STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL007015	A. BUILDING: _____ B. WING _____	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANTEGO REST HOME	143 SWAMP ROAD PANTEGO, NC 27860

(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 000	Initial Comments The Adult Care Licensure Section and the Beaufort County Department of Social Services conducted an Annual survey and a Follow-up survey on 03/03/22 and 03/04/22.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure that hot water temperatures were maintained at 100° to 116° degrees Fahrenheit (F) for 5 fixtures in the 1st common residents' bathroom and the men's bathroom with temperatures of 129.2° degrees F to 134.6° degrees F. The findings are: Observation of the 1st common residents' bathroom on 03/03/22 at 8:20am revealed: -The hot water temperature at the 1st sink was 129.2°F. -The hot water temperature at the 2nd sink was 130.0°F. Observation of the men's common bathroom on	D 113		

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D 113	Continued From page 1 03/03/22 at 8:27am revealed: -The hot water temperature at the 1st sink was 133.8°F. -The hot water temperature at the 2nd sink was 134.6°F. -The hot water temperature at the tub was 132.8°F. Interview with a resident on 03/03/22 at 8:52am revealed: -The hot water in the men's bathroom was really hot. -He used the men's bathtub on the morning of 03/03/22. -He had told the staff about the water being hot "the other day" (did not know the day). -Staff were to check the hot water temperature. Interview with a second resident on 03/03/22 at 9:00am revealed: -The hot water at the tub in the men's bathroom was too hot. -He had to pull his hand back when testing the hot water but did not scald or burn his hands. -He had not complained to staff about the water being too hot. Review of the hot water temperature log on 03/03/22 revealed the last hot water temperature check completed on 03/02/22 on one fixture in the 1st residents' common bathroom at the 1st sink at 105°F. Interview with the Manager on 03/03/22 at 8:50am revealed: -She called the Owner to come and check the hot water temperatures in the 1st common bathroom and the men's bathroom. -She completed hot water temperature checks on random fixtures at least three times daily.	D 113		

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-Residents had not complained about the hot water being too hot in the 1st residents' common bathroom or the men's bathroom.
-She did not remember when these bathrooms hot water temperature was checked.
-She knew the required hot water temperature was 100°F to 116°F.
-She was responsible for completing hot water temperature checks.
-She reported all issues with the hot water to a Maintenance staff.
-She would post "Do Not Use" signs on the 1st residents' common bathroom and men's bathroom doors.

Interview with a Maintenance staff on 03/03/22 at 9:36am revealed:
-He installed a new hot water heater on last week.
-The hot water heater temperature was 115°F.
-The Manager was responsible for completing hot water temperature checks.
-He was informed on 03/03/22 the hot water temperature was too hot in the 1st residents' common bathroom.
-He had planned to come and check the hot water heater on 03/03/22.
-He would turn down the hot water heater temperature.
-He would install a new knob on the tub in the 1st residents' common bathroom.

Observation of water thermometers being calibrated on 03/03/22 at 11:56am revealed:
-The Maintenance staff's and Surveyor's water thermometers were placed in a cup of ice water.
-The Maintenance staff's thermometer temperature was 32°F.
-The Surveyor's thermometer temperature was 32.6°F.

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Observations of re-check of water temperatures with Maintenance staff in the 1st residents' common bathroom on 03/03/22 revealed:
-At 12:06pm a "Do not use" sign had been placed on the door of the 1st residents' common bathroom.
-At 12:07pm the hot water temperature at the 1st sink was 109°F.
-At 12:08pm the hot water temperature at the 2nd sink was 107.6°F.
-At 12:09pm a knob for the hot water had been installed on the tub.
-At 12:10pm the hot water temperature at the tub was 108°F.

Observations of re-check of water temperatures with Maintenance staff in the men's bathroom on 03/03/22 revealed:
-At 12:14pm a "Do not use" sign had been placed on the men's bathroom door.
-At 12:15pm the hot water temperature at the 1st sink was 107.6°F.
-At 12:08pm the hot water temperature at the 2nd sink was 107°F.
-At 12:10pm the hot water temperature at the tub was 107°F.

Interview with the Owner on 03/03/22 at 9:19am revealed:
-He had called the Maintenance staff to come and check the hot water heater.
-There had been a new hot water heater installed the last week.
-The water temperatures were checked daily.
-The Manager was responsible for completing hot water temperatures.

Interview with the Administrator on 03/03/22 at 10:11am revealed:
-Residents had not complained to her about the

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D 113	Continued From page 4 water temperature being too hot. -The hot water temperature was to be checked three times a day. -The Manager was responsible for completing hot water temperatures and documenting the temperatures.	D 113		
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: Based on observations, interviews, and record reviews, the facility failed to ensure the referral and follow up to meet the acute healthcare needs for 1 of 3 residents (#2) sampled due to a fall which resulted in an injury. The findings are: Review of Resident #2's current FL-2 dated 12/08/21 revealed: -Diagnoses included schizophrenia paranoid type, difficulty hearing, asthma, diabetes arthritis and chronic obstructive pulmonary disease (COPD). -The resident was constantly disoriented, ambulatory, incontinent of bladder and continent of bladder. Review of Resident #2's care plan dated 12/08/21 revealed: -The resident was incontinent of bowel and continent of bladder. -The resident required staff assistance with ambulation, toileting, dressing, bathing, and grooming.	D 273		

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D 273	Continued From page 5 Review of the facility's falls policy revealed: -The policy completed assessments for residents identified as a fall risk. -The facility corridors, common areas, resident's rooms, residents' clothing and equipment as potential fall risk factors. -The falls policy did not state information on contacting the Primary Care Physician (PCP). Review of Resident #2's incident/accident report dated 02/18/22 revealed: -The incident occurred at 10:00pm. -A Medication Aide (MA) completed the form. -The incident stated Resident #2 lost his balance in his room and fell. -Resident #2 hit his right eye and had a "dash". -The right eye was blue. -The MA contacted the Manager about Resident #2's fall. -There was no documentation the family or PCP was notified. Observation of Resident #2 on 03/03/22 at 9:29am revealed: -The resident was lying on his bed. -He stood up when he heard the knock on his door. -Resident #2's walk was unsteady as he walked to the door. -Resident #2 had a purplish color bruise under his right eye. Interview with Resident #2 on 03/03/22 at 9:30am revealed: -He had fallen at the facility. -He did not remember when he had fallen. -He did not go to the emergency room after the fall.	D 273		

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Interview with a personal care aide (PCA) on 03/03/22 at 3:28pm revealed:
-She noticed the bruise under Resident #2's right eye 02/25/22.
-The bruise under Resident #2's right eye was purplish in color.
-She learned of Resident #2 fall from another staff.
-She knew to report all witnessed and unwitnessed falls to the MA or the Manager.

Interview with a second PCA on 03/03/22 at 3:46pm revealed:
-She provided personal care to Resident #2.
-She had not witnessed Resident #2's fall.
-She noticed Resident #2 had a black right eye on 02/21/22.
-She asked Resident #2 if he had fallen but he was unable to tell her that he had fallen.

Interview with a MA on 03/03/22 at 3:56pm revealed:
-She noticed Resident #2 right eye was bruised when she returned to work on 02/26/22.
-She was notified of Resident #2's bruised eye by the Manager.
-There was no progress note completed relating to Resident #2's fall or the bruised eye.
-Resident #2 refused medical attention.
-The Manager or MAs were responsible for notifying the PCP whenever a resident had a fall.

Interview with the Manager on 03/04/22 at 8:10am revealed:
-She was notified of the fall when she returned to work on 02/19/22.
-Resident #2 had fallen off of his bed on 02/18/22 and had hit his right eye.
-The emergency medical transport was not called because the resident did not want to go to the

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emergemcy room.
-A follow up appointment was not scheduled with Resident #2's PCP.
-The PCP was not notified of Resident #2's fall.
-She or the MAs were responsible for notifying the PCP of all falls.

Attempted telephone interview with Resident #2's PCP on 03/04/22 at 9:28am was unsuccessful.

Telephone interview with the Medical Director at medical facility on 03/03/22 at 3:11pm revealed:
-He saw residents for follow up appointments after being treated at the emergency room (ER).
-He had last seen Resident #2 on 07/23/20 for a follow up after an ER visit.
-Resident #2's assigned PCP had last seen him on 12/09/21.
-He had not been notified of Resident's #2's fall.

Telephone interview with the Nurse at Resident #2's mental health provider on 03/04/22 at 9:14 am revealed:
-Resident #2 was last seen on 02/14/22.
-Resident #2 had not had a bruised eye.
-Resident #2 had been diagnosed with a late onset of Alzheimer's.
-Resident #2 was not capable of making decision for medical treatment.

Interview with the Administrator on 03/04/22 at 10:22am revealed:
-She had not known of 02/18/22 fall of Resident.
-Resident #2's PCP was to be notified whether the fall was witnessed or unwitnessed.
-The Manager or the MA were responsible for notifying the PCP.