STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey with an onsite visit on February 02, 2021, a desk review survey from February 03, 2021 to February 05, 2021, and a telephone exit on February 05, 2021.	{D 000}		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the facility was free of hazards as evidenced by a resident carrying a cleaning chemical in the hallway and topical and oral medications left unsecured in occupied resident rooms accessible to all residents in the facility including residents known to have dementia and/or wandering behaviors. The findings are: 1. Observation of the 100 hall on 02/02/21 at 10:00am revealed: -There was a resident carrying a white manufacturer spray bottle with blue writing and a cleaning cloth. -The resident was wiping the handrails of the facility with the cloth. -The resident was not wearing eye protection or gloves.	D 079		

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D 079	Continued From page 1 -The housekeeper looked at surveyor then approached the resident. -The housekeeper took the spray bottle and cleaning cloth from the resident. Interview with the transporter/housekeeper on 02/02/21 at 10:55am revealed: -The resident was wiping door knobs with window cleaner. -He did not know where the resident obtained the window cleaner. -The resident was sometimes confused. -Residents were not to have cleaning agents or access to cleaning agents. -He took the window cleaner from the resident. -He thought the resident was cleaning with window cleaner, but he was mistaken. -The resident was using a disinfecting cleaner instead of the window cleaner. -Cleaning products were to be locked and stored in the janitorial closet. Review of the label on 02/02/21 at 10:57am on the container identified by the housekeeper as the disinfectant cleaner taken away from the resident revealed: -It was labeled as a disinfectant cleaner used against bacteria, antibiotic resistant bacteria, viruses, fungi, mold, and mildew. -Avoid contact with eyes, skin and clothing. -Wear chemical splash goggles and chemical resistant gloves. -There was a precautionary statement of causing serious eye irritation. -If eye exposure, rinse cautiously with water for at least 15 minutes. Seek medical attention if eye irritation persists. -Immediately flush skin with water if contact occurred. If irritation occurred and persisted, get medication attention.	D 079		

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D 079	Continued From page 2	D 079		

-If swallowed rinse mouth, drink a capful of milk or water.

Interview with the resident on 02/02/21 at 11:00am revealed:
-He liked to help clean the facility.
-He was given the disinfectant cleaner used this morning "a while back".
-He would wipe down the handrails and door knobs with the disinfectant cleaner.
-He could not remember who gave him the cleaner.
-He had kept the disinfectant cleaner in his room.

Interview with the Administrator on 02/02/21 at 2:00pm revealed:
-It was expected residents to not have access to cleaning chemicals.
-The transporter/housekeeper told her he had taken the disinfectant cleaner from the resident.

Refer to interview with the Resident Care Coordinator (RCC) on 02/02/21 at 4:30pm.

2. Observation of resident room #228 on 02/02/21 at 10:30am revealed:
-There was an opened container of an over the counter (OTC) Mucinex (a chest decongestant).
-There was a container of hydrogen peroxide (a liquid used as an antiseptic and bleacher).
-There was a container of Flonase (a nasal inhalant used to treat allergy symptoms).
-There was an opened used packet of Neosporin (a topical triple antibiotic ointment used to treat infection).
-There was a bottle of sore throat spray.
-There was a container of Soothe eye drops (an eye drop used to treat dry eyes).

Interview with the resident who resided in room

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#228 on 02/02/21 at 10:32am revealed:
-He purchased the Mucinex himself. He could not remember when he purchased it.
-He would use the Mucinex about 3 - 4 times a month for chest congestion.
-He last used the Mucinex 2 days ago.
-He would use the Flonase for nasal congestion.
-He used the Flonase 1 or 2 times in the last 3 - 4 months for nasal congestion.
-He would use the sore throat spray about 5 times a week for sore throat relief.
-He last used the Neosporin 2 days ago for dry skin.
-He would use the Hydrogen Peroxide as a skin antiseptic about 1 time a week.
-He would use the eye drops to soothe dry eyes about 1 - 2 times a week.
-The Resident Care Coordinator (RCC) knew the medications were in his room.

A second interview with the resident who resided in room #228 on 02/02/21 at 4:55pm revealed he had a lockable drawer in his dresser, but he did not secure his medications.

Observation of resident room #205 on 02/02/21 at 10:50am revealed:
-There was a container of OTC Antacid relief with approximately 50% remaining on the window ledge.
-There was bottle of Hydrogen Peroxide with approximately 75% remaining on the top of an end table.

Interview with the resident who resided in room #205 on 02/02/21 at 10:52am revealed:
-She would use the Antacid as needed for indigestion. She could not remember the last time she used it.
-She would use the Hydrogen Peroxide to bleach

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D 079	Continued From page 4 the yellow out of her fingernails. She could not remember the last time she used it. A second interview with the resident who resided in room #205 on 02/02/21 at 4:58pm revealed she had a lockable drawer in her dresser, but she did not secure her medications. Interview with the medication aide/supervisor (MA/S) on 02/02/21 at 1:00pm revealed: -MAs and personal care aides (PCAs) would not inspect resident rooms for unsecured medications unless directed by the RCC. -If she saw medications in resident rooms, she would tell the RCC. -She had not seen unsecured mediations in any resident rooms. Interview with the RCC on 02/02/21 at 4:30pm revealed: -She was not concerned of the resident who was confused, had dementia, and wandered having access to unsecured medications in resident rooms because staff would monitor that resident. -The confused residents did not wander, and she was not concerned about them going into resident rooms where medications were not locked in a secured area. -The medications in resident rooms should have been locked in the resident's personal locked drawer to prevent access by other residents. Interview with the Administrator on 02/02/21 at 2:50pm revealed residents were expected to lock all medications in their lockable dresser drawer located in their room. Refer to interview with the RCC on 02/02/21 at 4:30pm. _____	D 079		

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D 079	Continued From page 5 Interview with the Resident Care Coordinator (RCC) on 02/02/21 at 4:30pm revealed: -There were 6 residents who were confused or had dementia residing in the facility. -One of those 6 residents would wander in other resident rooms.	D 079		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider (PCP) of a resident's agitation, hallucinations, and elopement behaviors (Resident #1) and blood pressure readings above the ordered parameters (Resident #4) which resulted in a delay of care for 2 of 5 sampled residents (#1 and #4). The findings are: 1. Review of Resident #1's current FL-2 dated 12/18/20 revealed: -Diagnoses included chronic pain syndrome, chronic kidney disease, encephalopathy, vitamin D deficiency, hypersensitivity lung disease, insomnia, arthritis, hepatitis, anemia, constipation, glaucoma, hypokalemia, depressive disorder, gastroesophageal reflex disease, sleep apnea, cardiovascular disease, vertigo, and kidney transplant. -The disoriented section and inappropriate	{D 273}		

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behavior were blank.
-Resident #2's level of care included semi-ambulatory with a cane and needed assistance with bathing and dressing.

Review of Resident #1's Care Plan dated 01/28/21 revealed:
-Her mental and social history included wandering.
-If she did not have enough sleep, she became confused and tried to leave.
-She had pacing behavior and agitation.

Review of Resident #1's Accident/Incident Report dated 02/02/21 at 10:34am revealed:
-The location of incident was Resident #1's room.
-It was witnessed and reported.
-Resident #1 was hallucinating and was sleep deprived.
-There was no injury noted.
-Resident #1 was taken to the Emergency Department (ED).
-Resident #1's primary care provider (PCP), the Administrator were notified, and there was a fax sent to the county Department of Social Services.

Review of Resident #1's Progress Note dated 01/31/21 at 2:22pm revealed:
-Resident #1's behavior was described as she was seeing and hearing things.
-She was trying to elope.
-Safety interventions were implemented which included watching Resident #1 frequently and staff were notified of the safety interventions.

Review of Resident #1's Progress Note dated 02/02/21 at 1:30am revealed Resident #1 was hallucinating and was delusional and thought someone was trying to kill her.

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{D 273}	Continued From page 7 Review of Resident #1's Progress Note dated 02/02/21 at 2:42am revealed: -Resident #1 was having severe hallucinations and paranoid situations tonight. -She was unable to sit still and was seeing things that were not there. -She had been walking in and out of her room and she stated that something was under her bed and there was "Boo Boo" on her floor. -She was also saying her family members were dead and someone was sending a dog to kill her. -She had not been to sleep at all, and she also would not eat anything because she thought "they" were trying to poison her. -She was unstable and barely could walk without leaning over and every time she heard someone talk, she thought it was about her. -Any and every little noise she heard made her jump and she thought someone was coming to attack and kill her. -She would not lay down or close her eyes she was constantly crying and talking about things that were not making sense at all. -She thought the woman who had come to hurt her family member was the person that was coming to kill her. -She really was unable to be left alone for a long period of time. -The Resident Care Coordinator (RCC) and the Administrator were notified without a specific time of notification documented. Review of Resident #1's Progress Note dated 02/02/2021 at 8:55am revealed: -There was a significant change or change in condition, the description included mental status/hallucinating. -The PCP was notified on 02/02/21 at 8:55am. Review of Resident #1's Progress Note dated	{D 273}		

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{D 273}	Continued From page 8 02/02/2021 at 8:59am revealed: -There was sleep pattern change noted on 02/02/21 at 9:00am. -Resident #1 was sleeping less, the description included no sleep in the last 3-4 days with anxiety and nausea. -There was no medication given. -The PCP was notified on 02/02/21 at 9:00am. Observation of the facility's hallway outside of Resident #1's room on 02/02/21 at 10:12-10:15am revealed: -There were three local law enforcement officers. -There were two Emergency Medical Services (EMS) employees with an empty stretcher. -The Administrator, the Activities Director, and a medication aide (MA) were entering and exiting Resident #1's room. Interview with police officer on 02/02/21 at 10:15am revealed: -Resident #1 was having "a lot" of hallucinations which started this weekend. -Resident #1 had not slept for five days. -They were there to assist EMS in case Resident #1 was combative. -If Resident #1 was not combative, she would ride with EMS personnel to the ED. Observation of Resident #1 on 02/02/21 at 10:24am revealed her walking out of her room to the stretcher. Interview with a MA on 02/02/21 at 10:25am revealed: -She worked at the facility both days this weekend as the MA with Resident #1. -Resident #1 had been hallucinating since the weekend (01/30/21 and 01/31/21). -Over the weekend, she was keeping an eye on	{D 273}		

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{D 273}	Continued From page 9 Resident #1 by monitoring her more frequently which meant visually checking on Resident #1 within her room and having conversations with Resident #1 to provide reassurance to her. -Resident #1 was started on an antibiotic "recently" for a urinary tract infection; she thought she administered Resident #1's first dose Saturday (01/30/21) or Sunday (01/31/21). -Resident #1 had "more" hallucinations over the last couple of days. -Resident #1 had not been sleeping. -She saw her PCP the week of 01/25/21. -The facility had been "trying" to get mental health set up for Resident #1. -Resident #1's responsible party, her supervisor, and EMS were notified this morning, 02/02/21, because Resident #1 was having an "increase" in hallucinations. Interview with another MA on 02/02/21 at 4:45pm revealed: -She last worked with Resident #1 on 02/01/21 on 2nd shift (3:00pm-11:00pm). -During this shift Resident #1 reported to the MA, she was scared but could never tell staff what she was afraid of and that she was hearing dogs barking. -The MA stated she sat with the resident several times throughout the shift and reassured her that she was safe. -The MA did not report the behaviors to the PCP because Resident #1 calmed down after reassurance was provided. -This was the first time the MA noted Resident #1 with these behaviors. -Resident #1 was normally alert and oriented to person and surroundings and was able to communicate wants and needs. Telephone interview with a MA on 02/03/21 at	{D 273}		

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{D 273}	Continued From page 10 1:31pm revealed: -The previous PCP's notification process was to fax the PCP notification form to a resident's PCP and complete a progress note within the computer. -The facility's previous PCP retired in November 2020. -She was not sure if there was timeframe when the MA or RCC) should receive a response from the PCP. -She would always call the PCP when she needed an immediate response from the PCP. -If she could not reach the PCP by phone or had not received a return call from the PCP within an hour, she would escalate the issue to the RCC. -Before the pandemic, Resident #1 was used to being mobile outside of the facility; she was able to see her family members. -It had been getting her down, she had become more depressed since she was not able to have family visitation. -The RCC had been in contact "more" with Resident #1's PCP about her behaviors. -On 01/31/21, Resident #1 was very agitated, she was pacing back and forth from her room to the facility's entrance/exit. -She had her coat and gloves on. -She was repeating over and over, "I have to go, I have to go." -On 01/31/21, the MA was monitoring Resident #1 every 10 minutes and would give her verbal reassurance. -On 01/31/21, the MA did not directly talk with Resident #1's PCP. -The MA had spoken with the RCC on "several" occasions over the weekend of 01/30/21-01/31/21 about the increase in Resident #1's behaviors. -She was not sure if the RCC had directly contacted Resident #1's PCP on 01/31/21.	{D 273}		

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{D 273}	Continued From page 11 Telephone interview with the RCC on 02/04/21 at 2:30pm revealed: -The MA would fax the PCP notification along with the resident's medication list to the PCP for any resident's behavior changes/anything not "normal." -The MA did not call the PCP. -The MA was responsible for confirming the transmission of the fax to the PCP by stapling the fax confirmation of the PCP notification to the original PCP notification. -The PCP would send a response via fax. -The PCP notification and the fax confirmation would remain in her possession until she received a PCP response to the fax. - "Anything" that goes over the fax would be placed in the RCC's box. -She was responsible for following-up with the PCP if there was no response to the faxed PCP notification. -She has not had any issues with receiving the PCP's response via fax, it was usually within 2 days. Telephone interview with Resident #1's PCP on 02/05/21 at 8:41am revealed: -Her preferred method to receiving notifications about the residents was through the facility's purchased text messaging system which was Health Insurance Portability and Accountability Act (HIPAA) protected. -When the facility sent the PCP notification via fax, the faxes arrived at the PCP's corporate office. -The corporate office would filter out the PCP's specific faxes to her which meant it could be a day or two until she received the faxed PCP notification. -When a message was sent to her via the	{D 273}		

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facility's text messaging system, her phone would buzz with the notification from the facility.
-She became Resident #1's PCP on 11/20/20.
-She was only aware of one episode when Resident #1 was hallucinating, having agitation, and was fatigued.
-She received notification on 02/02/21 via fax, the time was received was not provided.
-She was not notified on 01/31/21 of Resident #1's hallucinations, agitation, or elopement behaviors.
-It would have been important to be notified of Resident #1's behaviors on 01/31/21.
-If she was notified on 01/31/21, she would have been able to implement immediate interventions to address Resident #1's declining health condition and address her safety issues.

Telephone interview with the RCC on 02/05/21 at 10:05am revealed:
-The MAs did not use the facility's text messaging system because the application could not be set up on the computer, they used for resident medication administration documentation.
-The MAs still had access to PCP notification to send via fax or could contact the PCP by phone.
-If MAs did not receive a PCP response from the PCP by fax or phone notification and they could not "handle" the resident, they should send the resident to the hospital, and contact her.
-She had no concerns with any delays when communicating with the PCP.
-When a resident was experiencing aggression, confusion, anything out of their "normal" the MA should send the resident to the hospital.
-She was notified by a MA working first shift on 01/31/21 of Resident #1's hallucinations of seeing someone in her room.
-On 01/31/21, she did not notify Resident #1's PCP of her behaviors because Resident #1 was

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SOMERSET COURT OF ROCKY MOUNT	918 WESTWOOD DRIVE ROCKY MOUNT, NC 27802

(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 273}	Continued From page 13 not escalating and she did not have "enough" sleep. -She expected the MAs to offer to send the resident to the hospital. Telephone interview with the Administrator on 02/05/21 at 1:06pm revealed: -The facility was unable to locate Resident #1's PCP notification dated 01/31/21. -She expected Resident #1's PCP to be notified on 01/31/21 because she had a change in her "normal" status. Refer to telephone interview with the Administrator on 02/05/21 at 1:06pm. 2. Review of Resident #4's FL-2 dated 12/18/20 revealed diagnoses included hypertension, type II diabetes, chronic obstructive pulmonary disease (COPD), dementia without behaviors, chronic kidney disease and anemia. Review of Resident #4's signed physician orders dated 12/18/20 revealed: -There was an order to check blood pressure once weekly and was scheduled every Thursday. -The primary care physician (PCP) was to be notified if the systolic blood pressure (SBP) was greater than 180mmHg or less than 80mmHg. -The PCP was to be notified if the diastolic blood pressure (DBP) was greater than 100mmHg or less than 50mmHg. -There was an order for Clonidine 0.2mg one tablet three times daily. (Clonidine is used to lower blood pressure.) -There was an order for Carvedilol 6.25mg one tablet twice daily with meals. (Carvedilol is used to lower blood pressure and treat heart failure.) -There was an order for Hydralazine 50mg	{D 273}		

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{D 273}	Continued From page 14	{D 273}		

administer one and a half tablets, for a total dose of 75mg, four times daily. (Hydralazine is used to lower blood pressure.)
-There was an order for Lisinopril 40mg one tablet once daily. (Lisinopril is used to lower blood pressure and treat heart failure.)

Review of Resident #4's December 2020 medication administration record (MAR) revealed:
-There was an entry for the blood pressure to be checked weekly on Thursdays.
-Resident #4's blood pressure on 12/10/20 was documented to be 183/92 mmHg.
-There was no documentation noted on the MAR that the PCP was notified.

Review of Resident #4's January 2021 MAR revealed:
-There was an entry for the blood pressure to be checked weekly on Thursdays.
-Resident #4's blood pressure on 01/21/21 was documented to be 182/87 mmHg.
-There was no documentation noted on the MAR that the PCP was notified.

Telephone interview with Resident #4's current PCP on 02/05/21 at 8:43am revealed:
-She was notified via fax of Resident #4's blood pressure reading of 183/92 mmHg documented on 12/10/20 but received the fax notification on 12/11/20; no new orders were written.
-She was not notified of Resident #4's blood pressure reading of 182/87 mmHg documented on 01/21/21.
-Not being aware of elevated blood pressures could have caused Resident #4 to have cardiac issues such as a stroke or a heart attack.
-She expected to be notified immediately of abnormal vital signs or changes in a residents' status so that interventions could be implemented

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{D 273}	Continued From page 15	{D 273}		

immediately.
-She preferred to be notified by the facility via telephone or the text message system to ensure that concerns were addressed immediately.

Telephone interview with a personal care aide/medication aide (PCA/MA) on 02/03/21 at 2:50pm revealed:
-He had administered medications to Resident #4 on different occasions.
-He was aware that Resident #4 had an order for blood pressure checks weekly but was not aware of the blood pressure parameters.
-If any resident had a SBP greater than 200 mmHg, he would recheck the blood pressure three times and would notify the PCP if the SBP was greater than 200 mmHg.
-He would send a fax to the PCP that noted the abnormal blood pressure and placed the fax confirmation in the Resident Care Coordinator's (RCC) communication box in the medication room for her to follow up with any new orders received.

Telephone interview with the Administrator on 02/03/20 at 4:19pm revealed:
-It was the responsibility of the MA to notify the PCP immediately via telephone of vital signs that were outside of ordered parameters.
-The PCP should be notified of vital sign results outside of the ordered parameters via telephone and not via fax.
-Abnormal vital signs communicated via fax could delay the PCP putting interventions in place for residents.
-The MAs updated the RCC on the abnormal vital signs and new orders received from the PCP.

Telephone interview with the RCC on 02/04/20 at 1:08pm revealed:

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{D 273}	Continued From page 16 -It was the responsibility of the MAs to notify the PCP of abnormal vital signs. -The MAs notified the PCP of abnormal vital signs via fax; the fax confirmation was placed in the RCC's communication box located in the medication room and the RCC used the fax confirmation to track the PCP's response. -The PCP received and reviewed the information faxed from the facility and the PCP faxed over new orders and/or acknowledgement of receiving the facility's fax. -She had no problems with the PCP responding to information faxed from the facility; the PCP usually responded to faxes within two days. Refer to telephone interview with the Administrator on 02/05/21 at 1:06pm. Telephone interview with the Administrator on 02/05/21 at 1:06pm revealed: -She expected staff to handle immediate responses with a phone call to the PCP. -Immediate responses to the PCP constituted anything out of the normal, severe injury, the resident had a fall and hit their head, heart attack, and a mental status change which included hallucinations, delusions, and trying to leave the facility. -All other needed PCP responses could be send to the PCP via fax. -All PCP communications would be followed up within a 24-hour time frame by the RCC. The facility failed to ensure referral to the hospital for medical evaluation for Resident #1 who was having agitation, hallucinations, anxiety, fatigue, and elopement behaviors from 01/31/21-02/02/21 which resulted in a delay to address her declining medical condition and her safety; and ensure notification of Resident #4's primary care provider	{D 273}		

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{D 273}	Continued From page 17 (PCP) was notified of blood pressure readings above parameters which could have resulted in a stroke or a heart attack. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/04/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 23, 2021.	{D 273}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure provision of adequate and appropriate care and services to residents related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider (PCP) of a resident's agitation, hallucinations, and elopement behaviors (Resident #1) and blood pressure readings above the ordered parameters (Resident #4) which resulted in a delay of care for 2 of 5 sampled residents (#1 and #4). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type B	{D912}		

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{D912}	Continued From page 18 Violation)].	{D912}		