STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL050017	A. BUILDING: ______ B. WING ______	R 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERMITAGE	185 BRICKFARM ROAD DILLSBORO, NC 28725

(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 conducted a follow up survey and a complaint investigation on 09/28/22.	D 000		
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 A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to meet the health care needs for 1 of 1 sampled residents (#3) by failing to follow-up with monthly visits to the urologist for urinary catheter exchanges. The findings are: Review of Resident #3's current FL2 dated 06/27/22 revealed: -Diagnoses included type 2 diabetes, neuropathy, and vertigo. -The level of care was assisted living facility. Review of Resident #3's current Care Plan dated 06/28/22 revealed: -The resident was sometimes disoriented. -The resident required extensive assistance with toileting, ambulation/locomotion, bathing, grooming/personal hygiene, and transfers. -The resident had an indwelling urinary catheter. -There were no instructions related to how often the indwelling urinary catheter should be changed.	D 273		

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Observation of Resident #3's room during the initial tour on 09/28/22 at 8:50am revealed there was a foul odor permeating into the hallway from the room.

Observation of Resident #3 on 09/28/22 at 2:39pm revealed the resident had an indwelling urinary catheter with no drainage bag attached but a flip valve in place to enable the resident to empty her urine.

Review of Resident #3's Urology visit note dated 07/19/22 revealed:
-The indwelling catheter was removed and replaced.
-There was an order for a follow-up appointment with the Urologist on 08/04/22 at 3:15pm.

Review of Resident #3's hospital notes dated 08/06/22 to 08/10/22 revealed:
-The resident was admitted to the hospital on 08/06/22.
-The admitting diagnoses included shortness of breath, hypoxia, possible pneumonia, right rib fractures status post fall, and gait instability with frequent falls.
-The discharge diagnoses included shortness of breath, hypoxia, pneumonia, right rib fractures status post fall, gait instability with frequent falls, chronic urinary retention with indwelling urinary catheter.
-The resident arrived at the hospital with an indwelling urinary catheter which was last changed on 07/19/22.
-There was no documentation the catheter was changed during the hospital stay.

Review of Resident #3's discharge summary dated 08/10/22 revealed:
-Resident #3 was progressing with physical

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therapy (PT) services.
-There was an order to follow-up with home health.
-There was an order to follow-up with palliative care.
-There was an order to follow-up with primary care provider (PCP) within 1 week.

Review of Resident #3's PCP order dated 09/14/22 revealed cefdinir (used to treat urinary tract infection) 300mg 1 capsule two times a day for 7 days.

Review of Resident #3's September 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for cefdinir 300mg 1 capsule twice a day scheduled at 8:00am and 8:00pm.
-The cefdinir was documented as administered as ordered from 09/15/22 at 8:00am to 09/21/22 at 8:00pm.

Interview with the Resident Care Coordinator (RCC) on 09/28/22 at 11:15am revealed:
-Resident #3 had an indwelling urinary catheter.
-Resident #3 went to the urology office monthly for catheter changes.
-It was his understanding Resident #3's catheter was changed during the hospitalization on 08/06/22 to 08/10/22.

Interview with Resident #3 on 09/28/22 at 2:40pm revealed:
-Her urinary catheter was last changed at her last visit to the urology office (07/19/22).
-She had recently had a urinary tract infection (UTI).
-She did not think the UTI had "cleared up", because her back was "killing her."

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Telephone interview Resident #3's family member on 09/28/22 revealed:
-She thought the hospital had changed Resident #3's urinary catheter when she was hospitalized from 08/06/22 to 08/10/22.
-She knew the catheter had not been changed in the last 7 or 8 weeks since the hospitalization.
-Resident #3's next urology appointment for a urinary catheter change was scheduled for 10/06/22.
-She and the facility transport staff called the urology office and tried to get an earlier appointment for a catheter change, but they were not successful.

Interview with the Special Care Coordinator (SCC) on 09/28/22 at 3:10pm revealed:
-She had not seen the order for a home health follow-up in Resident #3's hospital discharge summary on 08/10/22.
-A home health agency physical therapist had come to the facility to continue PT services with Resident #3 after she was discharged from the hospital on 08/10/22.
-The physical therapist told her there was an order for home health nursing to perform Resident #3's urinary catheter changes.
-She told the physical therapist Resident #3 went to a urology office monthly for catheter changes.
-The physical therapist discontinued the order for home health to care for the catheter since Resident #3 was already established with a urology office.
-The facility Transportation staff had scheduled an appointment for Resident #3 to see the urologist on 10/06/22 for a catheter change.

Interview with the Administrator on 09/28/22 at 11:55am revealed:
-She knew Resident #3 had an indwelling urinary

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catheter and the catheter should be changed monthly.
-Resident #3 refused to go to the urology appointment scheduled 08/04/22.
-Resident #3 was hospitalized from 08/06/22 to 08/10/22.
-According to verbal information provided by the Transportation staff, Resident #3's indwelling urinary catheter was changed during a hospitalization from 08/06/22 to 08/10/22.
-Resident #3's urology appointment was rescheduled to 10/06/22 at 1:45pm.
-The Transportation staff made several attempts to schedule an earlier appointment date with Resident #3's urology office for a catheter change, however the only available appointment was on 10/06/22.

Interview with Transportation staff on 09/28/22 at 12:05pm and 1:20pm revealed:
-Resident #3 refused to go to the urology appointment scheduled on 08/04/22.
-Resident #3 was hospitalized from 08/06/22 to 08/10/22 for pneumonia.
-She knew Resident #3's catheter had been changed at the hospital, because she observed hospital staff change Resident #3's urinary drainage bag to a urinary leg drainage bag at discharge.

Telephone interview with Resident #3's urologist certified medical assistant (CMA) on 09/28/22 at 2:20pm revealed:
-Resident #3 had not been back to their office for a catheter change since 07/19/22.
-Resident #3's catheter should have been changed by 08/19/22.
-Indwelling urinary catheters should be changed every month.
-On the visit on 07/19/22, they performed a fill

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and flow study on Resident #3.
-Resident #3 was unable to void so a new indwelling urinary catheter was put in place.
-Resident #3 was scheduled for another fill and flow study on 08/04/22.
-The goal was for Resident #3 to be able to void without the use of a urinary catheter.
-Facility staff had notified them on 08/03/22 at 4:33pm they needed to cancel Resident #3's appointment on 08/04/22.
-They rescheduled Resident #3's appointment for the fill and flow study to 10/06/22.
-If Resident #3's catheter was not changed during hospitalization from 08/06/22 to 08/10/22, the appointment to change the catheter should have been rescheduled sooner.
-Catheter changes could be performed by office staff without having to have an appointment time with the urologist.
-There was no record of facility staff of the resident's family member calling their office to request an earlier appointment date for Resident #3 for a catheter change.

Telephone interview with Resident #3's PCP on 09/28/22 at 4:05pm revealed:
-Indwelling urinary catheters should be changed at least once a month.
-Failing to change an indwelling urinary catheter increased the resident's risk of infection.
-Typically, a bladder infection would occur first, however a more serious infection called pyelonephritis (inflammation of the substance of the kidney as a result of bacterial infection) could occur when an infection progressed to the kidneys.

Telephone interview with the same CMA from Resident #3's urology office on 09/29/22 at 3:07pm revealed when she asked another

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urologist in the same office the potential risks of leaving an indwelling urinary catheter in without changing it monthly he stated it could lead to sepsis (a potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues) as well as urethral breakdown (inflammation of the urethral meatus).

Review of the facility's policy on health care referral and follow-up dated September 2021 revealed:
-It was the policy of the community to assure referral and follow-up to meet the routine and acute health care needs of residents with notifications to providers and documentation in the resident record.
-Hospital discharge follow-up care was listed as documentation that would be included in the resident record.

____

The facility failed to change Resident #3's indwelling urinary catheter change in excess of 2 months which increased the resident's risk of sepsis and urethral breakdown resulting in substantial risk of physical harm which constitutes a Type A2 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/28/22 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 27, 2022.

D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

G.S. 131D-21 Declaration of Residents' Rights
Every resident shall have the following rights:

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D912	Continued From page 7 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 observations, interviews, and record reviews, the facility failed to ensure residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care referral and follow up. The findings are: Based on observations, interviews, and record reviews, the facility failed to meet the health care needs for 1 of 1 sampled residents (#3) by failing to follow-up with monthly visits to the urologist for urinary catheter exchanges. [Refer to Tag 0273, 10A NCAC 13F .0902 (b) Health Care (Type A2 Violation)].	D912		