D932	G.S. 131D-4.4A (b) At Requirements G.S. 131D-4.4A Adult Prevention Requirement		D932			
	(b) In order to prevent hepatitis B, hepatitis C pathogens, each adult the following, beginnir (1) Implement a writte consistent with the fed	transmission of HIV, C, and other bloodborne care home shall do all of				

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	.E CONSTRUCTION	(X3) DATE	SURVEY
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				DEFICIENCY)		
D932	Continued From page	277	D932			
5002	, -		D332			
		s at least all of the following:				
	a. Proper disposal of	single-use equipment used				
1	to puncture skin, muc	ous membranes, and other				
1	tissues, and proper d	isinfection of reusable				
	patient care items tha	t are used for multiple				
	residents.					
	b. Sanitation of rooms	and equipment, including				
	cleaning procedures,	agents, and schedules.				
		ction control devices and				
	supplies.					
	d. Blood and bodily flu	uid precautions.				
		ollowed when adult care				
		to blood or other body				
	-	on in a manner that poses a				
	· ·	smission of HIV, hepatitis B,				
	hepatitis C, or other b					
		bit adult care home staff				
		or weeping dermatitis from				
		ident care that involves the				
	potential for contact b					
	equipment, or devices					
	dermatitis until the co					
		tor compliance with the				
	facility's infection cont					
	(3) Update the infection					
		the transmission of HIV,				
		C, and other bloodborne				1
	pathogens.	s, and other bloodborne				
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revealed:

not give any cleaning/disinfection instructions.

Observation of a finger stick blood sugar (FSBS) check for a resident on 12/04/19 at 9:14 am

-The medication aide (MA) retrieved a glucometer from the medication cart that was labeled with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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D932	Continued From page	e 279	D932			
	Resident #14's name	1.				
		esident #14's glucometer				
	and picked up a gluce	ometer labeled with Resident				
	#2's name.	4				
	-She carried the gluco	ometer labeled with to Resident #14's room.				
		gloves, opened the pouch				
	and turned on the glu					
	Resident #2's name.					
		esident # 14's finger with				
	disposable lancet.	ed to prick her finger with a				
	•	ucometer labeled with				
	Resident #2's name a	and began to move toward				
	Resident #14's finger.					
		edure was stopped by the ying blood to the wrong				
	glucometer.	ing blood to the wrong				
	-There was not any di	isinfection wipe available.				
	-The MA placed the g					
	labeled pouch and ret cart.	turned it to the medication				
	Cart.					
	Observation of medica 9:34am revealed:	ation cart A on 12/04/19 at				
	•	ometer cases labeled with				
		glucometers inside the				
	casesThere were 3 glucom	neters of Brand A and 2				
	glucometers of Brand					
	Observation of medic	ation cart B on 12/04/19 at				
	10:15am revealed:	Attorroate B of 12/04/10 at				
	_	ometer cases labeled with				
	residents' names with cases.	glucometers inside the				
	-There were 3 glucom	eters Brand A and 2				
	glucometers Brand C.					
	There were 9 resident	ts in the building with orders				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		A. BUILDING:	(X3) DATE SURVEY COMPLETED		
	HAL030007		B. WING		12/13/2019
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D932	for FSBS checks and available for use. 1. Review of Residem 05/14/19 revealed dia Mellitus Type II and described finger stick blood sugared finger stick blood sugared finger stick blood sugared finger stick blood finger s	disposable lancets were #14's current FL2 dated gnoses included Diabetes iabetic neuropathy. #14's physicians order dated fre was an order to check far (FSBS) before meals. #14's signed physician orders ed there was an order to fod sugar (FSBS) before #14's November and #14's November and #15's before meals scheduled #14's Brand A glucometer's #14's Brand A glucometer's #14's Brand A glucometer's #15's Brand A glucometer's #16's Brand A glucomet	D932		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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D932	-On 11/26/19, FSBS of FSBS value of 130 at on the eMAR, but not glucometer historyOn 11/27/19, FSBS of FSBS value of 254 at of 158 at 4:30pm were but not in Resident #1-On 11/29/19, FSBS of documented on the el #14's glucometer historyThe FSBS values documented on the gliphone of 11/25/19 at 7:30am, 11:30am, and 11/27/17 FSBS values in the gliphone of 11/25/19 at 7:30am, 11:30am, and 11/27/17 FSBS values documented on the gliphone of 11/25/19 at 7:30am, 11:30am, and 11/27/17 FSBS values documented on the gliphone of 11/25/19 at 11/25/19 at 11/25/19, FSBS value of 128 at on the eMAR, but not gliphone of 127 at 11/25/19 at 11/25/1	value of 123 at 7:30am and 11:30am were documented in Resident #14's value of 117 at 7:30am, 11:30am, and FSBS value of documented on the MAR, 4's glucometer history value of 169 at 11:30am was MAR, but not in Resident ory. Cumented on the eMAR for 1/26 at 7:30am and 9 at 7:30 am matched ucometer for Resident #2. Itues on the November 2019 or matched up to Resident glucometer. Pented on Resident #14's Revere not recorded in meter history with examples follows: eadings that were MAR that were not in meter history. alue of 296 at 11:30am and 4:30pm were documented in Resident #14's value of 88 at 7:30 am and 11:30am were documented in Resident #14's values on the eMAR for and 12/03/19 at 7:30am and 13.0am were documented in Resident #14's values in the mt #2. values on the December 2019 e matched up to Resident	D932		

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED				
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE			
D932	Continued From page	282	D932					
	Interview with Reside 9:18am revealed: -Her blood sugar was -She thought each regular glucometerShe thought the mediglucometer when her -She never looked at whose name was on interview with an MA or revealed: -She took Resident #2 #14's room to check himorningThere were no disinfectean the glucometers -Resident #14's gluconthree weeksShe used Resident #Resident #14's FSBS workedShe had observed of Resident's glucometer FSBS.	checked before meals. sident had their own lication aide (MA) used her FSBS was checked. the glucometer to see t. on 12/04/19 at 9:19am It's glucometer into Resident her FSBS at 9:14am this lecting wipes available to after each use. In meter had not worked for 2's glucometer to check before meals when she						
	the Supervisor, and the #14's glucometer not v	e Administrator of Resident working.						
		he Administrator had told other residents' glucometer b's FSBS.						
	properly for three wee -There were no disinfe clean the glucometers	meter had not been working ks. ecting wipes available to						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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D932	Continued From page	283	D932			
D932	had to check Residen -She had informed the Administrator that Res not working properlyThe Administrator an instructed her to use a glucometer to check F Interview with the Sup 10:02am revealed: -She did not know Res not work properlyIf she had been told F did not work she woul oneShe had passed med residents FSBS's, but Interview with the Adn 10:35am revealed: -She did not know tha did not work properlyShe had not tried to g glucometer for Reside Refer to interview with 12/04/19 at 10:35am. Refer to interview with (PCP) on 12/04/19 at 4 2. Review of Resident 01/23/19 revealed: -Diagnoses included D and polyneuropathy of -There was an order to	t #14's FSBS. e Supervisor and the sident #14's glucometer was d the Supervisor had another residents' Resident #14's FSBS. ervisor on 12/04/19 at sident #14's glucometer did Resident #14's glucometer d have ordered her a new lications and checked it had been a while. hinistrator on 12/04/19 at Resident #14's glucometer d have been a while. hinistrator on 12/04/19 at the Resident #14's glucometer get a replacement are placement in the Administrator on the primary care provider 4:05pm. #2's current FL2 dated Diabetes Mellitus Type II	D932			
	Review of Resident #2	e's signed physician orders				

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-On 11/27/19, FSBS value of 255 at 5:00pm was documented on the eMAR, but not in Resident

-There were FSBS values on the November 2019 eMAR that could not be matched up to Resident

-FSBS values documented on Resident #2's December 2019 eMAR were not recorded in Resident #2's glucometer history with examples

#2's glucometer history.

of inconsistencies as follows:

-There were 2 FSBS values that were

#2's glucometer.

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STATEMENT OF DEFICIENCIES (X1) PR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		HAL030007	D. WING		12/	13/2019	
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THE HERI	TAGE OF CEDAR ROCK	(STVIEW DRIVE				
0/41/15	CHMMADVCT		ILLE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D932	Continued From page	e 286	D932				
	-She had informed the Administrator that Renot working properlyThe Administrator are instructed her to use glucometer to check in Refer to interview with 12/04/19 at 10:35am. Refer to interview with (PCP) on 12/04/19 at interview with the Administrator with the Administra	e Supervisor and the sident #14's glucometer was and the Supervisor had another residents' Resident #14's FSBS. The Administrator on the primary care provider 4:05pm. ministrator on 12/04/19at ents who had ordersfor liagnosis of bloodborne resident to have their own					
	glucometers were bro	A's to report to her when sken.					
	revealed: -She did not know the glucometersEach resident were siglucometerTheir could be cross to resident especially any bloodborne patho The facility failed to in procedures consistent placing residents received.	nplement infection control t with CDC guidelines eiving finger stick blood cometers at risk due to					
	diseases for Resident	s #14 and #2. This failure health safety and welfare					

Division of Health Service Regulation

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		HAL030007	B. WING		12/13	3/2019			
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE								
			ILLE, NC 2702						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE			
D932	Continued From page	287	D932						
	of the residents and c Violation.	onstitutes a Type B							
	The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/04/19 for this violation.			STATE APPROVED OSHA TRAINING W					
1	CORRECTION DATE VIOLATION SHALL N 2019.	FOR THE TYPE B IOT EXCEED JANUARY 27,		EXPRESS CARE PHARMACY.	D1				
D934	G.S. 131D-4.5B. (a) A Requirements	CH Infection Prevention	D934						
	G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements								
	Service Regulation sh annual in-service train home medication aide practices for injections during which bleeding glucose monitoring. Es successfully complete program shall receive determined by the Dep	ach medication aide who s the in-service training partial credit, in an amount partment, toward the requirements for adult care s established by the							
	2.								

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	of Health Service Reg					W AFFROVE			
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY			
7.0.0	o. contact	IDENTIFICATION NOMBER.	A. BUILDING:		COM	PLETED			
		HAL030007	B. WING		12	2/13/2019			
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE					
THE HED	ITACE OF CEDAR BOOK	191 CRI	STVIEW DRIVE						
INE NEK	ITAGE OF CEDAR ROC		VILLE, NC 27028						
(X4) 1D		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)			
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTIO		COMPLETE			
170	112002110111011	(200 IOEIVII TINO INI ONIVATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY		DATE			
D934	Cantinued Francis	- 000							
D334	Continued From pag	le 288	D934						
	This Rule is not met								
	TYPE B VIOLATION					1			
	Based on record rou	iews and interviews, the							
		re 7 of 7 medication aides							
		f C, E, F, I, J, and K) and the							
	Administrator had co	mpleted the state approved							
	mandatory annual in	fection control training.							
	The findings are:								
	1 Review of Staff C'	s, medication aide(MA),							
	personnel record rev		1 0						
	-Staff C was hired on								
	-Staff C passed the w	ritten medication aide exam							
	on 11/20/17.								
		tation Staff C had completed							
	an online computer to	raining of the state approved							
	-There was no docum	rol training dated09/06/19. nentation for subsequent	1 1						
		te approved infection control							
		uiring return demonstration.							
		on 12/12/19 at 4:20pm							
	revealed:								
	-She was rehired in J								
	2010.	he facility off and on since				1 1			
		tate approved mandatory							
		ng online on the computer.							
		e state approved mandatory							
		ng could not be completed							
	as an online compute	r training.							
		ere was a skills validation							
	section that required	returned demonstration.							
	[Refer to Tan D032 G	.S. 131D-4.4A(b) ACH							
		Requirements.(Type B							
	Violation).]	toganomenta.(Type D							

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL030007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 12/13/2019	
						11312013
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	E, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCI	191 CRE	STVIEW DRIVE			
		MOCKS	VILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D934	Continued From pag	e 289	D934			
	Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am. Refer to interview with the Administrator on 12/12/19 at 5:25pm. 2. Review of Staff E's, medication aide (MA), personnel record revealed: -Staff E was hired on 06/27/19.					
	-Staff E had not take medication aide exar	n and passed the written n as of 12/10/19.				
	an online computer to	ntation Staff E had completed raining of the state approved fection control training dated				
	-There was no docum	nentation for subsequent te approved mandatory ing.				
	Interview with Staff E revealed:	on 12/12/19 at 10:37am				
	the facility in July 201 the facility on 09/05/1					
	 She worked as a MA medications to reside She completed the s 					
	infection control traini -She did not know the	ing online on the computer. e state approved mandatory ing could not be completed				
	as an online computer-She did not know the					
		ent on 12/12/19 at 4:00pm a MA at the facility and				

Division o	of Health Service Requ	ulation			FOR	M APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		HAL030007	B. WING		12/	/13/2019
NAME OF P	PROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STATE	E, ZIP CODE		
THE HEBI	ITAGE OF CEDAR ROCK	191 CRF	ESTVIEW DRIVE			
THE HEIST	TAGE OF CEDAR ROOM		SVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
D934	Continued From page	e 290	D934			
	[Refer to Tag D932 G	G.S. 131D-4.4A(b) ACH Requirements.(Type B				
	Refer to the telephon contracted Pharmacy 9:40am.	ne interview with the y Consultant on 12/10/19 at				
	Refer to interview with 12/12/19 at 5:25pm.	th the Administrator on				
	personnel record reve					
	 Staff F was hired on Staff F passed the w on 03/24/10. 	08/16/19. written medication aide exam				
	-There was no docum completed training of mandatory annual info					
	Interview with Staff F revealed: -She worked as a MA	on 12/11/19 at 5:00pm				
	08/16/19. -She administered me	edications to residents at the				
	infection control traini	state approved mandatory ing online on the computer.				
	infection control training as an online compute					
		ere was a skills validation returned demonstration.				
		ent on 12/12/19 at 4:00pm a MA at the facility and tions to the resident.				
						,

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE ((X2) MULTIPLE CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			D. MENO			
		HAL030007	B. WING		12/13/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK	(STVIEW DRIVE			
			VILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	DBE COMPLETE	
D934	Continued From page	e 291	D934			
) u	Violation).]					
	Refer to the telephon contracted Pharmacy 9:40am.	e interview with the Consultant on 12/10/19 at				
	Refer to interview wit 12/12/19 at 5:25pm.	h the Administrator on				
	4. Review of Staff I's, medication aide (MA), personnel record revealed: -Staff I was hired on 03/13/19.					
	-Staff I passed the written medication aide exam on 06/12/02.					
	-There was no docum					
	completed training of		1 1			
1	manuatory annual ini	ection control training.				
	Interview with Staff I or revealed:	on 12/11/19 at 4:38pm				
	then transitioned to a	e Activity's Director and she medication aide (MA) in				
	March 2019She completed state	approved mandatory				
	infection control traini -She did not know sta	ng online on the computer. ite approved mandatory				
	infection control traini as an online compute	ng could not be completed r training.				
	Observation of Staff I 12:00pm revealed Sta medications to reside					
		.S. 131D-4.4A(b) ACH Requirements.(Type B				
	Refer to the telephone contracted Pharmacy 9:40am.	e interview with the Consultant on 12/10/19 at				

Division of Health Service Regulation

Division of Health Service Regul	lation		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL030007	B. WING	12/13/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATE, ZIP CODE	
THE HERITAGE OF CEDAR ROCK		VIEW DRIVE	
THE HEIGHT OF GEDAR ROOK		LE, NC 27028	

NIAME OF I	PROVIDED OF SUPPLIED	CTDEET ADE	DEED CITY OF	ATE 710 CODE	
INAIVIE OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST. FVIEW DRIVE	ATE, ZIP CODE	
THE HER	ITAGE OF CEDAR ROCK		LLE, NC 27028	3	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D934	Continued From page 292		D934		
	Refer to interview with the Administrator on 12/12/19 at 5:25pm.	1			
	Refer to interview with the Administrator on				

PRINTED: 01/13/2020 **FORM APPROVED** Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D934 Continued From page 293 D934 Refer to interview with the Administrator on 12/12/19 at 5:25pm. 6. Review of Staff K's, medication aide (MA), personnel record revealed: -Staff K did not have a hire date in her record -Staff K passed the written medication aide exam on 08/28/13. -There was no documentation Staff K had completed the state approved mandatory annual infection control training. -There was no documentation for subsequent completion of the state approved mandatory infection control training. Telephone interview with Staff K on 12/12/19 at

4:38pm revealed:

- -She was hired as the Activity's Director at the beginning of October 2019 and she also worked as a medication aide (MA).
- -She completed the state approved mandatory infection control training online on the computer. -She did not know there was a skills validation section that required returned demonstration.

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).]

Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

- 7. Review of the Administrator's personnel record revealed:
- -The Administrator was hired on 11/01/18.
- -The Administrator passed the written medication

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D934 Continued From page 294 D934 aide exam on 01/10/19. -There was documentation the Administrator had completed an online computer training of the state approved mandatory annual infection control training dated 03/05/19. -There was no documentation for subsequent completion of the state approved mandatory infection control training. Interview with the Administrator on 12/12/19at 5:35pm revealed: -She was hired as the Administrator in November 2018 and started working at the facility in January 2019. -She completed the state approved mandatory infection control training online on the computer on 03/05/19. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements. (Type B Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am revealed: -He was responsible for providing infection control training for the MAs at the facility.

Division of Health Service Regulation

vear ago.

-He was hired by the contracted pharmacy one

contracted pharmacy had approval by the State for the annual infection control to be taken on the

-He was told by a member at the contracted pharmacy, when he was hired, that the

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D934 Continued From page 295 D934 computer along with other trainings required. -He did not know the state approved mandatory annual infection control training had skills evaluations that had to be validated by a return demonstration therefore could not be approved as an online computer training with out documentaiton of return demonstration. -He would arrange for a corporate nurse or contracted nurse to come to the facility to do competency validations for the infection control training and complete training certifications. Interview with the Administrator on 12/12/19at 5:25 revealed: -The facility contracted pharmacy taught the state approved mandatory infection control training on -She did not know the state approved mandatory infection control training could not be completed as an online computer training. -She did not know there was a skills validation section that required return demonstration. The facility failed to assure the state approved mandatory annual infection control training for 7 of 7 sampled medication aides (Staff C, E, F, I, J, and K) and the Administrator was completed resulting in staff sharing of alucometers between 2 residents exposing the residents to possible blood borne pathogen diseases. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/19 for this violation. CORRECTION DATE FOR THE TYPE B

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2020.

VIOLATION SHALL NOT EXCEED JANUARY 27,

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D935 G.S.§ 131D-4.5B(b) ACH Medication Aides; D935 Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed thefollowing: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and

exists.

Prevention guidelines on infection control and, if

applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding

Division	of Health Service Reg	ulation			· ORWINI THOUED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL030007	B. WING		12/13/2019
	ROVIDER OR SUPPLIER	191 CRI	ADDRESS, CITY, STATESTVIEW DRIVE	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D935	b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure 6 of 7 sampled staff (Staff C, E, F, I, J, and K) who administered medications, had employment verification or completed the 5, 10, or 15-hour		D935	DEFICIENCY)	
	I, J, and K), complete Administration Skills K), and passed the sexam (Staff E) prior to The findings are: 1. Review of Staff C's personnel record revestaff C was hired or There was no docur verification confirming within the past 24 months of the S, 10 or 15-hour straining. There was no docur training. There was no docur the Medication Admin checklist.	Validation (Staff C, E, F, and tate written medication aide to administering medications. s, medication aide (MA) ealed: 08/27/18. nentation of employment g Staff C worked as a MA			

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D935 D935 Continued From page 298 Review of a residents' electronic Medication Administration Record (eMAR) revealed Staff C documented administration of medications 15 days in October 2019, 14 days in November 2019, and 2 days in December 2019. Telephone interview with Staff C on 12/12/19 at 4:20pm revealed: -She worked off and on at the facility since 2010 and she recently came back to work at the facility in January 2019. -There was no verification for employement as a medication aide within the last 24 months available for review. -She administered residents' medications including oral medications, eye drops, creams, and insulin, and she obtained residents' finger stick blood sugars. -She did not know which 5, 10, or 15-hour medication administration training she completed or when she completed the course. -She was "checked off on the medication cart" by a Registered Nurse (RN) (date unknown). Interview with the Administrator on 12/12/19 at 5:35pm revealed: -She did not know Staff C had not completed the 5, 10, or 15-hour medication administration -She did not know Staff C had not completed a Medication Administration Skills Validation checklist. -She had not audited Staff C's personnel record for Staff C's employment verification. [Refer to Tag D358 10A NCAC 13F .1004(a)

Medication Administration (Type B Violation)].

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK MOCKSVILLE, NC 27028 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 299 D935 Infection Prevention Requirements (Type B Violation)]. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 2. Review of Staff E's, medication aide (MA) personnel record revealed: -Staff E was hired on 06/27/19. -There was no documentation of employment verification confirming Staff E worked as a MA within the past 24 months. -There was no documentation Staff E completed the 5, 10 or 15-hour medication administration training. -There was no documentation Staff E completed the Medication Administration Skills Validation -There was no documentation Staff E passed the state written MA exam. Review of a residents' eMAR revealed Staff E documented administration of medications 12 days in October 2019, and 4 days in November 2019. Interview with Staff E on 12/12/19 at 10:37am -She was originally hired in June 2019, she left the facility in July 2019, and she was re-hired at the facility on 09/05/19. -She had been a MA since 2004, but she was not employed as a MA consecutively over the past 24 months.

-She administered residents' medications

including oral medications, eye drops, and insulin, and she obtained residents' finger stick blood

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) P

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CONNECTION IDENTIFICATION IN		IDENTIFICATION NUMBER.	A. BUILDING:		COMPL	-C ! ED
		HAL030007	B. WING		12 <i>I</i> ·	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK	(STVIEW DRIVE			
	0.000		VILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D935	sugarsShe was never aske paperwork to the faci -She did not complete medication administration -She did not know shin order to pass medi -She was "checked of 2019She did not know who skills Validation checked personnel recordShe was scheduled exam in January 2022 -She did not know show the waster within 60 days and within 60	d to provide her MA lity. e the 5, 10, or 15-hour ation training. e needed the 5-hour course cations to the residents. If by a nurse" in November by the Medication Clinical cklist was not in her to take the state written MA o. e needed to take the written ays of completing the kills Validation checklist; the r she had 90 days until she m MA exam. Id her she "could cons because [she] was cations]". ministrator on 12/12/19 at thad 90 days from dication Clinical Skills o schedule and take the ocate the Medication Clinical klist completed for Staff E. aff E did not complete the 5, ation administration training. with the LHPS nurse on evealed she had not on Administration Skills	D935			

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:

HAL030007

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:

B. WING

(X3) DATE SURVEY
COMPLETED

12/13/2019

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF F	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY	Y, STATE, ZIP CODE	
THE HED	ITAGE OF CEDAR ROCK	191 CRESTVIEW DRI	₹IVE	
THE HER	TAGE OF GEDAR ROOK	MOCKSVILLE, NC 27	27028	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY I REGULATORY OR LSC IDENTIFYING INFORMA	FULL PREFIX		(X5) COMPLETE E DATE
PREFIX	Continued From page 301 Medication Administration (Type B Violation [Refer to Tag D932 G.S. 131D-4.4A(b) ACI [Infection Prevention Requirements (Type B Violation)]. Refer to interview with the Administrator or 12/12/19 at 5:25pm. Refer to telephone interview with the LHPS on 12/12/19 at 8:30pm. 3. Review of Staff F's, medication aide (MA personnel record revealed: -Staff F was hired on 08/16/19There was no documentation of employment verification confirming Staff F worked as all within the past 24 monthsThere was no documentation Staff F compeither the 5, or 10 hour, or the 15-hour mediadministration trainingThere was no documentation Staff F compeither the 5 and documentation Staff F compei	D935 D935 D935 D935 D936 D937 D937 D938 D938	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
	and 4 days in December 2019. Interview with Staff F on 12/11/19 at 5:00pr revealed: -Staff F was hired as a MA on 08/16/19.	m s ms, ger		

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING _ HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIR CODE

AIVIE OF F		DDRESS, CITY, STAT	E, ZIP CODE	
HE HERI	TAGE OF CEDAR ROCK	STVIEW DRIVE		
	MOCKS	VILLE, NC 27028		
(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) COMPLET DATE
D935	Continued From page 302	D935		
	-She did not know she needed to complete the			
	5-hour training prior to administering medications	4		
	to residents at the facility.			
	Interview with the Administrator on 12/12/19 at			
	5:35pm revealed:			
- 1	-She did not know Staff F had not completed the 5, 10, or 15-hour medication administration	1 1		
	training.			
- 1	-She had not audited Staff F's personnel record	1 1		
- 1	for Staff F's employment verification.			
	[Refer to Tag D358 10A NCAC 13F .1004(a)			
	Medication Administration (Type B Violation)].			
	[Refer to Tag D932 G.S. 131D-4.4A(b) ACH			
- 1	Infection Prevention Requirements (Type B			
	Violation)].			
	Refer to interview with the Administrator on			
	12/12/19 at 5:25pm.			
	Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm.			
	Review of Staff I's, medication aide (MA)			
	personnel record revealed:			
	-Staff I was hired on 03/13/19.			
	-There was no documentation of employment			
	verification confirming Staff I worked as aMA			
	within the past 24 months.			
	-There was no documentation Staff I completed			
	the 5, 10 or 15-hour medication administration			
	training.			
	-Staff I completed the Medication Administration			
	Skills Validation checklist on 03/04/19.			
	-Staff I passed the written MA exam on 06/12/02.			
	Review of a residents' eMAR revealed Staff I			
	documented administration of medications 2 days			

Division of Health Service Regulation

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D935 Continued From page 303 D935 in October 2019 and 3 days in November 2019. Observation of Staff I on 12/11/19 from 8:00am to 12:00pm revealed Staff I was administering medications to residents. Interview with Staff I on 12/11/19 at 4:38pm -She was hired as the Activity's Director and she then transitioned to a MA in March 2019. -She had completed the 15-hour medication administration training (date unknown). -She did not know why the 15-hour medication administration training was not in her personnel -She had been a nursing assistant for 30 years and she previously worked as a MA; she did not provide information regarding if she worked as a MA in the past 24 months. -She did not provide employment verification to the facility because she did not have it and she completed the MA training. -She started administering medications to residents in March 2019. Interview with the Administrator on 12/12/19 at 5:35pm revealed: -She knew Staff I had previously worked as a MA. -She did not know Staff I did not have documentation of the 5, 10, or 15-hour medication administration training. -She did not know why documentation of Staff I's 5, 10, or 15-hour medication administration training was not in her personnel record. -She had not audited Staff I's personnel record for Staff I's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES. (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D935 Continued From page 304 D935 [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)]. Refer to the interview with the Administrator on 12/12/19 at 5:25pm. Refer to the telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 5. Review of Staff J's, medication aide (MA) personnel record revealed: -Staff J was hired on 03/13/19. -There was no documentation of employment verification confirming Staff J worked as aMA within the past 24 months. -There was no documentation Staff J completed the 5, 10 hours, or 15-hour medication administration training. -Staff J completed the Medication Administration Skills Validation checklist on 03/04/19. -Staff J passed the written MA exam on 03/26/14. Review of a residents' eMAR revealed Staff J documented administration of medications 10 days in October 2019, 10 days in November 2019, and 1 day in December 2019. Telephone interview with Staff J on 12/12/19 at 4:38pm revealed: -She was hired as a MA in February 2019. -Staff J administered medications to residents including oral medications, nebulizer's, eye drops, and insulin. -She did not know if she completed the 5, 10 or 15-hour medication administration training. -She did not know she needed the 5-hour training before she administered medications to residents

at the facility.

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	FION NUMBER: A. BUILDING:		COMPLETED
		HAL030007	B. WING		12/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATI	E, ZIP CODE	
THE HER	TAGE OF CEDAR ROCK	191 CRES	STVIEW DRIVE		
	THE OF OLDS IN THE OTHER	MOCKSV	ILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
D935	Continued From page	305	D935		
D935	Interview with the Adi 5:35pm revealed: -She did not know Sta 5, 10, or 15-hour med trainingShe had not audited for Staff J's employmed [Refer to Tag D358 10 Medication Administration of Tag D358 10 Medication Prevention For Violation)]. Refer to Tag D932 Galfection Prevention For Violation)]. Refer to interview with 12/12/19 at 5:25pm. Refer to telephone into on 12/12/19 at 8:30pm. 6. Review of Staff K's personnel record reversity at 12 modern training and document within the past 24 modern trainingThere was no document trainingThere was no document trainingThere was no document the Medication AdminichecklistStaff K passed the was residents.	ministrator on 12/12/19 at aff J had not completed the lication administration Staff J's personnel record ent verification. DA NCAC 13F .1004(a) ation (Type B Violation)]. S. 131D-4.4A(b) ACH Requirements (Type B In the Administrator on erview with the LHPS nurse in. In medication aide (MA) ealed: In documented hire date, entation of employment ing Staff K worked as a MA	D935		
	Telephone interview v	vith Staff K on 12/12/19 at			

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D935 Continued From page 306 D935 4:38pm revealed: -She was hired as the Activity's Director at the beginning of October 2019 and she also worked as a MA. -She administered oral medications to residents at the facility. -She worked 3rd shift and she did not obtain residents' finger stick blood sugars and she did not administer insulin because blood sugar checks and insulin were not scheduled at the times she worked. -She had completed the 5-hour MA training, but did not provide documentation to the facility because she was not asked for the documentation. -She had not completed the Medication Administration Skills Validation checklist because she was waiting on a nurse to complete the checklist with return demonstration. -She worked as a MA for over 10 years and never had a break in her employment. -She did not provide employment verification to the facility because she was never asked for the documentation. Interview with the Administrator on 12/12/19 at 5:35pm revealed: -She did not have documentation of Staff K's 5-hour medication administration training. -She did not know why documentation of Staff K's 5-hour medication administration training was not in her personnel record. -She had not requested documentation of Staff K's employment verification. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

Division of Health Service Regulation

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 307 D935 Violation)]. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Refer to the telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. Interview with the Administrator on 12/12/19 at 5:25pm revealed: -She was responsible for personnel records and ensuring they were complete and up to date. -She was responsible for ensuring the 5, 10, or 15-hour training was completed by staff. -She did not know the 5-hour training was required before MAs administered medications to residents. -The obligation for staffing duties interfered with her administrative duties and interfered with her responsibility of ensuring MAs had the required training prior to administering medication. -The Licensed Health Personnel Support (LHPS) nurse conducted trainings including Medication Administration Skills Validation checklist. Telephone interview with the LHPS nurse on 12/12/19 at 8:30pm revealed: -She had been the LHPS nurse at the facility for 3 months. -She had not conducted any MA trainings at the -The Administrator did not request for her to complete any Medication Clinical Skills Validation checklists. The facility failed to assure the 5, 10, or 15-hour medication aide training with no previous

employment verification as a medication aide within the last 24 months were completed for 6 of 7 sampled medication aides (Staff C, E, F, I, J,

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 308 D935 D935 and K), the Medication Administration Skills Validation were completed for 4 of 7 staff (Staff C, E, F, and K), and the state approved MA exam was passed within 60 days of the Medication Administration Skills Validation completion for 1 of 7 sampled staff (Staff E) prior to the staff administering medications to the residents, which resulted in an increased the risk for medication errors and exposing the residents to possible blood borne pathogen diseases from staff sharing glucometers between residents. This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020. D980 G.S. § 131D-25 Implementation D980 G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the Administrator failed to assure the management,

Division o	of Health Service Requ	ulation			1 0111111111111111111111111111111111111
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL030007	B. WING		12/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATI	E. ZIP CODE	
		191 CRE	STVIEW DRIVE		
THE HERI	TAGE OF CEDAR ROCI	K	VILLE, NC 27028		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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				BEHOLEROTY	
D980	Continued From pag	je 309	D980		
	operations, and police	cies of the facility were			
		les were maintained for ACH			
		requirements, medication	1		
	administration, contro	The state of the s			
		l environment, personal care,	11 12		
	housekeeping and fu	ırnishings, criminal			
l II	background check, h	nealth care personnel registry			
	check, nutrition and f	food services, residents'			
	-	ersonnel registry, incident and			
	_	ivities, tuberculosis test,			
		edication aides; training and			
		nents, test for tuberculosis,			
1		Imonary resuscitation,			
	examination and scre	_			
		l care and other staffing,			
	competency validation	tasks, personal care training			
		inagement of resident funds,	1 11		
		abetic residents, staffing of			
	personal care aide su				
	implementation.	aportiono, aria			
	,				
- 1	The findings are:				
	Interview with a first s	shift medication aide (MA) on			
	Interview with a first shift medication aide (MA) on 12/12/19 at 11:37am revealed she reported				
		Administrator and the			
	Supervisor.				
		pervisor on 12/12/19 at			
	12:48pm revealed:	with recidents and staff to			
	the Administrator.	with residents and staff to			
		as responsible for the			
	operations of the facil				
	Interview with the Ad	ministrator on 12/12/19 at			
	5:25pm revealed:				
		dministrator since January			

2019.

DIVISION	of Health Service Requ	lation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		HAL030007	B. WING		12	2/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	= ZIP CODE		
		191 CRE	STVIEW DRIVE	1,2		
THE HER	TAGE OF CEDAR ROCK		VILLE, NC 27028			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR	PRECTION	N.E.
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D980	Continued From page	e 310	D980			
	left in late April 2019The RCC had been in assuring staff qualification including criminal back Care Personnel Registestings completed, a -The facility had expestaff turnoverThe Administrator has well as staffing for since the RCC left in a -"Her obligations for sher administrative duties."	rienced a large number of d assumed the RCC duties medication administration April 2019. taffing duties interfered with ies." ds were being transitioned to d some of the staffing				
	12:53pm revealed: -She was at the facility at least 10 hours a da -She was responsible the facility including ar regulationsHer duties included h staff to work, marketin business office function medications when she aide to workIt was difficult for her as Administrator becamore than Administrat. 1. Based on record reinterviews the facility for care and mental health health care providers fresidents (Residents #	for the total operations of otherence to rules and iring new staff, scheduling g and admissions, ons, and passing could not get a medication to fulfill her responsibilities use she was responsible for or tasks. Views, observations and ailed to contact the health in providers and specialist				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D980 Continued From page 311 D980 ulcer (#3), a resident with extreme muscle weakness resulting in falls who missed a nerve conduction study and two MRI appointments (#12), a resident with swollen lower extremities that caused pain when walking (#5), a resident with aggressive/agitated behaviors that velled at other residents, beat on the walls and threw chairs (#18), two residents with rashes which made the residents uncomfortable (#1 and #9) and a glucometer which did not work properly (#14). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 2. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered by a licensed practicing practitioner for 6 of 6 sampled residents (#1, #2, #3, #4, #5 and #12) related to a topical antiseptic (#3), an anti-coagulant and a narcotic pain reliever (#4), a rapid acting insulin (#2, #3 and #12), a diuretic (#5), and a gastric acid reducer (#1). [Refer to Tag D358 10A NCAC13F .1004(a) Medication Administration (Type A2 Violation)]. 3. Based on interviews, record reviews, and observations, the facility failed to assure 1 of 5 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 5 sampled residents (Resident #5) who was constantly disorientated and had wandering behaviors and eloped from the facility without staff's knowledge. [Refer to Tag D067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. 4. Based on record reviews and interviews, the facility failed to assure 9 of 12 sampled staff (Staff A, B, C, E, F, G, I, J, and K) were tested for Tuberculosis (TB) disease upon hire. [Refer to Tag D131 10A NCAC 13F .0406(a) Test for

Division	of Health Service Rep	ulation			. 0.	
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	IPLETED
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		HAL030007	B. WING		12	2/13/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
THE HERI	ITAGE OF CEDAR ROO	191 CR	STVIEW DRIVE			
THE HER	TAGE OF GEDAN NO		VILLE, NC 27028			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
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				DEFICIENCY)		
D980	Continued From pa	ge 312	D980			
	Tuberculosis (Type	B violation)].				
	5. Based on observ	ations, interviews and record				
		failed to assure 7 of 12				1
		B, E, F, G, I, J, and K) had a				
		d check completed prior to				
	_	0139 10A NCAC 13F .0407(a)				
	(7) Criminal Backgrown (7) Violation)].	ound Check (Type B				
	violation)].		1 1			
	6. Based on record	reviews and interviews, the	1 0			1
		re 4 of 11 sampled staff (Staff				
		provided personal care to				
		mentation of successful				
		hour personal care training aluation program. [Refer to				
		C 13F .0501 Personal Care				
	Training (Type B Vic					
			1 1			1
		ations, record reviews and				
		ty failed to assure 2 of 7 staff				
		nd the Administrator who and obtained finger stick				
		idents completed training on				
	care of the diabetic					
		ulin. [Refer to Tag D164 10A				1)
	NCAC 13F .0505 Tr	aining on Care of Diabetic				
	Residents (Type B \	/iolation)].				
	8 Rased on observ	ations, record reviews and				
		y failed to assure at least one				1
		the premises who had				1
		e last 24 months a course on				
	cardio-pulmonary re	suscitation (CPR) for 27 of 69				
		3 days in September 2019,				
		November 2019. [Refer to				
		C 13F .0507 Training on				
		esuscitation (Type B				1
	Cardio-Pulmonary R Violation)].	esuscitation (Type B				

DIVISION	of Health Service Regu	lation			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL030007	B. WING		12/13/2019
NAME OF P	ROVIDER OR SUPPLIER	etpeet /	ADDRESS, CITY, STA	TE ZIR CODE	
	NO VIDEN ON OUT LICH		STVIEW DRIVE	IL, ZIF GODE	
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	0.000		VILLE, NC 27028		
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D980	facility failed to assurstaff were present at of residents residing a shifts sampled for 23 October 2019, and Not Tag D188 10ANCAC and Other Staffing (Ty 10. Based on intervie facility failed to assure were staffed with a mincluding 16 hours of hours of supervision of toward personal care staffed with 16 hours supervisor hours when within 500 feet of the shifts when there was an unsprinkled facility NCAC 13F .0605(c) Stade Supervisor (Type 11. Based on observative reviews, the facility failed to 8 of 1 #5, #7, #8, #11, #12, #3 care to three residents residents having to wa #8, and #20), and residents having to wa #8, and #20). Personal Cal Violation)].	eviews and interviews, the e the minimum number of all times to meet the needs at the facility for 8 of 69 days in September 2019, ovember 2019. [Refer to 13F .0604(e) Personal Care ye B Violation)]. Ews and record review, the effirst and second shifts inimum of 20 hours personal care staff and 8 with up to 4 hours counted hours, and third shift was of personal care aide and 8 in there was not a supervisor facility for 5 of 69 sampled a census of 31 residents in . [Refer to Tag D214 10A staffing of Personal Care e B Violation)]. Itions, interviews and record illed to assure personal care 1 sampled residents (#1, #18, and #20) including foot is (#5, #12, and #18,); ait for incontinence care (#7, idents with a yeast rash (#1 g D269 10A NCAC 13F re and Supervision (Type B reviews, observation and ailed to provide supervision 2 of 5 sampled residents	D980		
	(Residents #5 and #12	2) who had muscle n to repeatedly fall (#12)			

Division	of Health Service Regi	ulation			1010	W. T. T. T. T. C. V. Z. D.
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE COMF	SURVEY
		HAL030007	B. WING		12	/13/2019
	PROVIDER OR SUPPLIER	191 CRI	ADDRESS, CITY, STAT	E, ZIP CODE		
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D980	knowledge (#5). [Ref 13F .0902(b) Person (Type B Violation)]. 13. Based on record facility failed to assur (Resident #19) were resulting a resident (assaulted by a medic to Tag D338 10A NC. Rights (Type B Violation) Rights (Type B Violation) Rights (Type B Violation) Rights (Type B Violation) Residents #4, #5, #1 prescribed for 5 of 8 s (Residents #4, #5, #1 prescribed Oxycodom zolpidem tartrate (#4) lorazepam (#5 and # NCAC 13F .1008(a) (B Violation)]. 15. Based on record facility failed to report abuse of a resident (B medication aide (Staf Personnel Registry (F 10A NCAC 13F .1205 Registry (Type B Violation) Registry (Type B Violation) Prevention guidelines control procedures for 2 of 3 sampled resider	fer to Tag D270 10A NCAC al Care and Supervision I review and interviews the re 1 of 17 sampled residents free of abuse and neglect #19) being physically ration aide (Staff M). [Refer AC 13F .0909 Resident tion)]. I review and interviews, and recility failed to assure stration of controlled intained, accurate and residents and #17, lyrica (#4), hydrocodone (#15), and 18). [Refer to Tag D392 10A Controlled Substances (Type reviews and interviews, the relagations of physical Resident #19) by a ff F), to the Health Care HCPR). [Refer to Tag D438 of Health Care Personnel record reviews, and	D980			

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	STVIEW DRIVE	E, ZIP CODE			
TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETE DATE	
affer to Tag D932 G.S. on Prevention Violation)]. eviews and interviews, the 7 of 7 medication aides C, E, F, I, J, and K) and the spleted the state approved ction control training. S. 131D-4.5B(a) ACH equirements (Type B tions, interviews and cility failed to assure 6 of 7 E, F, I, J, and K) who cons, had employment ed the 5, 10, or 15-hour ion courses (Staff C, E, F, the Medication alidation (Staff C, E, F, and the written medication aide administering medications. S. 131D-4.B(b) ACH and and Competency (Type ws and record reviews, the an examination and ence of controlled eted for 8 of 12 sampled J K) and the	D980				
	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 315 afer to Tag D932 G.S. on Prevention Violation)]. eviews and interviews, the 7 of 7 medication aides C. E. F. I. J. and K.) and the pleted the state approved ction control training. 3. 131D-4.5B(a) ACH equirements (Type B tions, interviews and ility failed to assure 6 of 7 E. F. I. J. and K.) who ons, had employment ed the 5, 10, or 15-hour ion courses (Staff C, E, F, the Medication aide administering medication aide administering medications. 3. 131D-4.B(b) ACH and and Competency (Type of controlled)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 315 D980 D	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 315 25 26 27 27 315 29 29 20 20 315 20 20 20 20 20 20 20 20 20 2	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 315 per to Tag D932 G.S. In Prevention Violation)]. eviews and interviews, the 7 of 7 medication aides C.E.F., I.J., and K) and the pleted the state approved cition control training. 3. 131D-4.5B(a) ACH equirements (Type B) tions, interviews and illity failed to assure 6 of 7 E.F., I.J., and K) who may have a decirated and insistering medication aide administering medication aide administering medications. 3. 131D-4.B(b) ACH and R) ACH and Representation and noe of controlled eted for 8 of 12 sampled J., K) and the ire. [Refer to Tag D992]	

Division (of Health Service Requ	lation			FOR	RM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		HAL030007	B. WING		12	2/13/2019
NAME OF F	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATI	E, ZIP CODE		
THE HER	TAGE OF CEDAR ROCK		STVIEW DRIVE VILLE, NC 27028			
0(4) ID	CLIMMADV DT	ATEMENT OF DEFICIENCIES		BBGV/BEBIG BLAN OF		_
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D980	while a resident who eloped from the facilit a resident experiencir a stage II pressure ulfrequent falls due to rin pain and discomfor and feet; a resident expsychotic behaviors to residents having rash care that burned and a missed gastroenter resident who had phy procedures which we resident being pushed a resident admitted to administered lovenox resident whose glucor properly which led to administered as order for the administration of 69 sampled shifts we medication aide (MA) and no staff available to residents; 6 MAs we MA requirements priomedications and 8 of staff was short of aide all times to meet the rineglect resulted in sul harm and neglect and Violation. The facility provided a accordance with G.S. CORRECTION DATE	was constantly disoriented by without staff's knowledge; and burning and stinging from over; a resident having nuscle weakness; aresident at due to swollen legs, ankles exhibiting aggressive owards other residents; as due to lack of personal caused pain; a resident with plogist appointment; a scian's orders for medical are not implemented; and and hit by a staff (Staff M); at the facility and not injection for 3 days; a meter was not working staff sharing glucometers; available and not red; inaccurate accounting of controlled substances; 5 where there was no supervior on the premises to administer medications ho had not completed the reto administering as sampled shifts where thours and not present at leeds of residents. This obstantial risk of physical constitutes a Type A2	D980			

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D992 Continued From page 317 D992 D992 G.S.§ 131D-45 (a) Examination and screening D992 G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency. and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination

and screening to verify the results of the prior

examination and screening.

Division of	of Health Service Regu	lation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPL	
		HAL030007	B. WING		12/1	3/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
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		MOCKS	SVILLE, NC 2702	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D992	Continued From page	e 318	D992			
	facility failed to assur- screening for the pres substances was com- staff (Staff B, C, E, F, Administrator prior to The findings are: 1. Review of Staff B's personnel record rever- Staff B was hired in A- There was no docum	and record reviews, the e an examination and sence of controlled pleted for 8 of 12 sampled I, J, K) and the hire. , personal care aide (PCA) ealed: August 2019. hentation Staff B completed		POLICIES WERE IN PLACE TO ASSURIESTING WAS IN PLACE AT THE TIMIRE FOR EMPLOYEES. ALL EMPLOY REQUIRED TO HAVE A DRUG TEST COMPLETED PRIOR TO HIRE. WHILE SURVEY HAD BEEN COMPLETED, TO WINERS FOUND SOME ADDITIONAL OCUMENTATION THAT SOME HAD TESTED, THE OWNER'S CHOSE TO PROBLEM OF THE OWNER STAFF MEMBERS THAT FAILED IN THE OWNER STA	ME OF YEES ARE AFTER HE DEEN ERFORM TAFF. D THESE WNER'S	
	controlled substance.	screen for the presence of		AS OF 2/7/2020, ALL RESIDENTS HAV PLACE IN AN APPROPRIATE LEVEL (WITH THE ASSISTANCE OF DAVIE CO D.S.S. AND THE HOME HAS BEEN CL	OF CARE OUNTY	
	revealed: -She was hired as a F -She provided person including bathing, toile -She did not complete screening for controlle -She did not know she a controlled substance screening prior to hire -The Administrator was completing her paper	eting, and feeding. e an examination and ed substances. e was required to complete e examination and				

-She was responsible for completing the

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D934 | Continued From page 288 D934 This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure 7 of 7 medication aides (MAs) sampled (Staff C, E, F, I, J, and K) and the Administrator had completed the state approved mandatory annual infection control training. The findings are: 1. Review of Staff C's, medication aide (MA), personnel record revealed: Staff C was hired on 08/27/18. -Staff C passed the written medication aide exam on 11/20/17. -There was documentation Staff C had completed an online computer training of the state approved annual infection control training dated 09/06/19. -There was no documentation for subsequent completion of the state approved infection control training with skills requiring return demonstration. Interview with Staff C on 12/12/19 at 4:20pm revealed: -She was rehired in January 2019. -She had worked at the facility off and on since 2010. -She completed the state approved mandatory infection control training online on the computer. -She did not know the state approved mandatory infection control training could not be completed as an online computer training. -She did not know there was a skills validation section that required returned demonstration. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).]

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D934 Continued From page 289 D934 Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am. Refer to interview with the Administrator on 12/12/19 at 5:25pm. 2. Review of Staff E's, medication aide (MA), personnel record revealed: -Staff E was hired on 06/27/19. -Staff E had not taken and passed the written medication aide exam as of 12/10/19. -There was documentation Staff E had completed an online computer training of the state approved mandatory annual infection control training dated 07/03/19. -There was no documentation for subsequent completion of the state approved mandatory infection control training. Interview with Staff E on 12/12/19 at 10:37am revealed: -She was originally hired in June 2019, she left the facility in July 2019, and she was re-hired at the facility on 09/05/19. -She worked as a MA and administered medications to residents. -She completed the state approved mandatory infection control training online on the computer. -She did not know the state approved mandatory infection control training could not be completed as an online computer training. -She did not know there was a skills validation section that required returned demonstration. Interview with a resident on 12/12/19 at 4:00pm revealed Staff E was a MA at the facility and administered medications to the resident.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL030007	B. WING		12	12/13/2019	
IAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATI	E, ZIP CODE		12/13/2019	
HE HEDI	TAGE OF CEDAR ROC	191 CRE	STVIEW DRIVE				
	TAGE OF GEDAN NOOF		VILLE, NC 27028				
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D934	Continued From pag	e 290	D934				
		G.S. 131D-4.4A(b) ACH Requirements.(Type B					
	Refer to the telephor contracted Pharmacy 9:40am.	ne interview with the y Consultant on 12/10/19 at					
	Refer to interview wit 12/12/19 at 5:25pm.	th the Administrator on					
	personnel record rev -Staff F was hired on						
	-There was no docum completed training of mandatory annual inf						
	revealed: -She worked as a MA	on 12/11/19 at 5:00pm					
	facility.	edications to residents at the					
	infection control traini -She did not know the	state approved mandatory ing online on the computer. e state approved mandatory ing could not be completed					
	-She did not know the	er training. ere was a skills validation returned demonstration.					
	Interview with a resid- revealed Staff F was administered medicat	ent on 12/12/19 at 4:00pm a MA at the facility and tions to the resident.					

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[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY PLETED
		HAL030007	B. WING		12	/13/2019
	ROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STA STVIEW DRIVE VILLE, NC 27028	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D934	Violation).] Refer to the telephonic contracted Pharmacy 9:40am. Refer to interview with 12/12/19 at 5:25pm. 4. Review of Staff I's, personnel record reversaff I was hired on 0-Staff I passed the wron 06/12/02. There was no docume completed training of mandatory annual infermediatory annual infermediato	e interview with the Consultant on 12/10/19 at the Administrator on medication aide (MA), caled: 03/13/19. Sitten medication aide exam tentation Staff I had the state approved ection control training. On 12/11/19 at 4:38pm Activity's Director and she medication aide (MA) in approved mandatorying online on the computer. It approved mandatorying could not be completed or training. On 12/12/19 from 8:00am to off I administered into at the facility. S. 131D-4.4A(b) ACH dequirements. (Type B	D934			

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(X1) PROVIDER/SUPPLIER/CLIA

HAL030007 B. WING 12/13/201	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID PROFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX
Refer to interview with the Administrator on 12/12/19 at 5:25pm. 5. Review of Staff Js, medication aide (MA), personnel record revealed: -Staff J was hired on 03/13/19Staff J yassed the written medication aide exam on 03/26/14There was documentation Staff J had completed an online computer training of the state approved mandatory annual infection control training dated 03/05/19There was no documentation for subsequent completion of the state approved mandatory annual infection control training infection control training. Interview with a resident on 12/12/19 at 4:00pm revealed Staff J was a MA at the facility and administered medications to the resident. Telephone interview with Staff J on 12/12/19 at 4:38pm revealed: -She was hired as a MA in February 2019She completed the state approved mandatory infection control training online on the computerShe did not know the state approved mandatory infection control training could not be completed as an online computer trainingShe did not know there was a skills validation section that required returned demonstration. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements. (Type B Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
		HAL030007	B. WING		12	2/13/2019
	PROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STATE STVIEW DRIVE VILLE, NC 27028	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D934	Refer to interview with 12/12/19 at 5:25pm. 6. Review of Staff K's personnel record reversaff K did not have a Staff K passed the won 08/28/13. There was no docume completed the state a infection control training. There was no docume completion of the state infection control training. There was no docume completion of the state infection control training. Telephone interview with 4:38pm revealed: She was hired as the beginning of October as a medication aide a she beginning of October as a medication aide a she beginning of October as a medication aide a she beginned to the section that required in the section of	n the Administrator on medication aide (MA), maled: a hire date in her record ritten medication aide exam entation Staff K had pproved mandatoryannual ng. entation for subsequent e approved mandatory ng. with Staff K on 12/12/19 at Activity's Director at the 2019 and she also worked (MA). ate approved mandatory ng online on the computer. re was a skills validation eturned demonstration. S. 131D-4.4A(b) ACH requirements.(Type B	D934			

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) D934 Continued From page 294 D934 aide exam on 01/10/19. -There was documentation the Administrator had completed an online computer training of the state approved mandatory annual infection control training dated 03/05/19. -There was no documentation for subsequent completion of the state approved mandatory infection control training. Interview with the Administrator on 12/12/19at 5:35pm revealed: -She was hired as the Administrator in November 2018 and started working at the facility in January 2019. -She completed the state approved mandatory infection control training online on the computer on 03/05/19. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements. (Type B Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am revealed: -He was responsible for providing infection control training for the MAs at the facility.

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vear ago.

-He was hired by the contracted pharmacy one

contracted pharmacy had approval by the State for the annual infection control to be taken on the

-He was told by a member at the contracted pharmacy, when he was hired, that the

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D934 Continued From page 295 D934 computer along with other trainings required. -He did not know the state approved mandatory annual infection control training had skills evaluations that had to be validated by a return demonstration therefore could not be approved as an online computer training with out documentaiton of return demonstration. -He would arrange for a corporate nurse or contracted nurse to come to the facility to do competency validations for the infection control training and complete training certifications. Interview with the Administrator on 12/12/19at 5:25 revealed: -The facility contracted pharmacy taught the state approved mandatory infection control training on -She did not know the state approved mandatory infection control training could not be completed as an online computer training. -She did not know there was a skills validation section that required return demonstration. The facility failed to assure the state approved mandatory annual infection control training for 7 of 7 sampled medication aides (Staff C, E, F, I, J, and K) and the Administrator was completed resulting in staff sharing of alucometers between 2 residents exposing the residents to possible blood borne pathogen diseases. This failure was

Division of Health Service Regulation STATE FORM

2020.

this violation.

detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/19 for

CORRECTION DATE FOR THE TYPE B

VIOLATION SHALL NOT EXCEED JANUARY 27,

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C	CONSTRUCTION		E SURVEY PLETED
		HAL030007	B. WING		12	/13/2019
	ROVIDER OR SUPPLIER	191 CRE	ADDRESS, CITY, STATE STVIEW DRIVE VILLE, NC 27028	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D935	(b) Beginning October home is prohibited fro any unsupervised methat individual has premedication aide during an adult care home or of the following: (1) A five-hour training Department that including all of the following: a. The key principles of administration. b. The federal Centers Prevention guidelines applicable, safe injection procedures for monitor bleeding occurs or the exists. (2) A clinical skills evan NCAC 13F .0503 and (3) Within 60 days from individual must have on a. An additional 10-hood developed by the Deptraining and instruction 1. The key principles of administration. 2. The federal Centers Prevention guidelines applicable, safe injection.	Adult Care Home ining and Competency ents. 1, 2013, an adult care mallowing staff to perform dication aide duties unless evicusly worked as a gethe previous 24 months in successfully completed all program developed by the destraining and instruction of medication for Disease Control and on infection control and, if ion practices and ring or testing in which expotential for bleeding cluation consistent with 10A 10A NCAC 13G.0503. In the date of hire, the completed the following: our training program artment that includes in all of the following: of medication of Disease Control and on infection control and, if on practices and ring or testing in which	D935			

	of Health Service Regit IT OF DEFICIENCIES	7				
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED
			A. BUILDING:		1	
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		HALUSUUU1			12	2/13/2019
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	E, ZIP CODE		
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	OLIMAN DV O		VILLE, NC 27028			
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D935	Continued From pag	e 297	D935			
	by the Division of He	eveloped and administered alth Service Regulation in section (c) of this section.				
	This Rule is not met a TYPE B VIOLATION					
	reviews, the facility fa sampled staff (Staff C administered medical verification or complete medication administration, J, and K), complete Administration Skills K), and passed the staff	C, E, F, I, J, and K) who tions, had employment eted the 5, 10, or 15-hour ation courses (Staff C, E, F,				
	The findings are:					
	personnel record reversity -Staff C was hired on -There was no docume verification confirming within the past 24 mo -There was no document the 5, 10 or 15-hour retraining.	08/27/18. nentation of employment g Staff C worked as a MA				

checklist.

-Staff C passed the written MA exam on 11/20/17.

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/13/2019	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK		IVIEW DRIVE LLE, NC 27028	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D935	Continued From page	298	D935			
	Review of a residents Administration Record documented administ days in October 2019 2019, and 2 days in D Telephone interview of 4:20pm revealed: -She worked off and of and she recently carn in January 2019There was no verificat medication aide within available for reviewShe administered resincluding oral medicat and insulin, and she of stick blood sugarsShe did not know wh medication administrator when she complete -She was "checked of a Registered Nurse (F Interview with the Adr 5:35pm revealed: -She did not know Sta 5, 10, or 15-hour medit trainingShe did not know Sta Medication Administrat checklistShe had not audited for Staff C's employm [Refer to Tag D358 10] Medication Administration	d'electronic Medication d'(eMAR) revealed Staff C tration of medications 15 1, 14 days in November December 2019. With Staff C on 12/12/19 at the facility since 2010 to back to work at the facility ation for employement as an the last 24 months sidents' medications tions, eye drops, creams, obtained residents' finger the facility ation training she completed at the course. If on the medication cart' by RN) (date unknown). Ininistrator on 12/12/19 at the facility ation administration aff C had not completed a faction Skills Validation Staff C's personnel record				

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Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PI

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY
		HAL030007	B. WING		12/	/13/2019
	ROVIDER OR SUPPLIER	191 CRE	ADDRESS, CITY, STATE STVIEW DRIVE VILLE, NC 27028	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D935	Violation)]. Refer to interview with 12/12/19 at 5:25pm. Refer to telephone in on 12/12/19 at 8:30p. 2. Review of Staff Et personnel record revisites and documenting of the personnel record revisites and documenting. There was no documented the following of the Medication Admit checklist. There was no documented administes and documented administer and documented administer and documented and documented administer and documented and documented administer and documented administer and documented administer and documented administer and documented and documented administer and documented	Requirements (Type B th the Administrator on Interview with the LHPS nurse om. s, medication aide (MA) realed: 106/27/19. Interview of employment g Staff E worked as a MA onths. Interview of employment g Staff E worked as a MA onths. Interview with the LHPS nurse of employment g Staff E worked as a MA onths. Interview of employment g Staff E worked as a MA onths. Interview of employment g Staff E worked as a MA onths. Interview of employment g Staff E completed medication Staff E completed inistration Skills Validation Interview with the LHPS nurse onterview of the past 24 Interview with the LHPS nurse onterview with the LHP	D935			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL030007	B. WING		12/13/2	2019
	ROVIDER OR SUPPLIER	191 CRES	DRESS, CITY, STATIVIEW DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE ((X5) COMPLETE DATE
D935	medication administra-She did not know she in order to pass medicashe was "checked or 2019. -She did not know who skills Validation checked or 2019. -She did not know who skills Validation checked or 2019. -She was scheduled the exam in January 2020. -She did not know she made within 60 days and within strator told her had to take the writter. -The Administrator told provided in the completion of the Medication checklist for written MA test. -She was unable to lose skills Validation checked. She did not know Staton, or 15-hour medicast Telephone interview with the Medication checklist for the completed a Medication checklist for the complete days and the completed a Medication checklist for the complete days and the	d to provide her MA ity. e the 5, 10, or 15-hour ation training. e needed the 5-hour course cations to the residents. If by a nurse" in November y the Medication Clinical klist was not in her to take the state written MA to. e needed to take the written ays of completing the kills Validation checklist; the she had 90 days until she in MA exam. d her she "could has because [she] was cations]". Ininistrator on 12/12/19 at had 90 days from dication Clinical Skills schedule and take the cate the Medication Clinical klist completed for Staff E. off E did not complete the 5, ation administration training. With the LHPS nurse on evealed she had not on Administration Skills	D935			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL030007		A. BUILDING: B. WING	CONSTRUCTION	COM	E SURVEY PLETED	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATI	= ZIR CODE	12	2/13/2019
	TAGE OF CEDAR ROCK	191 CRE	ESTVIEW DRIVE	2, ZIF GODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D935	[Refer to Tag D932 G Infection Prevention F Violation)]. Refer to interview with 12/12/19 at 5:25pm. Refer to telephone int on 12/12/19 at 8:30pm 3. Review of Staff F's personnel record reve- Staff F was hired on -There was no docum verification confirming within the past 24 more -There was no docum either the 5, or 10 hou administration training -There was no docum the Medication Admin checklistStaff F passed the w Review of a residents documented administ days in October 2019 and 4 days in December Interview with Staff F revealed: -Staff F was hired as a -She administered medical and insulin, and she of stick blood sugarsShe had not complete	ation (Type B Violation)]. S. 131D-4.4A(b) ACH Requirements (Type B In the Administrator on erview with the LHPS nurse In. In medication aide (MA) Italed:	D935			

Division of	of Health Service Regu	lation			FOR	M APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	' '	SURVEY PLETED
		HAL030007	B. WING		12/13/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK		ESTVIEW DRIVE SVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D935	-She did not know sh 5-hour training prior to residents at the factor to residents at the factor to residents at the factor training prior to residents at the factor staff prior to the factor of the	e needed to complete the o administering medications cility. ministrator on 12/12/19 at aff F had not completed the lication administration Staff F's personnel record ent verification. OA NCAC 13F .1004(a) ation (Type B Violation)]. S. 131D-4.4A(b) ACH Requirements (Type B In the Administrator on erview with the LHPS nurse in. medication aide (MA) caled: 13/13/19. entation of employment in Staff I worked as a MA in this. entation Staff I completed inedication administration Medication Administration	D935			
		eMAR revealed Staff I ration of medications 2 days				

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D935 Continued From page 303 D935 in October 2019 and 3 days in November 2019. Observation of Staff I on 12/11/19 from 8:00am to 12:00pm revealed Staff I was administering medications to residents. Interview with Staff I on 12/11/19 at 4:38pm -She was hired as the Activity's Director and she then transitioned to a MA in March 2019. -She had completed the 15-hour medication administration training (date unknown). -She did not know why the 15-hour medication administration training was not in her personnel -She had been a nursing assistant for 30 years and she previously worked as a MA; she did not provide information regarding if she worked as a MA in the past 24 months. -She did not provide employment verification to the facility because she did not have it and she completed the MA training. -She started administering medications to residents in March 2019. Interview with the Administrator on 12/12/19 at 5:35pm revealed:

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-She knew Staff I had previously worked as a MA.

-She did not know why documentation of Staff I's 5, 10, or 15-hour medication administration training was not in her personnel record. -She had not audited Staff I's personnel record

-She did not know Staff I did not have documentation of the 5, 10, or 15-hour medication administration training.

for Staff I's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING ___ HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK

(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
D935	Continued From page 304	D935		
	[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)].			
	Refer to the interview with the Administrator on 12/12/19 at 5:25pm.			
	Refer to the telephone interview with the LHPS nurse on 12/12/19 at 8:30pm.			
	5. Review of Staff J's, medication aide (MA) personnel record revealed: -Staff J was hired on 03/13/19There was no documentation of employment			
1	verification confirming Staff J worked as aMA within the past 24 monthsThere was no documentation Staff J completed the 5, 10 hours, or 15-hour medication			
	administration trainingStaff J completed the Medication Administration Skills Validation checklist on 03/04/19Staff J passed the written MA exam on 03/26/14.			
	Review of a residents' eMAR revealed Staff J documented administration of medications 10 days in October 2019, 10 days in November 2019, and 1 day in December 2019.			
	Telephone interview with Staff J on 12/12/19 at 4:38pm revealed: -She was hired as a MA in February 2019Staff J administered medications to residents including oral medications, nebulizer's, eye drops,			
	and insulinShe did not know if she completed the 5, 10 or 15-hour medication administration trainingShe did not know she needed the 5-hour training before she administered medications to residents at the facility.			

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL030007	B. WING		12/13/2019
NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE	
THE HER	TAGE OF CEDAR ROCK	191 CRE	STVIEW DRIVE		
		MOCKS	VILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D935	Continued From page	e 305	D935		
D935	Interview with the Adi 5:35pm revealed: -She did not know Sta 5, 10, or 15-hour med trainingShe had not audited for Staff J's employmed [Refer to Tag D358 1] Medication Administration of Prevention For Violation)]. Refer to Tag D932 Good Infection Prevention For Violation)]. Refer to interview with 12/12/19 at 5:25pm. Refer to telephone into no 12/12/19 at 8:30pm. 6. Review of Staff K's personnel record reversity at 12	aff J had not completed the dication administration Staff J's personnel record ent verification. OA NCAC 13F .1004(a) ation (Type B Violation)]. S.S. 131D-4.4A(b) ACH Requirements (Type B h the Administrator on terview with the LHPS nurse m. , medication aide (MA) ealed: a documented hire date. hentation of employment ing Staff K worked as a MA	D935		
	in November 2019. Telephone interview v	with Staff K on 12/12/19 at			

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D935 Continued From page 306 D935 4:38pm revealed: -She was hired as the Activity's Director at the beginning of October 2019 and she also worked as a MA. -She administered oral medications to residents at the facility. -She worked 3rd shift and she did not obtain residents' finger stick blood sugars and she did not administer insulin because blood sugar checks and insulin were not scheduled at the times she worked. -She had completed the 5-hour MA training, but did not provide documentation to the facility because she was not asked for the documentation. -She had not completed the Medication Administration Skills Validation checklist because she was waiting on a nurse to complete the checklist with return demonstration. -She worked as a MA for over 10 years and never had a break in her employment. -She did not provide employment verification to the facility because she was never asked for the documentation. Interview with the Administrator on 12/12/19 at 5:35pm revealed: -She did not have documentation of Staff K's 5-hour medication administration training. -She did not know why documentation of Staff K's 5-hour medication administration training was not in her personnel record. -She had not requested documentation of Staff K's employment verification. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

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[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/13/2019
	ROVIDER OR SUPPLIER	191 CRE	DDRESS, CITY, STAT STVIEW DRIVE VILLE, NC 27028	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
D935	Interview with the Adr 5:25pm revealed: -She was responsible ensuring they were co-She was responsible 15-hour training was co-She did not know the required before MAs a residentsThe obligation for state her administrative duti responsibility of ensur training prior to administration Skills was conducted train Administration Skills was 12/12/19 at 8:30pm results -She had been the LH monthsShe had not conducted facilityThe Administrator did complete any Medicate checklists. The facility failed to as medication aide training employment verification within the last 24 months.	e interview with the LHPS 8:30pm. Ininistrator on 12/12/19 at for personnel records and emplete and up to date, for ensuring the 5, 10, or completed by staff. 5-hour training was administered medications to ffing duties interfered with her ing MAs had the required istering medication. Personnel Support (LHPS) ings including Medication /alidation checklist. With the LHPS nurse on evealed: PS nurse at the facility for 3 and any MA trainings at the lanot request for her to ion Clinical Skills Validation	D935		

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 308 D935 D935 and K), the Medication Administration Skills Validation were completed for 4 of 7 staff (Staff C, E, F, and K), and the state approved MA exam was passed within 60 days of the Medication Administration Skills Validation completion for 1 of 7 sampled staff (Staff E) prior to the staff administering medications to the residents, which resulted in an increased the risk for medication errors and exposing the residents to possible blood borne pathogen diseases from staff sharing glucometers between residents. This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020. D980 G.S. § 131D-25 Implementation D980 G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21.

This Rule is not met as evidenced by:

Based on interviews and record reviews, the Administrator failed to assure the management,

TYPE A2 VIOLATION

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D980 Continued From page 309 D980 operations, and policies of the facility were implemented and rules were maintained for ACH infection prevention requirements, medication administration, controlled substances, supervision, physical environment, personal care, housekeeping and furnishings, criminal background check, health care personnel registry check, nutrition and food services, residents' rights, health care personnel registry, incident and accident reports, activities, tuberculosis test, health care, ACH medication aides; training and competency requirements, test for tuberculosis, training on cardio-pulmonary resuscitation, examination and screening for controlled substances, personal care and other staffing, competency validation for licensed health professional support tasks, personal care training and competency, management of resident funds, training on care of diabetic residents, staffing of personal care aide supervisors, and implementation. The findings are: Interview with a first shift medication aide (MA) on 12/12/19 at 11:37am revealed she reported resident issues to the Administrator and the Supervisor. Interview with the Supervisor on 12/12/19 at 12:48pm revealed: -She reported issues with residents and staff to the Administrator. -The Administrator was responsible for the

2019.

operations of the facility.

5:25pm revealed:

Interview with the Administrator on 12/12/19 at

-She had been the Administrator since January

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D980 Continued From page 310 D980 -The facility's Resident Care Coordinator (RCC) left in late April 2019. -The RCC had been responsible for hiring staff, assuring staff qualifications were completed, including criminal backgrounds checks, Health Care Personnel Registry checks, Tuberculosis testings completed, and scheduling staff. -The facility had experienced a large number of staff turnover. -The Administrator had assumed the RCC duties as well as staffing for medication administration since the RCC left in April 2019. -"Her obligations for staffing duties interfered with her administrative duties." -The personnel records were being transitioned to electronic records, and some of the staffing documents were not available for review. Interview with the Administrator on 12/13/19 at 12:53pm revealed: -She was at the facility at least 5 days a week and at least 10 hours a day. -She was responsible for the total operations of the facility including adherence to rules and

- regulations.
- -Her duties included hiring new staff, scheduling staff to work, marketing and admissions, business office functions, and passing medications when she could not get a medication aide to work.
- -It was difficult for her to fulfill her responsibilities as Administrator because she was responsible for more than Administrator tasks.
- 1. Based on record reviews, observations and interviews the facility failed to contact the health care and mental health providers and specialist health care providers for 7 of 11 sampled residents (Residents #1, #3, #5, #9, #12, #14, and #18) regarding a resident with a pressure

Division of Health Service Regulation

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION. (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D980 Continued From page 311 D980 ulcer (#3), a resident with extreme muscle weakness resulting in falls who missed a nerve conduction study and two MRI appointments (#12), a resident with swollen lower extremities that caused pain when walking (#5), a resident with aggressive/agitated behaviors that yelled at other residents, beat on the walls and threw chairs (#18), two residents with rashes which made the residents uncomfortable (#1 and #9) and a glucometer which did not work properly (#14). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 2. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered by a licensed practicing practitioner for 6 of 6 sampled residents (#1, #2, #3, #4, #5 and #12) related to a topical antiseptic (#3), an anti-coagulant and a narcotic pain reliever (#4), a rapid acting insulin (#2, #3 and #12), a diuretic (#5), and a gastric acid reducer (#1). [Refer to Tag D358 10A NCAC13F .1004(a) Medication Administration (Type A2 Violation)]. 3. Based on interviews, record reviews, and observations, the facility failed to assure 1 of 5 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 5 sampled residents (Resident #5) who was constantly disorientated and had wandering behaviors and eloped from the facility without staff's knowledge. [Refer to Tag D067 10A

(Type B Violation)].

NCAC 13F .0305(h)(4) Physical Environment

4. Based on record reviews and interviews, the facility failed to assure 9 of 12 sampled staff (Staff A, B, C, E, F, G, I, J, and K) were tested for Tuberculosis (TB) disease upon hire. [Refer to Tag D131 10A NCAC 13F .0406(a) Test for

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Violation)].

cardio-pulmonary resuscitation (CPR) for 27 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019. [Refer to Tag D167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B

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12. Based on record reviews, observation and interviews the facility failed to provide supervision to meet the needs of 2 of 5 sampled residents (Residents #5 and #12) who had muscle weakness causing him to repeatedly fall (#12) and a resident who eloped without staff's

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D980 Continued From page 314 D980 knowledge (#5). [Refer to Tag D270 10A NCAC 13F .0902(b) Personal Care and Supervision (Type B Violation)]. 13. Based on record review and interviews the facility failed to assure 1 of 17 sampled residents (Resident #19) were free of abuse and neglect resulting a resident (#19) being physically assaulted by a medication aide (Staff M). [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. 14. Based on observations, interviews, and record reviews, the facility failed to assure records of the administration of controlled substances were maintained, accurate and reconciled for 5 of 8 sampled residents (Residents #4, #5, #15, #17 and #18) who were prescribed Oxycodone (#4 and #17), lyrica (#4), zolpidem tartrate (#4), hydrocodone (#15), and lorazepam (#5 and #18). [Refer to Tag D392 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)]. 15. Based on record reviews and interviews the facility failed to report allegations of physical abuse of a resident (Resident #19) by a medication aide (Staff F), to the Health Care Personnel Registry (HCPR). [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]. 16. Based on observation, record reviews, and interviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control (CDC) and Prevention guidelines to assure proper infection control procedures for the use of glucometers for

2 of 3 sampled residents (Residents #2, and#14) with diabetes, resulting in sharing glucometers

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL030007	(X2) MULTIPLE (A. BUILDING: B. WING	CONSTRUCTION	СОМ	E SURVEY IPLETED 2/13/2019
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D980	between residents. 131D-4.4 ACH Infect Requirements (Type 17. Based on record facility failed to assure (MAs) sampled (Stat Administrator had common and atory annual in [Refer to Tag D934 (Infection Prevention Violation)]. 18. Based on observe record reviews, the fact sampled staff (Staff administered medical verification or complemedication administration Skills K), and passed the sexam (Staff E) prior to [Refer to Tag D935 (Medication Aide Trains Violation)]. 19. Based on intervificacility failed to assure screening for the presubstances was comstaff (Staff B, C, E, F, Administrator prior to G.S. 131D-45(a) Exaccontrolled Substance The Administrator necesponsibility for the	[Refer to Tag D932 G.S. ction Prevention e B Violation)]. d reviews and interviews, the are 7 of 7 medication aides off C, E, F, I, J, and K) and the empleted the state approved affection control training. G.S. 131D-4.5B(a) ACH Requirements (Type B vations, interviews and facility failed to assure 6 of 7 C, E, F, I, J, and K) who actions, had employment eted the 5, 10, or 15-hour ration courses (Staff C, E, F, ed the Medication Validation (Staff C, E, F, and state written medication aide to administering medications. G.S. 131D-4.B(b) ACH ining and Competency (Type diews and record reviews, the re an examination and escence of controlled angleted for 8 of 12 sampled of I, I, J, K) and the other. [Refer to Tag D992 amination and Screening for es (Type B Violation)].	D980			

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE. REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D980 Continued From page 316 D980 while a resident who was constantly disoriented eloped from the facility without staff's knowledge; a resident experiencing burning and stinging from a stage II pressure ulcer; a resident having frequent falls due to muscle weakness; aresident in pain and discomfort due to swollen legs, ankles and feet; a resident exhibiting aggressive psychotic behaviors towards other residents: residents having rashes due to lack of personal care that burned and caused pain; a resident with a missed gastroenterologist appointment; a resident who had physcian's orders for medical procedures which were not implemented; a resident being pushed and hit by a staff (Staff M); a resident admitted to the facility and not administered lovenox injection for 3 days; a resident whose glucometer was not working properly which led to staff sharing glucometers; medications not being available and not administered as ordered; inaccurate accounting for the administration of controlled substances; 5 of 69 sampled shifts where there was no medication aide (MA) supervior on the premises and no staff available to administer medications to residents; 6 MAs who had not completed the MA requirements prior to administering medications and 8 of 69 sampled shifts where staff was short of aide hours and not present at all times to meet the needs of residents. This neglect resulted in substantial risk of physical harm and neglect and constitutes a Type A2

Division of Health Service Regulation

2019.

Violation.

The facility provided a plan of protection in accordance with G.S. 131 D-34 on 12/12/19.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 12,

STATE FORM

NAME OF PROVIDER OR SUPPLIER THE HERITAGE OF CEDAR ROCK (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPANDED TO THE PROPERTY OF CORRECTION SHOULD SH		IENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE : COMPL	
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D992 Continued From page 317 D992	D992	Continued From page	317	D992			
G.S. § 131D-45. Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant prescribing physician first provides to the adult care home written verification from the applicant's prescribing physician hat every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician hall include the name of the controlled substance, the prescribed dosage andfrequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening to verify the results of the prior examination and screening to verify the results of the prior examination and screening to verify the results of the prior examination and screening to verify the results of the prior examination and screening to verify the results of the prior examination and screening to verify the results of the prior examination and screening to verify the results of the prior examination and screening to verify the results of the prior examination and screening to the prior examinati	D992	G.S. § 131D-45. Example presence of control for applicants for emphomes. (a) An offer of employ licensed under this Arconditioned on the apexamination and scresubstances. The example conducted in according to the enditor of applicants and may the results of the applicants and may the results of the applicant unless the adult care home wapplicant's prescribing controlled substance in examination and screen physician to treat the applicant unless than the applicant of the applic	mination and screening for olled substances required ployment in adult care home ficle to an applicant is plicant's consent to an ening for controlled mination and screening shall rdance with Article 20 of meral Statutes. A screening is a single-use test device examination and screening be administered on-site. If icant's examination and expresence of a controlled exare home shall not employ the applicant first provides to written verification from the examination and screening is prescribed by that applicant's medical or in. The verification from the examination is the name of the controlled sibed dosage and frequency, which the substance is lit of an applicant's or on and screening indicates trolled substance, the adult the a second examination by the results of the prior	D992			

Division of	of Health Service Regu	lation				
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D992	This Rule is not met a	as evidenced by:	D992	OLICIES WERE IN PLACE TO ASSUR	RE PPD	
	facility failed to assurs screening for the presubstances was comstaff (Staff B, C, E, F, Administrator prior to The findings are: 1. Review of Staff B's personnel record revestaff B was hired in A-There was no documthe examination and scontrolled substance. There was no conseivamination. Interview with Staff B revealed: She was hired as a F-She provided person including bathing, toiles he did not complete screening for controlled substance acontrolled substance screening prior to hires. The Administrator was completing her papers	pleted for 8 of 12 sampled I, J, K) and the hire. , personal care aide (PCA) ealed: August 2019. hentation Staff B completed screen for the presence of ht for a drug screening and On 12/11/19 at 4:29pm PCA at the end of July 2019. al care to residents eting, and feeding. e an examination and ed substances. e was required to complete e examination and es. es responsible for work when she was hired.		POLICIES WERE IN PLACE TO ASSURESTING WAS IN PLACE AT THE TIMIRE FOR EMPLOYEES. ALL EMPLOYEEQUIRED TO HAVE A DRUG TEST COMPLETED PRIOR TO HIRE. WHILE SURVEY HAD BEEN COMPLETED, TOWNERS FOUND SOME ADDITIONAL DOCUMENTATION THAT SOME HAD TESTED, THE OWNER'S CHOSE TO PROBLEM TO THE OWNER'S CHOSE TO PROBLEM TO THE OWNER'S THAT FAILED TEST WERE TERMINATED BY THE OWNED T	ME OF YEES ARE AFTER HE DEEN ERFORM TAFF. D THESE WNER'S E BEEN OF CARE OUNTY	

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DEFICIENCY)	COMPLETE				
D934 Continued From page 288 D934	TE DATE				
D934 Continued From page 288 D934					
This Rule is not met as evidenced by:					
TYPE B VIOLATION					
Based on record reviews and interviews, the					
facility failed to assure 7 of 7 medication aides					
(MAs) sampled (Staff C, E, F, I, J, and K) and the					
Administrator had completed the state approved					
mandatory annual infection control training.					
The Sedimentary					
The findings are:					
1. Review of Staff C's, medication aide(MA),					
personnel record revealed:					
-Staff C was hired on 08/27/18.					
-Staff C passed the written medication aide exam					
on 11/20/17.					
-There was documentation Staff C had completed an online computer training of the state approved					
annual infection control training dated 09/06/19.					
-There was no documentation for subsequent					
completion of the state approved infection control					
training with skills requiring return demonstration.					
Interview with Ct-EC as 40/40/40 at 4.00					
Interview with Staff C on 12/12/19 at 4:20pm revealed:					
-She was rehired in January 2019.					
-She had worked at the facility off and on since					
2010.					
-She completed the state approved mandatory					
infection control training online on the computer.					
-She did not know the state approved mandatory infection control training could not be completed					
as an online computer training.					
-She did not know there was a skills validation					
section that required returned demonstration.					
[Refer to Tag D932 G.S. 131D-4.4A(b) ACH					
Infection Prevention Requirements.(Type B Violation).]					

Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL030007	(X2) MULTIPLE (A. BUILDING: B. WING	CONSTRUCTION	СОМ	E SURVEY PLETED
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D934	Continued From pag	e 289	D934			
	Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.					
	Refer to interview wit 12/12/19 at 5:25pm.	th the Administrator on				
	2. Review of Staff E's personnel record rev -Staff E was hired on					
	-Staff E had not take medication aide exar	n and passed the written n as of 12/10/19.				
	an online computer to	ntation Staff E had completed raining of the state approved fection control training dated				
	-There was no docum	nentation for subsequent te approved mandatory ing.				
	Interview with Staff E revealed:	on 12/12/19 at 10:37am				
	the facility in July 201 the facility on 09/05/1					
	 She worked as a MA medications to reside She completed the s 					
	infection control training-She did not know the	ing online on the computer. state approved mandatory ing could not be completed				
	as an online computer-She did not know the					
		ent on 12/12/19 at 4:00pm a MA at the facility and				

Division (of Health Service Requ	ulation			FOR	RM APPROVED
STATEMEN'	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
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D934	Continued From page	ue 290	D934			
	[Refer to Tag D932 G	G.S. 131D-4.4A(b) ACH Requirements.(Type B				
	Refer to the telephon contracted Pharmacy 9:40am.	ne interview with the y Consultant on 12/10/19 at				
	Refer to interview wit 12/12/19 at 5:25pm.	th the Administrator on				
	personnel record reve					
	 Staff F was hired on Staff F passed the w on 03/24/10. 	ros/16/19. vritten medication aide exam				
	-There was no docum completed training of mandatory annual inf					
	Interview with Staff F revealed: -She worked as a MA	on 12/11/19 at 5:00pm				
	08/16/19.	edications to residents at the				
	-She completed the s infection control traini	state approved mandatory ing online on the computer.			JLD BE COMPLETE	
	infection control traini as an online compute					
		ere was a skills validation returned demonstration.				
		ent on 12/12/19 at 4:00pm a MA at the facility and tions to the resident.				

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		
		HAL030007	B. WING		12/13/2019
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	E, ZIP CODE	
THE HERI	TAGE OF CEDAR ROCK	(STVIEW DRIVE		
	0/18/4/17// 07		VILLE, NC 27028		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFINED TO THE	D BE COMPLETE
D934	Continued From page	e 291	D934		
	Violation).]				
	Refer to the telephon contracted Pharmacy 9:40am.	e interview with the Consultant on 12/10/19 at			
	Refer to interview wit 12/12/19 at 5:25pm.	h the Administrator on			
	personnel record reversible -Staff I was hired on (03/13/19. itten medication aide exam			
	completed training of				
	Interview with Staff I or revealed:	on 12/11/19 at 4:38pm			
		e Activity's Director and she medication aide (MA) in			
	-She did not know sta	ng online on the computer. Ite approved mandatory ng could not be completed			
	Observation of Staff I 12:00pm revealed Sta medications to reside				
		.S. 131D-4.4A(b) ACH Requirements.(Type B			
	Refer to the telephone contracted Pharmacy 9:40am.	e interview with the Consultant on 12/10/19 at			

Division of Health Service Regulation

Division of Health Service Regul	lation		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL030007	B. WING	12/13/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATE, ZIP CODE	
THE HERITAGE OF CEDAR ROCK		VIEW DRIVE	
THE HEIGHT OF GEDAR ROOK		LE, NC 27028	

NIAME OF I	PROVIDED OF SUPPLIED	OTDEET ADE	DECC CITY OF	ATE 7ID CODE	
INAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST. FVIEW DRIVE	ATE, ZIP CODE	
THE HER	ITAGE OF CEDAR ROCK		LLE, NC 27028	8	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMAT	S ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D934	Continued From page 292		D934		
	Refer to interview with the Administrator on 12/12/19 at 5:25pm.				
	5. Review of Staff J's, medication aide (MA) personnel record revealed: -Staff J was hired on 03/13/19Staff J passed the written medication aide on 03/26/14There was documentation Staff J had compan online computer training of the state appropriate mandatory annual infection control training 03/05/19There was no documentation for subseque completion of the state approved mandatory infection control training. Interview with a resident on 12/12/19 at 4:00 revealed Staff J was a MA at the facility and administered medications to the resident. Telephone interview with Staff J on 12/12/19 4:38pm revealed: -She was hired as a MA in February 2019She completed the state approved mandator infection control training online on the composite did not know the state approved mandator infection control training could not be completed as an online computer trainingShe did not know there was a skills validating section that required returned demonstration [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19:40am.	exam pleted roved dated int / Dpm I atory eted on n.			

PRINTED: 01/13/2020 **FORM APPROVED** Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D934 Continued From page 293 D934 Refer to interview with the Administrator on 12/12/19 at 5:25pm. 6. Review of Staff K's, medication aide (MA), personnel record revealed: -Staff K did not have a hire date in her record -Staff K passed the written medication aide exam on 08/28/13. -There was no documentation Staff K had completed the state approved mandatory annual infection control training. -There was no documentation for subsequent completion of the state approved mandatory infection control training. Telephone interview with Staff K on 12/12/19 at

4:38pm revealed:

- -She was hired as the Activity's Director at the beginning of October 2019 and she also worked as a medication aide (MA).
- -She completed the state approved mandatory infection control training online on the computer. -She did not know there was a skills validation section that required returned demonstration.

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements.(Type B Violation).]

Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am.

Refer to interview with the Administrator on 12/12/19 at 5:25pm.

- 7. Review of the Administrator's personnel record revealed:
- -The Administrator was hired on 11/01/18.
- -The Administrator passed the written medication

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D934 Continued From page 294 D934 aide exam on 01/10/19. -There was documentation the Administrator had completed an online computer training of the state approved mandatory annual infection control training dated 03/05/19. -There was no documentation for subsequent completion of the state approved mandatory infection control training. Interview with the Administrator on 12/12/19at 5:35pm revealed: -She was hired as the Administrator in November 2018 and started working at the facility in January 2019. -She completed the state approved mandatory infection control training online on the computer on 03/05/19. [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements. (Type B Violation).] Refer to the telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Telephone interview with the contracted Pharmacy Consultant on 12/10/19 at 9:40am revealed: -He was responsible for providing infection control training for the MAs at the facility.

Division of Health Service Regulation

vear ago.

-He was hired by the contracted pharmacy one

contracted pharmacy had approval by the State for the annual infection control to be taken on the

-He was told by a member at the contracted pharmacy, when he was hired, that the

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D934 Continued From page 295 D934 computer along with other trainings required. -He did not know the state approved mandatory annual infection control training had skills evaluations that had to be validated by a return demonstration therefore could not be approved as an online computer training with out documentaiton of return demonstration. -He would arrange for a corporate nurse or contracted nurse to come to the facility to do competency validations for the infection control training and complete training certifications. Interview with the Administrator on 12/12/19at 5:25 revealed: -The facility contracted pharmacy taught the state approved mandatory infection control training on -She did not know the state approved mandatory infection control training could not be completed as an online computer training. -She did not know there was a skills validation section that required return demonstration. The facility failed to assure the state approved mandatory annual infection control training for 7 of 7 sampled medication aides (Staff C, E, F, I, J, and K) and the Administrator was completed resulting in staff sharing of alucometers between 2 residents exposing the residents to possible blood borne pathogen diseases. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/19 for this violation. CORRECTION DATE FOR THE TYPE B

Division of Health Service Regulation

2020.

VIOLATION SHALL NOT EXCEED JANUARY 27,

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D935 G.S.§ 131D-4.5B(b) ACH Medication Aides; D935 Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed thefollowing: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and

exists.

Prevention guidelines on infection control and, if

applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL030007	(X2) MULTIPLE (A. BUILDING: B. WING	CONSTRUCTION	CON	E SURVEY IPLETED
		HAL030007	B. Willia			2/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
THE HERI	ITAGE OF CEDAR ROC	191 CRI	ESTVIEW DRIVE			
			VILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D935	Continued From pag	ge 297	D935			
	by the Division of He	leveloped and administered ealth Service Regulation in osection (c) of this section.				
	reviews, the facility f sampled staff (Staff administered medica					
	I, J, and K), complet Administration Skills K), and passed the s	ration courses (Staff C, E, F, ed the Medication Validation (Staff C, E, F, and state written medication aide to administering medications.				
	The findings are:					
	personnel record rev -Staff C was hired or -There was no docur verification confirmin within the past 24 me	n 08/27/18. mentation of employment g Staff C worked as a MA				
	the 5, 10 or 15-hour trainingThere was no docur the Medication Admi checklist.	medication administration mentation Staff C completed nistration Skills Validation written MA exam on 11/20/17.				

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D935 D935 Continued From page 298 Review of a residents' electronic Medication Administration Record (eMAR) revealed Staff C documented administration of medications 15 days in October 2019, 14 days in November 2019, and 2 days in December 2019. Telephone interview with Staff C on 12/12/19 at 4:20pm revealed: -She worked off and on at the facility since 2010 and she recently came back to work at the facility in January 2019. -There was no verification for employement as a medication aide within the last 24 months available for review. -She administered residents' medications including oral medications, eye drops, creams, and insulin, and she obtained residents' finger stick blood sugars. -She did not know which 5, 10, or 15-hour medication administration training she completed or when she completed the course. -She was "checked off on the medication cart" by a Registered Nurse (RN) (date unknown). Interview with the Administrator on 12/12/19 at 5:35pm revealed: -She did not know Staff C had not completed the 5, 10, or 15-hour medication administration -She did not know Staff C had not completed a Medication Administration Skills Validation checklist. -She had not audited Staff C's personnel record for Staff C's employment verification. [Refer to Tag D358 10A NCAC 13F .1004(a)

Medication Administration (Type B Violation)].

[Refer to Tag D932 G.S. 131D-4.4A(b) ACH

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK MOCKSVILLE, NC 27028 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 299 D935 Infection Prevention Requirements (Type B Violation)]. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 2. Review of Staff E's, medication aide (MA) personnel record revealed: -Staff E was hired on 06/27/19. -There was no documentation of employment verification confirming Staff E worked as a MA within the past 24 months. -There was no documentation Staff E completed the 5, 10 or 15-hour medication administration training. -There was no documentation Staff E completed the Medication Administration Skills Validation -There was no documentation Staff E passed the state written MA exam. Review of a residents' eMAR revealed Staff E documented administration of medications 12 days in October 2019, and 4 days in November 2019. Interview with Staff E on 12/12/19 at 10:37am -She was originally hired in June 2019, she left the facility in July 2019, and she was re-hired at the facility on 09/05/19. -She had been a MA since 2004, but she was not employed as a MA consecutively over the past 24 months.

-She administered residents' medications

including oral medications, eye drops, and insulin, and she obtained residents' finger stick blood

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) P

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE O	(X3) DATE SURVEY COMPLETED		
ANDFLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:	A. BUILDING:		-C ! ED
		HAL030007	B. WING		12 <i>I</i> ·	13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE		
THE HERI	TAGE OF CEDAR ROCK	(STVIEW DRIVE			
	0.000		VILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D935	sugarsShe was never aske paperwork to the faci -She did not complete medication administration -She did not know shin order to pass medi -She was "checked or 2019She did not know who skills Validation checked personnel recordShe was scheduled exam in January 2022 -She did not know show the waster within 60 days and within 60	d to provide her MA lity. e the 5, 10, or 15-hour ation training. e needed the 5-hour course cations to the residents. If by a nurse" in November by the Medication Clinical cklist was not in her to take the state written MA o. e needed to take the written ays of completing the kills Validation checklist; the r she had 90 days until she m MA exam. Id her she "could cons because [she] was cations]". ministrator on 12/12/19 at thad 90 days from dication Clinical Skills o schedule and take the ocate the Medication Clinical klist completed for Staff E. aff E did not complete the 5, ation administration training. with the LHPS nurse on evealed she had not on Administration Skills	D935			

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:

HAL030007

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:

B. WING

(X3) DATE SURVEY
COMPLETED

12/13/2019

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF F	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY	Y, STATE, ZIP CODE	
THE HED	ITAGE OF CEDAR ROCK	191 CRESTVIEW DRI	₹IVE	
THE HER	TAGE OF GEDAR ROOK	MOCKSVILLE, NC 27	27028	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY I REGULATORY OR LSC IDENTIFYING INFORMA	FULL PREFIX		(X5) COMPLETE E DATE
PREFIX	Continued From page 301 Medication Administration (Type B Violation [Refer to Tag D932 G.S. 131D-4.4A(b) ACI [Infection Prevention Requirements (Type B Violation)]. Refer to interview with the Administrator or 12/12/19 at 5:25pm. Refer to telephone interview with the LHPS on 12/12/19 at 8:30pm. 3. Review of Staff F's, medication aide (MA personnel record revealed: -Staff F was hired on 08/16/19There was no documentation of employment verification confirming Staff F worked as all within the past 24 monthsThere was no documentation Staff F compeither the 5, or 10 hour, or the 15-hour mediadministration trainingThere was no documentation Staff F compeither the 5 and documentation Staff F compei	D935 D935 D935 D935 D936 D937 D937 D938 D938	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
	and 4 days in December 2019. Interview with Staff F on 12/11/19 at 5:00pr revealed: -Staff F was hired as a MA on 08/16/19.	m s ms, ger		

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING _ HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIR CODE

AIVIE OF F		DDRESS, CITY, STAT	E, ZIP CODE	
HE HERI	TAGE OF CEDAR ROCK	STVIEW DRIVE		
	MOCKS	VILLE, NC 27028		
(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) COMPLET DATE
D935	Continued From page 302	D935		
	-She did not know she needed to complete the			
	5-hour training prior to administering medications	4		
	to residents at the facility.			
	Interview with the Administrator on 12/12/19 at			
	5:35pm revealed:			
- 1	-She did not know Staff F had not completed the 5, 10, or 15-hour medication administration	1 1		
	training.			
- 1	-She had not audited Staff F's personnel record	1 1		
	for Staff F's employment verification.			
	[Refer to Tag D358 10A NCAC 13F .1004(a)			
	Medication Administration (Type B Violation)].			
	[Refer to Tag D932 G.S. 131D-4.4A(b) ACH			
- 1	Infection Prevention Requirements (Type B			
	Violation)].			
	Refer to interview with the Administrator on			
	12/12/19 at 5:25pm.			
	Refer to telephone interview with the LHPS nurse on 12/12/19 at 8:30pm.			
	Review of Staff I's, medication aide (MA)			
	personnel record revealed:			
	-Staff I was hired on 03/13/19.			
	-There was no documentation of employment			
	verification confirming Staff I worked as aMA			
	within the past 24 months.			
	-There was no documentation Staff I completed			
	the 5, 10 or 15-hour medication administration			
	training.			
	-Staff I completed the Medication Administration			
	Skills Validation checklist on 03/04/19.			
	-Staff I passed the written MA exam on 06/12/02.			
	Review of a residents' eMAR revealed Staff I			
	documented administration of medications 2 days			

Division of Health Service Regulation

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D935 Continued From page 303 D935 in October 2019 and 3 days in November 2019. Observation of Staff I on 12/11/19 from 8:00am to 12:00pm revealed Staff I was administering medications to residents. Interview with Staff I on 12/11/19 at 4:38pm -She was hired as the Activity's Director and she then transitioned to a MA in March 2019. -She had completed the 15-hour medication administration training (date unknown). -She did not know why the 15-hour medication administration training was not in her personnel -She had been a nursing assistant for 30 years and she previously worked as a MA; she did not provide information regarding if she worked as a MA in the past 24 months. -She did not provide employment verification to the facility because she did not have it and she completed the MA training. -She started administering medications to residents in March 2019. Interview with the Administrator on 12/12/19 at 5:35pm revealed: -She knew Staff I had previously worked as a MA. -She did not know Staff I did not have documentation of the 5, 10, or 15-hour medication administration training. -She did not know why documentation of Staff I's 5, 10, or 15-hour medication administration training was not in her personnel record. -She had not audited Staff I's personnel record for Staff I's employment verification.

[Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES. (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D935 Continued From page 304 D935 [Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)]. Refer to the interview with the Administrator on 12/12/19 at 5:25pm. Refer to the telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. 5. Review of Staff J's, medication aide (MA) personnel record revealed: -Staff J was hired on 03/13/19. -There was no documentation of employment verification confirming Staff J worked as aMA within the past 24 months. -There was no documentation Staff J completed the 5, 10 hours, or 15-hour medication administration training. -Staff J completed the Medication Administration Skills Validation checklist on 03/04/19. -Staff J passed the written MA exam on 03/26/14. Review of a residents' eMAR revealed Staff J documented administration of medications 10 days in October 2019, 10 days in November 2019, and 1 day in December 2019. Telephone interview with Staff J on 12/12/19 at 4:38pm revealed: -She was hired as a MA in February 2019. -Staff J administered medications to residents including oral medications, nebulizer's, eye drops, and insulin. -She did not know if she completed the 5, 10 or 15-hour medication administration training. -She did not know she needed the 5-hour training before she administered medications to residents

at the facility.

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
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D935	Continued From page	305	D935		
D935	Interview with the Adi 5:35pm revealed: -She did not know Sta 5, 10, or 15-hour med trainingShe had not audited for Staff J's employmed [Refer to Tag D358 10] Medication Administration [Refer to Tag D932 Galfection Prevention For Violation)]. Refer to interview with 12/12/19 at 5:25pm. Refer to telephone into on 12/12/19 at 8:30pm. 6. Review of Staff K's personnel record reversity at 8:30pm. 6. Review of Staff K's personnel record reversity at 8:30pm. 7. There was no document within the past 24 monormore was no document within the past 24 monormore was no document within the past 24 monormore was no document to 5, 10 or 15-hour in trainingThere was no document the Medication Adminormore was no document the Medication Adminormore was no document within the past 24 monormore was no document to 5, 10 or 15-hour in trainingThere was no document within the past 24 monormore was no document within th	ministrator on 12/12/19 at aff J had not completed the lication administration Staff J's personnel record ent verification. DA NCAC 13F .1004(a) ation (Type B Violation)]. S. 131D-4.4A(b) ACH Requirements (Type B In the Administrator on erview with the LHPS nurse in. In medication aide (MA) ealed: In documented hire date, entation of employment ing Staff K worked as a MA	D935		
	Telephone interview v	vith Staff K on 12/12/19 at			

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D935 Continued From page 306 D935 4:38pm revealed: -She was hired as the Activity's Director at the beginning of October 2019 and she also worked as a MA. -She administered oral medications to residents at the facility. -She worked 3rd shift and she did not obtain residents' finger stick blood sugars and she did not administer insulin because blood sugar checks and insulin were not scheduled at the times she worked. -She had completed the 5-hour MA training, but did not provide documentation to the facility because she was not asked for the documentation. -She had not completed the Medication Administration Skills Validation checklist because she was waiting on a nurse to complete the checklist with return demonstration. -She worked as a MA for over 10 years and never had a break in her employment. -She did not provide employment verification to the facility because she was never asked for the documentation. Interview with the Administrator on 12/12/19 at 5:35pm revealed: -She did not have documentation of Staff K's 5-hour medication administration training. -She did not know why documentation of Staff K's 5-hour medication administration training was not in her personnel record. -She had not requested documentation of Staff K's employment verification. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].

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[Refer to Tag D932 G.S. 131D-4.4A(b) ACH Infection Prevention Requirements (Type B

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **191 CRESTVIEW DRIVE** THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 307 D935 Violation)]. Refer to interview with the Administrator on 12/12/19 at 5:25pm. Refer to the telephone interview with the LHPS nurse on 12/12/19 at 8:30pm. Interview with the Administrator on 12/12/19 at 5:25pm revealed: -She was responsible for personnel records and ensuring they were complete and up to date. -She was responsible for ensuring the 5, 10, or 15-hour training was completed by staff. -She did not know the 5-hour training was required before MAs administered medications to residents. -The obligation for staffing duties interfered with her administrative duties and interfered with her responsibility of ensuring MAs had the required training prior to administering medication. -The Licensed Health Personnel Support (LHPS) nurse conducted trainings including Medication Administration Skills Validation checklist. Telephone interview with the LHPS nurse on 12/12/19 at 8:30pm revealed: -She had been the LHPS nurse at the facility for 3 months. -She had not conducted any MA trainings at the -The Administrator did not request for her to complete any Medication Clinical Skills Validation checklists. The facility failed to assure the 5, 10, or 15-hour medication aide training with no previous

employment verification as a medication aide within the last 24 months were completed for 6 of 7 sampled medication aides (Staff C, E, F, I, J,

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 308 D935 D935 and K), the Medication Administration Skills Validation were completed for 4 of 7 staff (Staff C, E, F, and K), and the state approved MA exam was passed within 60 days of the Medication Administration Skills Validation completion for 1 of 7 sampled staff (Staff E) prior to the staff administering medications to the residents, which resulted in an increased the risk for medication errors and exposing the residents to possible blood borne pathogen diseases from staff sharing glucometers between residents. This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/11/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 27, 2020. D980 G.S. § 131D-25 Implementation D980 G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the Administrator failed to assure the management,

Division of Health Service Regulation

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D980	Continued From pag	je 309	D980		
	operations, and police	cies of the facility were			
		les were maintained for ACH			
		requirements, medication	1		
	administration, contro				
		l environment, personal care,	1 1		
	housekeeping and fu	ırnishings, criminal			
l II	background check, h	nealth care personnel registry			
	check, nutrition and f	food services, residents'			
	-	ersonnel registry, incident and			
	_	ivities, tuberculosis test,			
		edication aides; training and			
		nents, test for tuberculosis,			
1		Imonary resuscitation,			
	examination and scre	_			
		l care and other staffing,			
	competency validation	tasks, personal care training			
		inagement of resident funds,	1 11		
		abetic residents, staffing of			
	personal care aide su				
	implementation.	aportiono, aria			
	,				
- 1	The findings are:				
	Interview with a first s	shift medication aide (MA) on			
		revealed she reported			
		Administrator and the			
	Supervisor.				
	Laranta and a	, anala :			
		pervisor on 12/12/19 at			
	12:48pm revealed:	with recidents and staff to			
	the Administrator.	with residents and staff to			
		as responsible for the			
	operations of the facil				
	Interview with the Ad	ministrator on 12/12/19 at			
	5:25pm revealed:				
		dministrator since January			

2019.

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D980	Continued From page	e 310	D980			
	left in late April 2019The RCC had been in assuring staff qualification including criminal back Care Personnel Registestings completed, a -The facility had expestaff turnoverThe Administrator has well as staffing for since the RCC left in a -"Her obligations for sher administrative duties."	rienced a large number of d assumed the RCC duties medication administration April 2019. taffing duties interfered with ies." ds were being transitioned to d some of the staffing				
	12:53pm revealed: -She was at the facility at least 10 hours a da -She was responsible the facility including ar regulationsHer duties included h staff to work, marketin business office function medications when she aide to workIt was difficult for her as Administrator becamore than Administrat. 1. Based on record reinterviews the facility for care and mental health health care providers fresidents (Residents #	for the total operations of otherence to rules and iring new staff, scheduling g and admissions, ons, and passing could not get a medication to fulfill her responsibilities use she was responsible for or tasks. Views, observations and ailed to contact the health in providers and specialist				

Division of Health Service Regulation

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D980 Continued From page 311 D980 ulcer (#3), a resident with extreme muscle weakness resulting in falls who missed a nerve conduction study and two MRI appointments (#12), a resident with swollen lower extremities that caused pain when walking (#5), a resident with aggressive/agitated behaviors that velled at other residents, beat on the walls and threw chairs (#18), two residents with rashes which made the residents uncomfortable (#1 and #9) and a glucometer which did not work properly (#14). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 2. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered by a licensed practicing practitioner for 6 of 6 sampled residents (#1, #2, #3, #4, #5 and #12) related to a topical antiseptic (#3), an anti-coagulant and a narcotic pain reliever (#4), a rapid acting insulin (#2, #3 and #12), a diuretic (#5), and a gastric acid reducer (#1). [Refer to Tag D358 10A NCAC13F .1004(a) Medication Administration (Type A2 Violation)]. 3. Based on interviews, record reviews, and observations, the facility failed to assure 1 of 5 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 5 sampled residents (Resident #5) who was constantly disorientated and had wandering behaviors and eloped from the facility without staff's knowledge. [Refer to Tag D067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. 4. Based on record reviews and interviews, the facility failed to assure 9 of 12 sampled staff (Staff A, B, C, E, F, G, I, J, and K) were tested for Tuberculosis (TB) disease upon hire. [Refer to Tag D131 10A NCAC 13F .0406(a) Test for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER OR SUPPLIER THE HERITAGE OF CEDAR ROCK (X4) ID PREFIX TAG (X5) MULTIPLE CONSTRUCTION (X4) ID PREFIX TAG (X6) MULTIPLE CONSTRUCTION (X7) MOCKSVILLE, NC 27028 (X6) MULTIPLE CONSTRUCTION A BUILDING: B WING (X7) DEFICIENCY STATE, ZIP CODE 191 CRESTYLEW DRIVE MOCKSVILLE, NC 27028 DPROVIDER'S PLAN OF CA (EACH CORRECTIVE ADD REFIX TAG PREFIX TAG PROVIDER'S PLAN OF CA (EACH CORRECTIVE ADD REFIX TAG PROVIDER'S PLAN OF CA (EACH CORRECTIVE ADD REFIX TAG PROVIDER'S PLAN OF CA (EACH CORRECTIVE ADD REFIX TAG PROVIDER'S PLAN OF CA (EACH CORRECTIVE ADD REFIX TAG PROVIDER'S PLAN OF CA (EACH CORRECTIVE ADD REFIX TAG PREFIX TAG ROSS-REFERENCE DTO THE PREFIX TAG ROSS-REFERENCE DTO TAG ROSS-REFERENCE DTO TAG PREFIX TAG ROSS-REFERENCE DTO TAG ROSS-REFERENCE DTO TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDER'S TAG PREFIX TAG PREFIX TAG PROVIDER'S TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDER'S TAG PREFIX TAG PREFIX TAG PROVIDER'S TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDER'S TAG PREFIX TAG PROVIDER'S		
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NAME OF PROVIDER OR SUPPLIER THE HERITAGE OF CEDAR ROCK (X4) ID PREFIX TAG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D980 Continued From page 312 Tuberculosis (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to assure 7 of 12 sampled staff (Staff B, E, F, G, I, J, and K) had a criminal background check completed prior to hire. [Refer to Tag D139 10A NCAC 13F .0407(a) (7) Criminal Background Check (Type B Violation)]. 6. Based on record reviews and interviews, the facility failed to assure 4 of 11 sampled staff (Staff C, D, I, and J) who provided personal care to residents had documentation of successful completion of an 80 hour personal care to residents had documentation program. [Refer to Tag D150 10A NCAC 13F .0501 Personal Care Training (Type B Violation)]. 7. Based on observations, record reviews and interviews, the facility failed to assure 2 of 7 staff sampled (Staff F) and the Administrator who administered insulin and obtained finger stick blood sugars for residents completed training on care of the diabetic residents completed training on care of the diabetic residents prior to the administration of insulin. [Refer to Tag D164 10A NCAC 13F .0505 Training on Care of Diabetic Residents (Type B Violation)]. 8. Based on observations, record reviews and interviews, the facility failed to assure at least one	CON	IPLETED
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D80 Continued From page 312 Tuberculosis (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to assure 7 of 12 sampled staff (Staff B, E, F, G, I, J, and K) had a criminal background check completed prior to hire. [Refer to Tag D139 10A NCAC 13F. 0407(a) (7) Criminal Background Check (Type B Violation)]. 6. Based on record reviews and interviews, the facility failed to assure 4 of 11 sampled staff (Staff C, D, I, and J) who provided personal care to residents had documentation of successful completion of an 80 hour personal care training and competency evaluation program. [Refer to Tag D150 10A NCAC 13F. 0501 Personal Care Training (Type B Violation)]. 7. Based on observations, record reviews and interviews, the facility failed to assure 2 of 7 staff sampled (Staff F) and the Administrator who administered insulin and obtained finger stick blood sugars for residents completed training on care of the diabetic resident prior to the administration of insulin. [Refer to Tag D164 10A NCAC 13F. 0505 Training on Care of Diabetic Residents (Type B Violation)]. 8. Based on observations, record reviews and interviews, the facility falled to assure at least one		
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG CROSS-REFERENCED TO THE DEFICIENCY) D980 Continued From page 312 D980		
D980 Continued From page 312 Tuberculosis (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to assure 7 of 12 sampled staff (Staff B, E, F, G, I, J, and K) had a criminal background check completed prior to hire. [Refer to Tag D139 10A NCAC 13F .0407(a) (7) Criminal Background Check (TypeB Violation)]. 6. Based on record reviews and interviews, the facility failed to assure 4 of 11 sampled staff (Staff C, D, I, and J) who provided personal care to residents had documentation of successful completion of an 80 hour personal care training and competency evaluation program. [Refer to Tag D150 10A NCAC 13F .0501 Personal Care Training (Type B Violation)]. 7. Based on observations, record reviews and interviews, the facility failed to assure 2 of 7 staff sampled (Staff F) and the Administrator who administered insulin and obtained finger stick blood sugars for residents completed training on care of the diabetic resident prior to the administration of insulin. [Refer to Tag D164 10A NCAC 13F .0505 Training on Care of Diabetic Residents (Type B Violation)]. 8. Based on observations, record reviews and interviews, the facility failed to assure at least one		(X5)
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completed within the last 24 months a course on		
cardio-pulmonary resuscitation (CPR) for 27 of 69		
shifts sampled for 23 days in September 2019,		
Tag D167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B		
Violation)].		1
completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) for 27 of 69 shifts sampled for 23 days in September 2019, October 2019, and November 2019. [Refer to		

DIVISION	of Health Service Regu	liation			
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL030007	B. WING		12/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STDEET A	ADDRESS, CITY, STAT	E ZIR CODE	
	TO THE TOTAL OF TH		ESTVIEW DRIVE	L,ZIF GODE	
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D980	9. Based on record residents residents residing a shifts sampled for 23 October 2019, and Notage D188 10ANCAC and Other Staffing (Type 10. Based on intervier facility failed to assure were staffed with a mincluding 16 hours of hours of supervision whours of supervision who within 500 feet of the shifts when there was an unsprinkled facility NCAC 13F .0605(c) Saide Supervisor (Type 11. Based on observatives, the facility fawas provided to 8 of 1 #5, #7, #8, #11, #12, for care to three residents residents having to wa #8, and #20), and residents having to wa #8, and #20). Personal Cal Violation)].	eviews and interviews, the e the minimum number of all times to meet the needs at the facility for 8 of 69 days in September 2019, ovember 2019. [Refer to 13F .0604(e) Personal Care ype B Violation)]. Ews and record review, the efirst and second shifts inimum of 20 hours personal care staff and 8 with up to 4 hours counted hours, and third shift was of personal care aide and 8 in there was not a supervisor facility for 5 of 69 sampled a census of 31 residents in . [Refer to Tag D214 10A staffing of Personal Care a B Violation)]. Itions, interviews and record illed to assure personal care 11 sampled residents (#1, #18, and #20) including foot as (#5, #12, and #18,); ait for incontinence care (#7, idents with a yeast rash (#1 g D269 10A NCAC 13F re and Supervision (Type B reviews, observation and ailed to provide supervision 2 of 5 sampled residents	D980		
	(Residents #5 and #12 weakness causing him and a resident who ele	n to repeatedly fall (#12)			

Division	of Health Service Regi	ulation			101	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL030007		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	1 1	E SURVEY PLETED
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D980	knowledge (#5). [Ref 13F .0902(b) Person (Type B Violation)]. 13. Based on record facility failed to assur (Resident #19) were resulting a resident (assaulted by a medic to Tag D338 10A NC. Rights (Type B Violation) Rights (Type B Violation) Rights (Type B Violation) Rights (Type B Violation) Residents #4, #5, #1 prescribed for 5 of 8 s (Residents #4, #5, #1 prescribed Oxycodom zolpidem tartrate (#4) lorazepam (#5 and # NCAC 13F .1008(a) (B Violation)]. 15. Based on record facility failed to report abuse of a resident (Find Registry (Find Registry (Find Registry (Type B Violation)]. 16. Based on observinterviews, the facility written infection contributed for the facility	fer to Tag D270 10A NCAC al Care and Supervision Treview and interviews the re 1 of 17 sampled residents free of abuse and neglect #19) being physically ration aide (Staff M). [Refer AC 13F .0909 Resident rion)]. Trations, interviews, and racility failed to assure stration of controlled residents 5, #17 and #18) who were re (#4 and #17), lyrica (#4), refer to Tag D392 10A Controlled Substances (Type reviews and interviews, the rallegations of physical Resident #19) by a f F), to the Health Care record reviews, and record reviews, and record reviews, and	D980			

Division of Health Service Regulation

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	r Prevention Violation)]. views and interviews, the of of 7 medication aides of E, F, I, J, and K) and the oleted the state approved tion control training. 131D-4.5B(a) ACH quirements (Type B) ons, interviews and ity failed to assure 6 of 7 of E, F, I, J, and K) who has, had employment of the 5, 10, or 15-hour on courses (Staff C, E, F, and the written medication aide deministering medications. 131D-4.B(b) ACH of and record reviews, the mexamination and the of controlled	Prevention Violation)]. views and interviews, the of of 7 medication aides of E. F. I. J. and K. and the oleted the state approved tion control training. 131D-4.5B(a) ACH quirements (Type B) ons, interviews and of ity failed to assure 6 of 7 of E. F. I. J. and K. Who of the state apployment of the 5, 10, or 15-hour of courses (Staff C, E, F. T.	Prevention Violation)]. views and interviews, the 7 of 7 medication aides 8, E, F, I, J, and K) andthe leted the state approved tion control training. 131D-4.5B(a) ACH quirements (Type B) ons, interviews and ity failed to assure 6 of 7 E, F, I, J, and K) who is, had employment if the 5, 10, or 15-hour on courses (Staff C, E, F, he Medication idation (Staff C, E, F, and e-written medication aide dministering medications. 131D-4.B(b) ACH g and Competency (Type s and record reviews, the in examination and icce of controlled ted for 8 of 12 sampled J, K) and the e. [Refer to Tag D992 ination and Screening for	Prevention Violation)]. views and interviews, the Y of 7 medication aides E. F., I., J., and K) and the leted the state approved tion control training. 131D-4.5B(a) ACH quirements (Type B) ons, interviews and ity failed to assure 6 of 7 E. F., I., J., and K) who is, had employment If the 5, 10, or 15-hour on courses (Staff C, E, F, he Medication idiation (Staff C, E, F, and is written medication aide diministering medications. 131D-4.B(b) ACH g and Competency (Type s and record reviews, the in examination and ice of controlled ited for 8 of 12 sampled J., K) and the e. [Refer to Tag D992 ination and Screening for

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D980	while a resident who eloped from the facilitar resident experiencina stage II pressure ultifrequent falls due to nin pain and discomformand feet; a resident expsychotic behaviors to residents having rash care that burned and a missed gastroenter resident who had phy procedures which were resident being pushed a resident admitted to administered lovenox resident whose glucor properly which led to administered as order for the administration of 69 sampled shifts with medications and employed and no staff available to residents; 6 MAs with MA requirements priomedications and 8 of staff was short of aide all times to meet the neglect resulted in suth harm and neglect and Violation. The facility provided a accordance with G.S. CORRECTION DATE	was constantly disoriented by without staff's knowledge; and burning and stinging from over; a resident having muscle weakness; aresident at due to swollen legs, ankles exhibiting aggressive owards other residents; as due to lack of personal caused pain; a resident with plogist appointment; a scian's orders for medical are not implemented; and and hit by a staff (Staff M); at the facility and not injection for 3 days; a meter was not working staff sharing glucometers; available and not red; inaccurate accounting of controlled substances; 5 where there was no supervior on the premises to administer medications ho had not completed the reto administering as sampled shifts where thours and not present at leeds of residents. This obstantial risk of physical constitutes a Type A2	D980			

PRINTED: 01/13/2020 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING HAL030007 12/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 191 CRESTVIEW DRIVE THE HERITAGE OF CEDAR ROCK **MOCKSVILLE, NC 27028** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D992 Continued From page 317 D992 D992 G.S.§ 131D-45 (a) Examination and screening D992 G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency. and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination

and screening to verify the results of the prior

examination and screening.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION :	(X3) DATE S	
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THE HERI	TAGE OF CEDAR ROCK		STVIEW DRIVE			
			VILLE, NC 2702			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D992	Continued From page	e 318	D992			
	facility failed to assurs screening for the pressubstances was computed (Staff B, C, E, F, Administrator prior to The findings are: 1. Review of Staff B's personnel record reversations and scontrolled substance. There was no documple was no consequent to the examination and scontrolled substance. There was no consequent as a reversal to the provided person including bathing, toiled she did not complete substance.	and record reviews, the e an examination and sence of controlled pleted for 8 of 12 sampled I, J, K) and the hire. , personal care aide (PCA) ealed: August 2019. hentation Staff B completed screen for the presence of at for a drug screening and on 12/11/19 at 4:29pm PCA at the end of July 2019. al care to residents eting, and feeding. e an examination and		POLICIES WERE IN PLACE TO ASSUFTESTING WAS IN PLACE AT THE TIM HIRE FOR EMPLOYEES. ALL EMPLOY REQUIRED TO HAVE A DRUG TEST COMPLETED PRIOR TO HIRE. WHILE SURVEY HAD BEEN COMPLETED, THOWNERS FOUND SOME ADDITIONAL DOCUMENTATION THAT SOME HAD TESTED, THE OWNER'S CHOSE TO PLORUG TESTS ON ALL REMAINING STOWN STAFF MEMBERS THAT FAILED TEST WERE TERMINATED BY THE OMMEDIATELY. AS OF 2/7/2020, ALL RESIDENTS HAV PLACE IN AN APPROPRIATE LEVEL OF MITH THE ASSISTANCE OF DAVIE COURS. AND THE HOME HAS BEEN CLO	AFTER AFTER BEEN ERFORM AFF. OTHESE WNER'S E BEEN DF CARE DUNTY	
	a controlled substance screening prior to hire -The Administrator was	e was required to complete e examination and				
	Interview with the Adr 5:40pm revealed: -She was responsible	ninistrator on 12/12/19 at				