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 _____	09/07/2023

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 conducted an annual survey and complaint investigation on September 6, 2023 to September 7, 2023. The complaint investigation was initiated by the Edgecombe County Department of Social Services on August 17, 2023.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of orders for 1 of 5 sampled residents (#5) related to an order for fluid restrictions. The findings are: Review of Resident #5's current FL-2 dated 07/12/23 revealed diagnoses included diabetes, hypertension, and glaucoma. Review of a nephrologist order for Resident #5 dated 07/28/23 revealed there was an order for 2 liters of fluid restriction. Review of Resident #5's July 2023 electronic treatment administration record (eTAR) revealed there was no entry for 2 liter fluid restriction from 07/28/23 to 07/31/23.	D 276		

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 276	Continued From page 1 Review of Resident #5's August 2023 eTAR revealed there was no entry for 2 liter fluid restriction from 08/01/23 to 08/30/23. Review of Resident #5's September 2023 eTAR revealed there was no entry for 2 liter fluid restriction from 09/01/23 to 09/06/23. Interview with a medication aide (MA) on 09/07/23 at 9:15am revealed: -When a resident returned from a physician appointment, the MA or the Resident Care Coordinator (RCC) faxed the physician order to the facility's contracted pharmacy. -The pharmacy entered any orders to the resident's eTAR. Interview with the RCC on 09/07/23 at 9:29am revealed: -She faxed physician orders to the facility's contracted pharmacy when a resident returned from an appointment, or the facility received new orders from a physician. -If the resident returned after hours, the MA on duty would fax the physician order to the facility's contracted pharmacy. -The pharmacy entered orders for the eTAR and she would file physician orders in the resident's chart. -She did not know how the physician order for 2 liter fluid restrictions for Resident #5 was missed. -The order for 2 liter fluid restrictions should have been on the resident's eTAR. -She thought she had faxed the physician order for the fluid restrictions to the pharmacy, but she had evidently missed faxing the order. -Resident #5 usually only drank liquids at meals, but the 2 liter fluid restriction order should have been implemented and followed by staff.	D 276		

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D 276	Continued From page 2 Interview with the Administrator on 09/07/23 at 4:27pm revealed: -The RCC or MA were expected to fax all physician orders to the facility's contracted pharmacy as soon as the resident returned from an appointment, or the facility received new orders from a resident's physician. -The pharmacy entered orders on a resident's eTAR. -Resident #5's order from the nephrologist should have been faxed to the pharmacy so the order could be on the eTAR. -She expected the RCC or MA to ensure all orders were faxed to the pharmacy. -Resident #5's 2 liter fluid restriction should have been implemented by the RCC and MAs in order to monitor his fluid intake. Attempted telephone interview with Resident #5's nephrologist on 09/07/23 at 2:08pm was unsuccessful.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the rights of one resident were maintained related to a resident not being offered an alternative breakfast meal (#3). The findings are:	D 338		

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 _____	09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 3 Review of Resident #3's FL2 dated 02/02/23 revealed: -Diagnoses of chronic obstructive pulmonary disease, hypertension, amputation left leg, history of other infectious and parasitic disease, neuropathy/phantom limb/shoulder pain and clinical depression. -A diet order for no concentrated sweets. Observation of the breakfast meal on 09/07/23 at 9:11am revealed: -Resident #3 entered the dining room and placed himself at a table. -The table had left over food where residents had been seated for breakfast. Observation of the breakfast meal on 09/07/23 at 9:12am revealed: -The Medication Aide Supervisor yelled out to Resident #3 telling him that breakfast was over. -She asked Resident #3 why he had not come in earlier to eat breakfast. -Resident #3 did not provide a response. -The Cook came to the dining room door and stated there was no breakfast food left. -Resident #3 was offered a bowl of cereal after the Surveyor asked if there was an alternative meal to be served to Resident #3. Interview with the Medication Aide Supervisor on 09/07/23 at 9:13am revealed she yelled at Resident #3 because she noticed he had eaten from a plate that had left over food from another resident. Interview with Resident #3 on 09/07/23 at 9:14am revealed: -He woke up late and when he saw bacon had been served, he took a piece off a plate that was	D 338		

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	HAL033005	A. BUILDING: _____ B. WING _____	09/07/2023

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D 338	Continued From page 4	D 338		

on a plate on the table.
-He did not want to eat the cereal because he did not like cereal.
-He was not offered anything else to eat beside the cereal.

Interview with the Cook on 09/07/23 at 9:43am revealed:
-Resident #3 had not come down for breakfast on most days.
-Meals were not prepared for residents who did not come to the dining room for breakfast.
-There were not plates prepared and set aside for residents who came late for meals.
-If a resident came to breakfast late, and there was no extra food, the resident would be offered cereal or a breakfast sandwich.
-She offered Resident #3 a breakfast sandwich, but he declined.

Second Interview with Resident #3 on 09/07/23 at 11:22am revealed:
-He normally went for breakfast at least once weekly.
-He overslept but decided to go in to eat breakfast once he noticed bacon was served.
-He had only been offered cereal, but he did not like cereal.
-He was not offered a breakfast sandwich.
-He did not eat breakfast.

Interview with the Administrator on 009/07/23 at 11:42am revealed:
-Residents who came in late for a meal, a plate was made if there was extra food.
-Residents were offered cereal or a sandwich if they miss breakfast and no extra food was left.
-The staff were to notify the Cook when a resident came to the dining room late or missed a meal.
-Meals were prepared and saved for residents

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	HAL033005	A. BUILDING: _____ B. WING _____	09/07/2023

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D 338	Continued From page 5 who have appointments and will be returning after the meal. -Residents who came in late for breakfast would be offered cereal or a sandwich if there was not extra food. -Meals were not served in residents' rooms but were announced.	D 338		
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 were administered as ordered for 2 of 3 residents (#7, #8) observed during the medication pass including errors with medications used to treat an infectious disease (#7) and a medication used to lower blood sugar (#8). The findings are: The medication error rate was 9% as evidenced by 3 errors out of 33 opportunities during the 8:00am medication pass on 09/06/23. a. Review of Resident #7's current FL-2 dated 02/02/23 revealed: -Diagnosis included an infectious disease.	D 358		

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 358	Continued From page 6 -There was an order for Intelence 200mg (used to treat an infectious disease) twice a day after meals. Observation of the 8:00am medication pass on 09/06/23 revealed Intelence 200mg was administered to Resident #7 at 8:04am. Observation of Resident #7 on 09/06/23 revealed: -Resident #7 was sitting at a table in the dining room. -Resident #7 received his meal and began eating at 9:12am. -Resident #7 began eating 1 hour and 9 minutes after receiving Intelence 200mg. Review of Resident #7's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Intelence 200mg 2 times daily after meals scheduled for administration at 8:00am and 6:00pm. -Intelence 200mg was documented as administered at 8:00am on 09/06/23. Interview with Resident #7 on 09/06/23 at 10:57am revealed he normally ate breakfast about 30 minutes after receiving all his morning medications. Interview with the medication aide (MA) on 09/06/23 at 1:02pm revealed: -If a resident had a medication that was ordered to be administered after a meal, then it should be administered after the resident ate. -Breakfast at the facility was usually served at 8:00am. -The pharmacy entered medication administration times in the eMAR system. -Resident #7 usually received Intelence after his	D 358		

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 _____	09/07/2023

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HERITAGE CARE OF ROCKY MOUNT	1650 COKEY ROAD ROCKY MOUNT, NC 27801

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D 358	Continued From page 7	D 358		

meal and she "messed up" by administering it before his meal on 09/06/23.

Interview with the Resident Care Coordinator (RCC) on 09/06/23 at 1:07pm revealed:
-If a medication was ordered to be administered after a meal, it should be administered to a resident after the resident had eaten.
-MAs received training on the timing of administering medications.

Interview with the Administrator on 09/06/23 at 1:12pm revealed if a resident's medication was ordered to be administered after a meal, she expected the MA not to administer the medication until the resident had eaten.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/07/23 at 2:17pm revealed:
-Intelence was used to slow the progression of an infectious disease.
-Intelence should be administered after a meal because food affected the way the medication was absorbed by the body.
-Administering Intelence prior to a meal might decrease the amount of medication the resident received.

Attempted telephone interview with Resident #7's infectious disease specialist on 09/07/23 at 8:59am was unsuccessful.

b. Review of Resident #7's current FL-2 dated 02/02/23 revealed:
-Diagnosis included an infectious disease.
-There was an order for Norvir 100mg (used to treat an infectious disease) daily with a meal.

Observation of the 8:00am medication pass on

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	HAL033005	A. BUILDING: _____ B. WING _____	09/07/2023

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

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D 358	Continued From page 8	D 358		

09/06/23 revealed Norvir 100mg was administered to Resident #7 at 8:04am.

Observation of Resident #7 on 09/06/23 revealed:
-Resident #7 was sitting at a table in the dining room.
-Resident #7 received his meal and began eating at 9:12am.
-Resident #7 began eating 1 hour and 9 minutes after receiving Norvir 100mg.

Review of Resident #7's September 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Norvir 100mg every day with a meal scheduled for administration at 7:00am.
-Norvir 100mg was documented as administered at 7:00am on 09/06/23.

Interview with Resident #7 on 09/06/23 at 10:57am revealed:
-He normally ate breakfast about 30 minutes after receiving all his morning medications.
-He felt fine and was not having any nausea, vomiting, or stomach cramping or pain.

Interview with the medication aide (MA) on 09/06/23 at 1:02pm revealed:
-If a medication was ordered to be administered with a meal, it should be administered while the resident was eating.
-Breakfast at the facility was usually served at 8:00am.
-The pharmacy entered medication administration times in the eMAR system.
-She was not aware that breakfast was served late on 09/06/23.

Interview with the Resident Care Coordinator

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D 358	Continued From page 9	D 358		

(RCC) on 09/06/23 at 1:07pm revealed:
-If a medication was ordered to be administered with a meal, she expected it to be administered while the resident was eating because that was the way it was ordered by the primary care provider (PCP).
-MAs received training on the timing of administering medications.

Interview with the Administrator on 09/06/23 at 1:12pm revealed:
-If a resident's medication was ordered to be administered with a meal the MA should read the eMAR and not administer the medication until the resident was eating.
-It was important to administer Resident #7's Norvir with a meal because that was the way the PCP ordered it to be administered.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/07/23 at 2:17pm revealed:
-Norvir was used to slow the progression of an infectious disease.
-Not administering Norvir with a meal could cause gastrointestinal (GI) side effects such as nausea and vomiting.

Attempted telephone interview with Resident #7's infectious disease specialist on 09/07/23 at 8:59am was unsuccessful.

c. Review of Resident #8's current FL-2 dated 01/18/23 revealed:
-Diagnosis included diabetes.
-There was an order for metformin 1000mg (used to treat high blood sugars) twice a day.
-There was an order for fingerstick blood sugar (FSBS) check at 4:00pm.

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	HAL033005	A. BUILDING: _____ B. WING _____	09/07/2023

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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 358	Continued From page 10	D 358		

Observation of the 8:00am medication pass on 09/06/23 revealed metformin 1000mg was administered to Resident #8 at 8:18am.

Observation of Resident #8 on 09/06/23 revealed:
-Resident #8 was seated at a table in the facility's dining room.
-Resident #8 received his meal and began eating at 9:03am.
-Resident #8 began eating 45 minutes after receiving metformin 1000mg.

Review of Resident #8's September 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for metformin 1000mg twice a day with food scheduled for administration at 7:00am and 4:00pm.
-Metformin 1000mg was documented as administered at 7:00am on 09/06/23.

Interview with Resident #8 on 09/06/23 at 10:46am revealed:
-He normally took his morning medications before he ate but he was not sure how far in advance before he ate.
-He was not currently experiencing any nausea, vomiting, or stomach pain.
-He did not have any feelings of dizziness or any other feelings like his FSBS was too low.

Interview with the medication aide (MA) on 09/06/23 at 1:02pm revealed:
-If a medication was ordered to be administered with a meal, it should be administered while the resident was eating.
-Breakfast at the facility was usually served at 8:00am.
-The pharmacy entered medication administration times in the eMAR system.

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	HAL033005	A. BUILDING: _____ B. WING _____	09/07/2023

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 358	Continued From page 11 -She was not aware that breakfast was served late on 09/06/23. Interview with the Resident Care Coordinator (RCC) on 09/06/23 at 1:07pm revealed: -If a medication was ordered to be administered with a meal, she expected it to be administered while the resident was eating because that was the way it was ordered by the primary care provider (PCP). -MAs received training on the timing of administering medications. Interview with the Administrator on 09/06/23 at 1:12pm revealed: -If a resident's medication was ordered to be administered with a meal the MA should read the eMAR and not administer the medication until the resident was eating. -It was important to administer Resident #8's metformin with a meal because that was the way the PCP ordered it to be administered and it might affect his FSBS. Interview with Resident #8's PCP on 09/06/23 at 11:11am revealed: -It was important that Resident #8 receive metformin with a meal because taking metformin on an empty stomach could cause nausea and bloating. -Resident #8's FSBS could go too low if he received metformin before eating a meal.	D 358		