Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092201	A. BUILDING: _____ B. WING _____	11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MANOR AT PERRY CREEK	7305 PERRY CREEK ROAD RALEIGH, NC 27616

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on November 8 and 10, 2016.	C 000		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that walls, ceilings, and floors in the kitchen, hallway, and hall bathroom were kept clean and in good repair. The findings are: Observation of the floor in the kitchen floor on 11/08/2016 at 10:00am revealed: -There was an irregular, circular shaped area of torn linoleum floor covering close to the doorway exiting the kitchen. -The sub-floor was visible where the linoleum floor covering was torn in the kitchen. Observations of the carpet in the hallway on 11/08/2016 at 11:00am revealed: -There was an area close to the hall bathroom where the carpet was ripped at the seam which measured approximately 18 inches long. -There was an area close to the end of the hall where the carpet was ripped at the seam which measured approximately 12 inches long.	C 074	Facility was in communication with landlord to start repairing home, prior to annual survey. POC: The landlord has granted permission for facility to change carpet and flooring in the kitchen. This will be completed prior → 12/20/16 to the end of December as repair has to be done one room at a time. The walls in hallway → 11/15/16 bathroom has already been	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ellen Edwards-Samuels — TITLE: Administrator — (X6) DATE

STATE FORM 6899 — 6IOR11 — If continuation sheet 1 of 13

Reviewed and accepted with revisions - HF 12/16/2016.

Division of Health Service Regulation

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C 074	Continued From page 1 Observations of the hall bathroom used by the residents on 11/08/2016 at 11:05am revealed: -There were numerous small scattered areas of peeling paint on the wall left of the bathroom entranceway above the handrail next to the tub/shower. -There were numerous small scattered areas of peeling paint on the wall surrounding the tub/shower combo. -The linoleum floor covering around the commode had a dark discoloration. -There were areas of peeling paint on the wall and door casing close to the light switch. Interview with the Supervisor-in-Charge (SIC) on 11/08/2016 at 11:20am revealed: -She was aware of the ripped carpet areas in the hallway. -She was aware of the torn linoleum in the kitchen. -She had seen the peeling paint in the hall bathroom. -The Administrator had been made aware of the torn linoleum and ripped carpet and had plans to replace the linoleum and carpet. -She vacuumed the carpet every morning. Confidential interviews with the three residents revealed: -The residents had not fallen or ever seen anyone trip or fall in the hallway where the carpet was ripped. -The residents had never seen any of the peeling paint fall from the walls in the bathroom. -The residents thought the carpet should be replaced. -One resident felt the torn linoleum in the kitchen and ripped carpet in the hallway was a safety concern.	C 074	painted. -The facility will ensure that all maintenance and repair/replace work to be done promptly. Facility staff to report any repairs that needs to be promptly to management. For prompt Services, Facility has agreed with landlord to repair any thing that is landlord responsibility and send invoice to landlord.	

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C 074	Continued From page 2 Review of the Environmental Health Report for the facility dated 09/13/2016 revealed demerits deducted include demerits for torn floor covering in the kitchen, torn/ripped carpet in the hallway, and peeling paint on the bathroom walls. Interview with the Administrator on 11/10/2016 at 12:35pm revealed: -She was working with the home owner regarding needed repairs. -She was not aware of and did not realize there were areas of peeling paint in the hallway bathroom. -She would have taken care of the peeling paint had staff made her aware of it. -Staff usually notified her if there was "a breakdown of functioning" and she need staff to keep her informed. -She was aware of the ripped carpet in the hallway. -She was waiting for the home owner to get back to her about changing the carpet in the facility. -She was aware of the ripped linoleum on the kitchen floor and had talked to the home owner about it. -She was waiting for approval from the landlord to make any changes to the home. -She had received a copy of the September 2016 environmental health report. -She did not review the September 2016 environmental health report but staff had told her about the carpet and kitchen floor needing repairs. -She could go ahead and get the linoleum in the kitchen replaced.	C 074	Addendum to POC per telephone conversation with Ellen Kolber-Samuels, Admin on 12/16/2016 at 2:15pm: - Staff have been provided a direct number to contact maintenance when house repairs are identified as necessary. - The Administrator has re-inforced to Staff that a general house cleaning will be done every Friday to ensure all areas of the house are clean. -The house manager or Administrator will perform a house inspection every four (4) weeks. Date of completion is 12/30/2016.	
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care	C 246		

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C 246	Continued From page 3 (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 assure referral and follow-up for 2 of 3 residents (#1, #3) sampled regarding ordered laboratory tests. The findings are: 1. Review of Resident #1's current FL-2 dated 05/25/2016 revealed diagnoses included schizoaffective disorder, and bipolar with paranoid features. Review of Resident #1's Resident Register revealed an admission date of 11/20/2014. Review of a Physician Assistant's (PA) encounter visit report dated 07/07/2016 for Resident #1 revealed: -Resident #1's had a past medical history included obesity, hyperlipidemia, and vitamin D deficiency. -There was a review of the resident's lab dated 06/21/2016 included results for complete metabolic panel (CMP) glucose 122 (normal reference range is 70 - 105); lipid panel HDL 22 (normal reference range is 35 -55), triglycerides 505 (normal reference range is 40 - 150); and vitamin D 16.7 (normal reference range is greater than 30). -The assessment and plan included orders to discontinue current vitamin D and start vitamin D 50,000 units weekly, recheck vitamin D level in 3 months; hyperlipidemia - uncontrolled, will start gemfibrizol 600mg twice daily; check CMP in one month; check lipids in one month; follow up in 3	C 246	Addendum to POC per telephone conversation with Ellen Eslick-Samuels, Administrator on 12/16/2016 at 2:15 pm. - Staff will call the House manager as soon as need for resident referral is identified. - The Administrator or House Manager will request a referral order from the PCP when staff identify a resident need for referral. - The House Manager will be responsible to immediately schedule the appointment with the physicians. - The resident's physician will be contacted by the Supervisor-in-Charge for Health care needs identified as a result of Health care monitoring when physicians have ordered specific parameters. - Date of Completion is 12/15/2016.	

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C 246	Continued From page 4 months. Review of a PA encounter visit report dated 09/09/2016 for Resident #1 revealed: -Resident #1 was started on vitamin D and gemfibrizol in July 2016 for vitamin D deficiency and hyperlipidemia and had tolerated the medications without difficulty. -The assessment and plan included orders continue vitamin D as ordered; hyperlipidemia - continue gemfibrizol, monitor lipids; and follow up in 3 months. Review of Resident #1's record for lab results revealed: -There were no lab results for a CMP drawn after the 06/21/2016 lab results. -There were no lab results for a lipid panel drawn after the 06/21/2016 lab results. -There were no lab results for a vitamin D level drawn after the 06/21/2016 lab results. Interview with the Supervisor-in-Charge (SIC) on 11/08/2016 at 12:45pm revealed: -Results of lab drawn for Resident #1 would be in the resident's record. -The PA sent someone to the facility to perform ordered lab work. -Resident #1 was transported by facility transporter every month for other lab work to be drawn related to a medication prescribed by a mental health provider. Interview with the SIC on 11/10/2016 at 11:05am revealed: -Someone came to the facility to drawn resident's blood work. -The PA was responsible for scheduling resident's lab to be drawn. -The facility did not get copies of the lab results.	C 246	As explained to Surveyor, labs were ordered and drawn by the doctor's office. prior to using this new medical services, all labs were done by facility, however, when the facility contracted with the new medical group, they informed Facility that they will be responsible for doing labs and that they will send their lab tech to come and draw labs at facility and they were doing so. When the PA ordered lab they lab techs will come and do labs without the facility doing anything, so the PCP office were	11/15/16

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C 246	Continued From page 5 -Resident #1 had lab work drawn at the facility on 06/21/2016 and no one had been to the facility to draw any lab work since then. -The facility transporter took Resident #1 to the lab today 11/10/2016). -The SIC did not know what labs were going to be drawn on today (11/10/2016). Interview with a facility Transporter staff on 11/10/2016 at 11:15am revealed: -She would be transporting Resident #1 to a local lab today. -She received a copy of the order dated 11/09/2016 and a request from the SIC to take the resident for lab work. Second interview with a facility transporter on 11/10/2016 at 12:10pm revealed: -She did not know anything about the 07/07/2016 ordered lab work for Resident #1. -She did not work in this facility but did transport the facility residents to appointments. -The process she was used to with regards to resident lab draws included the PA would give the facility SIC the order and the SIC was responsible to fax the order to the PA's clinic number for the lab draw to be scheduled and done. -Starting in October 2016, the facility began transporting the residents to a local lab for lab work to be drawn. Review of an order for Resident #1 dated 11/09/2016 and presented by the SIC on 11/10/2016 at 11:30am revealed an order to "D/C [discontinue] order written 7/7/16 for CMP & lipid panel, check CMP/lipid panel - facility to have lab drawn." Interview with the SIC on 11/10/2016 at 11:30am revealed the PA may have written the 11/09/2016	C 246	Supposed to have taken Care of labs like they usually do. Facility was informed few months down the road, after administrator Conducted them about labs, and they responded that they just stopped doing labs at facility - Administrator questioned them of why facility was not notified, there was no tangible answers given. Facility has resumed taking residents for labs as it was done prior to new PCP office doing labs. POC: facility has instructed all staff that when lab is ordered, to notify house manager, who does appointment	

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C 246	Continued From page 6 order because the person who was supposed to come to the facility to draw the labs did not come. Interview with a second facility transporter on 11/10/2016 at 12:05pm revealed: -PA ordered lab work used to be drawn at the facility by someone from the PA's office. -The PA's office staff stopped drawing lab work at the facility "just this month", and now the facility transported the residents to a local lab to have lab work drawn. -She had not transported Resident #1 to the lab. Telephone interview with a representative from the PA's clinic on 11/10/2016 at 2:40pm revealed: -The PA ordered lab at the facility, gave the order to the facility staff, and facility staff was to send the order to the clinic representative. Either by fax, email, or electronic medical record. -The facility was scheduled for lab once a month. -She would call the facility one week before the lab technician was due to go to the facility. -The last order she received for Resident #1 was dated 06/21/2016 and the lab was drawn on 06/21/2016. -She did not receive any orders dated 07/07/2016 for lab work for Resident #1. -The facility was supposed to send lab orders directly to the clinic representative according to instructions. -The SIC was responsible to send the orders to the clinic representative. -She would always let the provider know if ordered labs for residents had not been drawn and the provider would reorder the labs. -The clinic sent the facility an email on 10/06/2016 notifying them a lab technician would no longer be sent to the facility for lab draws and the last lab draw by the clinic would be 10/21/2016.	C 246	to immediately schedule lab visit as soon as it's possible. And also to document on communication log when labs done. Facility has already put plan into action prior to survey, Since Facility learned of PCP office not doing labs any more. Since the facility is incharge of labs now, the facility will ensure all labs are done in a timely manner. Facility staff was instructed also to alert administrator of all lab orders as soon as it's given in order to schedule it promptly.	

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C 246	Continued From page 7 Telephone interview with the PA on 11/10/2016 at 4:00pm revealed: -The PA clinic was responsible for resident lab draws until the end of October 2016. -She had ordered lab work for Resident #1 because she had started the resident on a new medication for a low vitamin D level and wanted to follow up to make sure the medication was working. -The labs ordered for Resident #1 were not urgent labs, but she expected the lab work to be drawn around the time specified in the order "give or take". -She always left a hard script of orders with the SIC when she made visits to the facility. -The facility would have been responsible to get the lab work drawn until a d/c order was given. -The labs got missed. -It was important that we get labs drawn. Refer to interview with the SIC dated 11/10/2016 at 11:20am. Refer to interview with the Administrator dated 11/10/2016 at 12:20pm. 2. Review of Resident #3's current FL-2 dated 05/25/2016 revealed diagnoses included schizoaffective disorder, hypertension, chronic obstructive pulmonary disease, hypothyroidism, hyponatremia, and overweight. Review of Resident #3's Resident Register revealed an admission date of 12/04/2014. Review of a Physician Assistant's (PA) encounter visit report dated 08/024/2016 for Resident #3 revealed: -Resident #3 was seen at the resident' request.	C 246		

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C 246	Continued From page 8 -Resident #3 reported having some frequent urination which had been going on for some time. The resident's urine was dip-sticked and was negative for nitrites, leukocytes. -There was a review of the resident's lab dated 05/25/2016 that included lab values from a complete blood count (CBC), complete metabolic panel (CMP), lipid panel, and thyroid stimulating hormone (TSH) that were within the refernce range values. -The assessment and plan included an order to check the resident's hemoglobin A1C. Review of orders dated 08/24/2016 revealed orders to check complete blood count, complete metabolic panel, vitamin D level, thyroid stimulating hormone (TSH). Review of Resident #3's record for lab results revealed: -There were no lab results for a CBC drawn after the 05/25/2016 lab results. -There were no lab results for a CMP drawn after the 05/25/2016 lab results. -There were no lab results for a vitamin D level drawn. -There were no lab results TSH drawn after the 05/25/2016 lab results. Interview with the Supervisor-in-Charge (SIC) on 11/08/2016 at 12:45pm revealed the PA sent someone to the facility to perform ordered lab work. Interview with the SIC on 11/10/2016 at 11:05am revealed: -Someone came to the facility to drawn resident's blood work. -The PA was responsible for scheduling resident's lab to be drawn.	C 246		

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C 246	Continued From page 9 -The facility did not get copies of the lab results. Second interview with a facility transporter on 11/10/2016 at 12:10pm revealed: -She did not know anything about the 08/24/2016 ordered lab work for Resident #3. -She did not work in this facility but did transport the facility residents to appointments. -The process she was used to with regards to resident lab draws included the PA would give the facility SIC the order and the SIC was responsible to fax the order to the PA's clinic number for the lab draw to be scheduled and done. -Starting in October 2016, the facility began transporting the residents to a local lab for lab work to be drawn. Review of an order for Resident #3 dated 11/09/2016 and presented by the SIC on 11/10/2016 at 11:30am revealed an order to " D/C [discontinue] order written 8/24/16 for hgbA1C. " Interview with the SIC on 11/10/2016 at 11:30am revealed the PA may have written the 11/09/2016 order because the person who was supposed to come to the facility to draw the labs did not come. Interview with a second facility transporter on 11/10/2016 at 12:05pm revealed: -PA ordered lab work used to be drawn at the facility by someone from the PA's office. -The PA's office staff stopped drawing lab work at the facility "just this month", and now the facility transported the residents to a local lab to have lab work drawn. -She had not transported Resident #3 to the lab. Telephone interview with a representative from the PA's clinic on 11/10/2016 at 2:40pm revealed:	C 246		

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C 246	Continued From page 10 -The PA ordered lab at the facility, gave the order to the facility staff, and facility staff was to send the order to the clinic representative. Either by fax, email, or electronic medical record. -The facility was scheduled for lab once a month. -She would call the facility one week before the lab technician was due to go to the facility. -The last order she received for Resident #3 was dated 05/24/2016 and the lab was drawn on 05/25/2016. -She did not receive any orders dated 08/24/2016 for lab work for Resident #3. -The facility was supposed to send lab orders directly to the clinic representative according to instructions. -The SIC was responsible to send the orders to the clinic representative. -She would always let the provider know if ordered labs for residents had not been drawn and the provider would reorder the labs. -The clinic sent the facility an email on 10/06/2016 notifying them a lab technician would no longer be sent to the facility for lab draws and the last lab draw by the clinic would be 10/21/2016. Telephone interview with the PA on 11/10/2016 at 4:05pm revealed: -The PA clinic was responsible for resident lab draws until the end of October 2016. -She always left a hard script of orders with the SIC when she made visits to the facility. -She had ordered lab work for Resident #3 because she thought the resident was having questions about whether she was diabetic or not. -The PA wanted to check the HgbA1C because Resident #3 was urinating a lot. -Resident #3 had all labs done on 05/25/2016 but the PA did not see the lab results when the PA made her visit, so the labs were reordered.	C 246		

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C 246	Continued From page 11 -The PA wanted to make sure the lab results were available for other disciplines. -The PA liked to have a hard copy of the lab results in the resident ' s record. -She normally ordered labs yearly unless the resident was on a medication that needed monitoring. -She did not want the labs redrawn after the 05/25/2016 labs were reviewed. -The facility would have been responsible to get the lab work drawn until a d/c order was given. -The labs got missed. -It was important that we get labs drawn. Refer to interview with the SIC dated 11/10/2016 at 11:20am. Refer to interview with the Administrator dated 11/10/2016 at 12:20pm. --- Interview with the SIC on 11/10/2016 at 11:20am revealed: -When the PA wanted lab work done, the PA wrote an order. -When the facility got the dates that the PA had scheduled the resident for lab, a facility transporter would take the resident to the lab. -The PA would give the lab order to the SIC or faxed it to the Administrator. -If the order was faxed to the Administrator, she would give the lab order to the SIC. -The Administrator was responsible to contact a facility transporter about resident appointments. Telephone interview with the Administrator on 11/10/2016 at 12:20pm revealed: -The facility had changed physician providers in May 2016.	C 246		

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THE MANOR AT PERRY CREEK	7305 PERRY CREEK ROAD RALEIGH, NC 27616

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C 246	Continued From page 12 -The physician providers told the facility they were responsible for drawing ordered resident lab work. -If the PA ordered lab, they would send a technician to do the lab draw. -No one ever came from the PA's office to draw the follow up lab for the resident. -She was not aware the lab work had not been drawn until 11/08/2016. -She "assumed" the PA's clinic technician had been to the facility to draw the lab work. -She contacted the PA on 11/09/2016 and the PA informed the Administrator she would send another order for labs and would discontinue some of the labs previously ordered. -The PA's clinic staff were responsible to make sure the resident's lab work was drawn.	C 246		