STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033005	A. BUILDING: _____ B. WING _____	R-C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE OF ROCKY MOUNT	1650 COKEY ROAD ROCKY MOUNT, NC 27801

(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 Edgecombe County Department of Social Services conducted a follow-up survey and complaint investigations on August 31, 2022 to September 1, 2022. The complaint investigations were initiated by the Edgecombe County Department of Social Services on June 28, 2022 and August 15, 2022.	D 000		
D 201	10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And 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 or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 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 or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or	D 201		

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D 201	Continued From page 1 resident census). (For staffing chart, see Rule .0606 of this Subchapter.)	D 201		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure aide hours met the minimum requirements for 1 of 15 shifts sampled from 06/10/22 to 08/31/22.

The findings are:

Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 126 beds.

Review of the facility's resident census report revealed the assisted living (AL) census was 74 on 06/15/22 which required 32 aide hours on first and second shift and 24 hours on third shift.

Review of staff timecards dated 06/15/22 revealed there was a total of 17 hours and 41 minutes on third shift leaving a shortage of 6 hours and 19 minutes.

Telephone interview with a personal care aide (PCA) on 09/01/22 at 3:03am revealed:
-He worked third shift which was 11:00pm to 7:00am.
-There was normally 3 staff members on third

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shift.
-He worked third shift on 06/15/22.
-He did not recall if there were only 2 staff members that worked third shift on 06/15/22.
-He was responsible for providing incontinence care for residents that needed assistance throughout the night.
-There was a time when there were only two staff members total that worked on third shift but he did not recall how often that happened or when it happened last.

Interview with a medication aide (MA) on 09/01/22 at 8:00am revealed:
-She was scheduled to come in from 6:00am to 2:00pm on the morning of 06/16/22.
-When she arrived at the facility there were only 2 staff members working third shift the night of 06/15/22.
-There were normally 3 staff members scheduled to work third and she did not recall a time when she came in other than the morning of 06/16/22 that there was only two staff working.
-There was a lot of residents that needed care throughout the night and it would be difficult for only 2 staff members to be on duty.
-If there was a call out on a shift and staff was not able to fill the spot, then they should have notified the lead MA.

Interview with the lead MA on 09/01/22 at 8:20am revealed:
-She was responsible for making the facility schedule.
-The facility staffed 3 people on third shift.
-If there was a call out on a shift and staff was not able to cover it, they were to notify her because she lived on-site and would come to work the shift.
-She was not aware that there were only 2 staff

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D 201	Continued From page 3 members working third shift on 06/15/22. -It was not safe for 2 staff members to be responsible for the whole building. Interview with the Administrator on 09/01/22 at 8:25am revealed: -She was not aware that there were only 2 staff members working the third shift of 06/15/22. -The facility should be staffed by at least 3 staff members on third shift to ensure patient safety and ensure that resident personal care was performed as needed for the residents. -She expected staff to notify the lead MA if there was only 2 staff members working third shift since she lived on-site; and if they were unable to get a hold of the lead MA staff was expected to call her for assistance. Telephone interview with one of the facility's contracted primary care providers (PCP) on 09/01/22 at 11:43am revealed he expected the facility to staff according to the regulations to provide proper care for the residents based on their needs and ensure the safety of the residents at the facility. Attempted telephone interview with the third shift MA on 08/31/22 at 2:30pm and 09/01/22 at 9:58am was unsuccessful.	D 201		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.	D 271		

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This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on interviews and record reviews, the facility failed to ensure immediate response and intervention by staff for 1 of 5 residents sampled (Resident #4) who was found by staff to be unresponsive and without a pulse by failing to start cardiopulmonary resuscitation (CPR) immediately.

The findings are:

Review of facility's policy for Accident or Injury to a Resident, dated 09/11/19 revealed:
-Personal care aide (PCA): immediately notify the lead medication aide (MA), MA, and/or Administrator.
-If staff has reason to believe that a resident may be injured or their life may be in danger, do not hesitate to dial 911 immediately.

Review of Resident #4's current FL-2 dated 06/02/22 revealed:
-Diagnoses included sleep apnea, morbid obesity, seizure disorder, hypothyroidism, gastric reflux disease, and cholecystitis.
-He was ambulatory.
-There was no information regarding his orientation status.

Review of Resident #4's Resident Register

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revealed an admission date of 06/02/22 as a transfer from another assisted living facility.

Review of Resident #4's current care plan dated 06/02/22 revealed:
-He was sometimes disoriented and sometimes forgetful with reminders needed.
-He was occasionally incontinent of bowel and had daily continence of urine.
-He was independent with toileting and ambulating.
-He required limited assistance with eating.
-He required extensive assistance with bathing, dressing, and grooming/personal hygiene.

Review of Resident #4's record revealed there were no progress notes completed by staff.

Review of Resident #4's record revealed there was no DNR (Do Not Resuscitate) order.

Review of an accident report dated 06/16/22 revealed:
-There was no time noted on the report.
-Resident #4 was found on the floor unresponsive.
-Emergency Medical Services (EMS) was immediately called.
-Cardiopulmonary resuscitation (CPR) was done and EMS reported the resident was dead on arrival.
-Resident #4's family member was notified of the incident.

Interview with the medication aide (MA) that filled out Resident #4's accident report on 06/28/22 at 12:04pm revealed:
-She arrived at the facility on 06/16/22 a little around 5:55am and 3rd shift was providing personal care to the residents and getting them

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up for the day.
-She was at the nurses station preparing to start giving her medications when the third shift PCA came to ask her where the third shift MA was at.
-She told the PCA which room the third shift MA was in.
-The PCA did not tell her that he found Resident #4 on the floor, unresponsive.
-The PCA went to the room where the third shift MA was and they returned to the nurses station.
-The third shift MA asked her if the PCA reported that Resident #4 was lying on the floor facing the air conditioning unit to which she replied no.
-At that point, she went with the third shift PCA and another first shift staff member to Resident #4's room where he was lying face down.
-She checked for a pulse and there was none, so she left the two other staff members in the room with the resident and went to the nurses station to call 911.
-The EMS dispatcher asked her if anyone started CPR and she stated "no" that there were staff members in the room with him.

Second interview with the MA on 08/31/22 at 2:00pm revealed:
-She had not seen Resident #4 on the morning of 06/16/22 before being told he was unresponsive when she went to his room.
-She did not recall what time she went to Resident #4's room but that it was before 7:00am because she was getting ready to start administering her 7:00am medications.
-The resident was lying face down when she got to the room with the other first shift MA and third shift PCA.
-She checked for a pulse and when he did not have one, she left the room to go call 911.
-The third shift PCA and first shift MA did not start CPR when she left.

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-She was CPR certified, as were the other two staff members in the room with Resident #4.
-CPR should have been started when Resident #4 was found unresponsive because he was a full code.

Review of a second accident report for Resident #4 dated 06/16/22 revealed:
-Resident #4 was found laying on the floor in his room between the bed and heating system face down.
-The MA recording the accident report checked for a pulse "but it was not a very good one" so she checked again after she turned him over on his back.
-Resident #4's face was purple so she "called for help but not come at that time".
-They were not able to get Resident #4 up.
-EMS was called by the day shift MA.
-There was no time noted on the accident report.

Attempted telephone interview with the third shift MA that wrote the second accident report on 07/11/22 at 4:22pm, 08/31/22 at 2:30pm and 09/01/22 at 9:58am was unsuccessful.

Review of the county fire department incident report dated 06/16/22 revealed:
-The fire department was dispatched to the facility for a male in cardiac arrest.
-Resident #4 was found lying on the ground.
-The fire department provided basic life support until the county EMS arrive on the scene at 7:13am.

Attempted telephone interview with the county fire department on 06/30/22 at 8:45am was unsuccessful.

Review of the county's EMS report for Resident

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D 271	Continued From page 8 #4 on 06/16/22 revealed: -They received a call at 7:05am for an unresponsive resident. -When they arrived to Resident #4's room at 7:14am they found that the county fire department had initiated chest compressions and placed the resident on an AED (automated external defibrillator). -The EMS crew took over and the resident was shown to be in asystole (no heartbeat present). -Resident #4 was noted to be blue/purple from the nipple up. -They were told by facility staff that the resident was found around 6:00am. -Facility staff members were not able to tell the EMS crew the last time that Resident #4 was seen alive. -Facility staff members were not able to tell the EMS crew why it took them over an hour to call EMS when Resident #4 was found unresponsive. Attempted telephone interview with the county's EMS technician on 07/01/22 at 1:20pm and 08/31/22 at 4:50pm was unsuccessful. Telephone interview with a PCA on 07/11/22 at 4:22pm revealed: -He worked third shift the night of 06/15/22. -He went into Resident #4's room to perform incontinence care on his roommate and found the resident on the floor. -He called Resident #4's name and touched his arm which was warm. -He went to the nurses station and paged the third shift MA because he could not locate any other staff at that time. -When the third shift MA came to the nurses station he told her that Resident #4 was found on the floor and they both went to Resident #4's room.	D 271		

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-The third shift MA checked Resident #4's pulse and said that he did not have one.
-He was not sure who called 911 or if CPR was started.

Second telephone interview with the PCA on 09/01/22 at 3:03am revealed:
-He was CPR certified.
-He did not check Resident #4's pulse when he found him on the floor and he did not start CPR when he found him.

Interview with a second MA on 09/01/22 at 10:10am revealed:
-She was working first shift on 06/16/22.
-She heard an overhead page 'stat' to Resident #4's room.
-She arrived at Resident #4's room with the other first shift MA and the third shift PCA.
-She could not recall where the third shift MA was when she arrived at Resident #4's room.
-The staff turned Resident #4 over and he was blue colored.
-The other day shift MA went to the nurses station to call 911.
-She panicked and left the room because she "never saw anything like that before".
-She knew that the third shift PCA was CPR certified when she left the room but she was not sure if he started CPR.
-She was CPR certified.

Interview with Resident #4's roommate on 08/03/22 at 1:50pm revealed:
-He heard Resident #4 scream for help and thought he heard Resident #4 fall on the floor around 3:00am on 06/16/22.
-He thought he saw a staff member shut the door shortly after Resident #4 screamed for help.
-No staff member came into the room until

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around 7:00am.

Interview with the lead MA on 08/31/22 at 2:19pm revealed:
-She expected staff to respond immediately to a resident that was found unresponsive.
-When staff found Resident #4, they should have immediately called for help, started CPR if they were CPR certified, and called 911.
-Both the third shift MA and third shift PCA working on 06/15/22 were CPR certified.

Interview with the Administrator on 08/31/22 at 2:45pm revealed:
-All of the MAs were CPR certified and the third shift PCAs were CPR certified.
-She expected staff to initiate CPR when Resident #4 was found unresponsive and without a pulse.
-Resident #4 was a full code and did not have a DNR order.
-Staff was not able to assess whether the resident was alive or dead and should have performed resuscitative measures until EMS personnel arrived.
-She was not aware that the staff that found Resident #4 unresponsive the morning of 06/16/22 did not immediately initiate CPR.

Telephone interview with Resident #4's primary care provider (PCP) on 09/01/22 at 11:19am revealed:
-He was notified by the facility of Resident #4 being found dead on the morning of 06/16/22.
-He expected CPR certified staff to begin resuscitative measures immediately when Resident #4 was found until EMS arrive.
-He was not able to tell if staff would have started CPR when they immediately found Resident #4, if it would have made a difference because the

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D 271	Continued From page 11 timeline was unclear. -Staff should have followed emergency protocols and provided immediate resuscitation to Resident #4. _____ The facility failed to respond immediately to ensure the initiation of CPR for Resident #4 who was found unresponsive and without a pulse. The resident died. The facility's failure resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/31/22 for this violation. THE CORRECTION DATE FOR THE A1 VIOLATION SHALL NOT EXCEED OCTOBER 1, 2022.	D 271		
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 interviews and record reviews, the facility failed to ensure that the primary care provider was notified of an episode of low blood pressure and high heart rate for 1 of 5 residents sampled (Resident #4). The findings are: Review of Resident #4's current FL-2 dated	D 273		

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06/02/22 revealed diagnoses included sleep apnea, morbid obesity, seizure disorder, hypothyroidism, gastric reflux disease, and cholecystitis.

Review of Resident #4's Resident Register revealed an admission date of 06/02/22 as a transfer from another assisted living facility.

Review of Resident #4's Licensed Health Professional Support (LHPS) Review and Evaluation dated 06/13/22 revealed:
-He was oriented to person and place, but not to time.
-He was confused.
-His blood pressure was 88/63.
-His heart rate was 123.
-The LHPS nurse performing the resident assessment noted that she notified staff of the resident's vital signs.

Review of the first shift Communication Report on 06/13/22 revealed:
-Resident #4's blood pressure was checked by the LHPS nurse and she stated that it was a little low and pulse was very high (88/63, 123).
-Resident #4's low blood pressure and high heart rate were reported to the oncoming medication aide (MA).

Review of the second shift Communication Report on 06/13/22 revealed:
-Resident #4 was ambulating in the hallway during second shift.
-Resident #4 voiced no complaints during second shift.

Review of Resident #4's record revealed:
-There was no documentation of any vital signs recorded.

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-There was no documentation of any progress notes from the facility.

Telephone interview with the facility's LHPS nurse on 09/01/22 at 10:14am revealed:
-She was at the facility performing an initial LHPS assessment on Resident #4 on 06/13/22 because he was a newly admitted resident.
-She checked Resident #4's blood pressure which she assessed as low at 88/63.
-She checked Resident #4's heart rate which she assessed as high at 123 beats per minute.
-She notified the first shift medication aide (MA) of Resident #4's blood pressure and heart rate which were abnormal and instructed her to recheck his vital signs in an hour.
-She notified the MA that if Resident #4's blood pressure was still low that they would need to notify the doctor or he would need to be sent to the emergency room for evaluation.

Interview with the first shift MA on 09/01/22 at 9:29am revealed:
-The LHPS notified her of Resident #4's low blood pressure and high heart rate.
-She was getting ready to leave for the day, so she reported Resident #4's vital signs to the oncoming MA.
-She notified the oncoming MA that the LHPS nurse instructed them to recheck Resident #4's blood pressure and to call the doctor or send him to the emergency room if it was low.

Interview with the second shift MA on 09/01/22 at 10:20am revealed:
-He was not notified by the first shift MA of Resident #4's blood pressure and heart rate needing to be rechecked, as instructed by the LHPS nurse.
-If he would have rechecked the resident's blood

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	HAL033005	A. BUILDING: _____ B. WING _____	R-C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE OF ROCKY MOUNT	1650 COKEY ROAD ROCKY MOUNT, NC 27801

(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 14	D 273		

pressure and it was still low, he would have sent him to the emergency room for evaluation.

Interview with the lead MA on 09/01/22 at 10:40am revealed:
-She expected staff to recheck a resident's vital signs if they were reported to be low.
-She was not aware of Resident #4's abnormal vital signs until "after the fact" when the Administrator was reviewing the shift to shift Communication Report.
-She expected the MAs to communicate instructions with each other.
-She would have expected the second shift MA to recheck Resident #4's blood pressure and if it was low that he be sent to the emergency room.
-Resident #4 was "in-between" providers because he had not been seen by the facility's primary care provider (PCP) yet.
-Resident #4's PCP from his previous facility was still following the resident until the facility's PCP saw him.
-There were no parameters for Resident #4's blood pressure or vital signs to call the PCP or send to the emergency room.

Interview with the Administrator on 09/01/22 at 10:55am revealed:
-She expected the MA to recheck Resident #4's blood pressure and heart rate as instructed by the LHPS nurse.
-She expected staff to send the resident to the emergency room if his blood pressure and heart rate were still low.
-She tells staff "when in doubt, send them out".

Telephone interview with Resident #4's PCP on 09/01/22 at 11:45am revealed:
-He expected staff to have rechecked Resident #4's blood pressure and heart rate on 06/13/22.

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D 273	Continued From page 15 -He would have expected staff to notify him of Resident #4's low blood pressure and high heart rate on 06/13/22. -If the resident's blood pressure and heart rate were still abnormal after re-checking, he would have instructed them to send him to the emergency room for evaluation. _____ The facility failed to recheck Resident #4's blood pressure and heart rate as instructed by the LHPS nurse on 06/13/22. The primary care provider would have expected to be notified of the resident's abnormal vital signs. The facility's failure to provide notification to the provider and follow-up 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 09/01/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 16, 2022.	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 interviews, and record reviews, the facility failed to ensure residents received care	D912		

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D912	Continued From page 16 and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care. The findings are: Based on interviews and record reviews, the facility failed to ensure that the primary care provider was notified of an episode of low blood pressure and high heart rate for 1 of 5 residents sampled (Resident #4) [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents free of neglect and received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision. The findings are: Based on interviews and record reviews, the facility failed to ensure immediate response and intervention by staff for 1 of 5 residents sampled (Resident #4) who was found by staff to be	D914		

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D914	Continued From page 17 unresponsive and without a pulse by failing to start cardiopulmonary resuscitation (CPR) immediately [Refer to Tag 271, 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A1 Violation)].	D914		