

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL007019</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/02/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASHINGTON MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>609 WEST 2ND STREET WASHINGTON, NC 27889</b>
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D 000	Initial Comments  The Adult Care Licensure Section and the Beaufort County Department of Social Services conducted an annual survery on 11/02/21	D 000		
D 113	<p>10A NCAC 13F .0311(d) Other Requirements</p> <p>10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure hot water temperatures were maintained at 100° to 116° degrees Fahrenheit (F) for 4 fixtures in the common residents' bathroom located on the east hall with temperatures of 122.6°degrees F to 125.6° degrees F.</p> <p>The findings are:</p> <p>Observation of the common residents' bathroom on the east hall on 11/02/21 at 9:58am revealed:</p> <ul style="list-style-type: none"> <li>-The hot water temperature at the sink was 126.6°F.</li> <li>-The hot water temperature at the shower was 122.6°F.</li> <li>-There was visible steam coming from the running hot water in the shower.</li> </ul>	D 113		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 113	<p>Continued From page 1</p> <p>Interview with a resident on 11/02/21 at 10:01am revealed: -He had added extra cold water to the hot water when it felt too hot. -He had not been scolded or burned because of the high hot water temperature. -He had not asked staff to turn down the hot water.</p> <p>Interview with the Medication Aide (MA) on 11/02/21 at 10:11am revealed: -He did not know when he last checked hot water temperatures. -He had kept hot water logs and discarded all of the hot water logs about three weeks ago. -There were two different hot water heaters for the facility. -The regulation for hot water temperatures was 116°F to 125°F. -The residents who used the east hall common bathroom had not complained about the hot water being too hot. -He would place up a "Do Not Use" sign on the bathroom doors until he had adjusted the hot water temperature. -He would check the hot water heater and adjust the hot water temperature.</p> <p>Observation of water thermometers being calibrated on 11/02/21 at 5:00pm revealed: -The MA and Surveyor's water thermometer were placed in a cup of ice water. -Both water thermometers temperatures were calibrated to 32°F.</p> <p>Observation of re-checked water temperatures 11/02/21 at revealed: -The "Do not Use" sign was not placed on the bathroom door. -At 5:08 pm, the hot water temperature at the sink</p>	D 113		

Division of Health Service Regulation

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D 113	<p>Continued From page 2</p> <p>in the east common bathroom was 100°F. -At 5:09pm, the hot water temperature at the shower in the east common bath room was 98.4°F.</p> <p>Interview with the Administrator 11/02/21 at 10:24am revealed: -The residents had not complained to her about the hot water temperature. -The hot water temperatures were 116°F to 120°F. -The MA completed hot water temperature checks twice a month. -The MA used to keep a hot water temperature check log. -The MA was responsible for checking and adjusting the hot water temperature.</p>	D 113		
D 234	<p>10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam &amp; Immunizatio</p> <p>10A NCAC 13F .0703 Tuberculosis Test, Medical Examination &amp; Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 residents sampled (Residents #1 and #3) were tested upon admission for tuberculosis (TB) disease in</p>	D 234		

Division of Health Service Regulation

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D 234	<p>Continued From page 3</p> <p>compliance with control measures adopted by the Commission for Health Services.</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL-2 dated 02/11/21 revealed diagnoses included mild intellectual and developmental disability, schizophrenia disorder and anxiety disorder.</p> <p>Review of Resident's #1 Resident Register revealed: -Resident #1 was admitted to the facility on 08/14/18.</p> <p>Review of Resident #1's record revealed: -There was documentation that a TB test was administered on 08/14/12 and read as negative on 08/16/12. -There was no documentation a second step TB test administered since Resident #1 was admitted to the facility on 08/14/18.</p> <p>Interview with the Medication Aide (MA) on 11/02/21 at 3:25pm revealed: -He had been employed as a MA for at least 10 yrs. -He was not aware Resident #1 needed a second step TB test because Resident #1 had come from another facility.</p> <p>Refer to interview with the MA on 11/02/21 at 3:25pm.</p> <p>Refer to interview with Facility Consultant on 11/02/21 at 5:15pm.</p> <p>Refer to interview with the Administrator on 11/02/21 at 12:30pm.</p>	D 234		

Division of Health Service Regulation

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D 234	<p>Continued From page 4</p> <p>2. Review of Resident #2's current FL-2 dated 03/12/21 revealed diagnoses included dementia, schizoaffective, chronic obstructive pulmonary disease, chronic lower back pain, anxiety and hypertension.</p> <p>Review of Resident Register revealed: -Resident #2 was admitted to the facility on 02/18/21.</p> <p>Review of Resident #2's record revealed: -Resident #2 was admitted to the facility on 02/18/21. -There was documentation that a TB test was administered on 02/18/21 and read as negative on 02/20/21. -There was no documentation a second step TB test administered since Resident #3 was admitted to the facility on 02/18/21.</p> <p>Interview with the MA on 11/02/21 at 12:25pm revealed he was aware Resident #2 had not completed a 2nd TB test.</p> <p>Refer to interview with Facility Consultant on 11/02/21 at 5:15pm.</p> <p>Refer to interview with the Administrator on 11/02/21 at 12:30pm.</p> <p>Interview with the MA on 11/02/21 at 12:25pm revealed: -He and the Administrator scheduled appointments to have TB test completed. -There is a Facility Consultant that completed record reviews every three months. -He would schedule TB testing for Residents #1 and #2 -The Administrator was responsible for ensuring</p>	D 234		

Division of Health Service Regulation

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D 234	Continued From page 5  all TB test were completed.  Interview with the Facility Consultant on 11/02/21 at 5:15pm revealed: -She completed record reviews every 6 months. -The last record review was completed in August 2021. -She had over looked the 2nd step testing for Residents #1 and #2. -The Administrator was responsible to ensure all TB test had been completed.  Interview with the Administrator on 11/02/21 at 12:30 am revealed: -There was a Facility Consultant who had reviewed the records at least every four months. -She had not been made aware of the TB testing not completed for Residents #1 and #2. -The MA was responsible for scheduling TB testing appointments. -She was responsible for ensuring all TB tested had been completed.	D 234		
D 358	10A NCAC 13F .1004(a) Medication Administration  10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.  This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications	D 358		

Division of Health Service Regulation

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D 358	<p>Continued From page 6</p> <p>were available for administration for 1 of 3 sampled residents (Resident #1) related to medication prescribed as needed for chest pains.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 01/14/21 revealed: -Diagnoses included dementia, hypothyroidism, hypertension, and hyperlipidemia. - Nitrostat 0.4mg was to be administered 1 tablet as needed (PRN) every 5 minutes to relieve chest pain.</p> <p>Review of Resident #1's September 2021 electronic Medication Administration Record (eMAR) revealed: -The Nitrostat 0.4mg had been administered for PRN to relieve chest pain. -There was not an entry as administered for the Nitrostat 0.4mg from 09/01/21 to 09/30/21.</p> <p>Review of Resident #1's October 2021 eMAR revealed: -The Nitrostat 0.4mg had been administered for PRN to relieve chest pain. -There was not an entry as administered for the Nitrostat 0.4mg from 10/01/21 to 10/31/21.</p> <p>Review of Resident #1's November 2021 eMAR revealed: -The Nitrostat 0.4mg had been administered for PRN to relieve chest pain. -There was an entry as administered for the Nitrostat 0.4mg from 11/01/21 to 11/02/21.</p> <p>Observation of medications on hand on 11/02/21 at 3:45pm revealed Nitrostat .0.4mg was not available to administer to Resident #1.</p>	D 358		

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D 358	<p>Continued From page 7</p> <p>Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable.</p> <p>Interview with the Medication Aide (MA) on 11/02/21 at 3:49pm revealed:</p> <ul style="list-style-type: none"> <li>-He had accidentally thrown the Nitrostat 0.4mg away on last week with the other expired medications.</li> <li>-He completed medication cart audits weekly.</li> <li>-He had not documented the medication cart audits.</li> <li>-He had not realized the Nitrostat was missing from the cart until 11/02/21.</li> <li>-Resident #1 had not requested the Nitrostat in over three years.</li> <li>-If Resident #1 had complained of chest pains, he would had call 911 for Resident #1.</li> <li>-He had not documented the Nitrostat 0.4mg had been discarded.</li> <li>-He called the pharmacy to refill the Nitrostat 0.4mg on 11/02/21.</li> </ul> <p>Telephone interview with the local Pharmacist on 11/02/21 at 4:03pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 had an order for Nitrostat 0.4mg as a PRN for 1 tablet every 5 minutes.</li> <li>-An order for Nitrostat .0.4mg was called in for a refill on 11/02/21 at 3:38pm.</li> <li>-The facility had not submitted documentation of discarding the Nitrostat.</li> </ul> <p>Telephone interview with Resident #1's Primary Care Physician (PCP) on 11/02/21 at 3:57pm revealed:</p> <ul style="list-style-type: none"> <li>-The Nitrostat 0.4mg had been prescribed as a safety precaution for someone with a history of chest pains.</li> <li>-The Nitrostat should be been replaced within 24 hours after being discarded.</li> </ul>	D 358		

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D 358	<p>Continued From page 8</p> <ul style="list-style-type: none"> <li>-The staff could call 911 if Resident #1 experienced chest pains and the Nitrostat was not on site to be administered.</li> </ul> <p>Interview with the Facility Consultant on 11/02/21 at 5:13pm revealed:</p> <ul style="list-style-type: none"> <li>-She completed medication cart audits at least monthly.</li> <li>-She did not remember the date of the last medication cart audit.</li> <li>-During medication cart audits, medication had been compared to the current FL2 and physician orders.</li> <li>-She reported any discrepancies to the pharmacy.</li> <li>-All discarded and expired medications were to be documented and sent back to the pharmacy.</li> </ul> <p>Interview with the Administrator on 11/02/21 at 4:19pm revealed:</p> <ul style="list-style-type: none"> <li>-The MA had notified the pharmacy about expired medication which had been sent back to the pharmacy.</li> <li>-Medication that had been discarded had not been documented.</li> <li>-The MA had discarded the Nitrostat by mistake.</li> <li>-Staff did not need to notify her when medications had been discarded.</li> <li>-The MA was responsible for completing a medication cart audit weekly.</li> <li>-The Facility Consultant completed medication cart audits at least once a monthly.</li> <li>-All issues with medications had been reported to the pharmacy.</li> </ul>	D 358		