STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086002	A. BUILDING: _____ B. WING _____	R 01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL LONG TERM CARE FACILITY	340 SNOWHILL DRIVE MOUNT AIRY, NC 27030

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{D 000}	Initial Comments Surveyor: 13264 The Adult Care Licensure Section and the Surry County Department of Social Services conducted a follow-up survey on January 11-12, 2017. Surveyor: NC355	{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: Surveyor: 13264 FOLLOW-UP TO A TYPE A2 VIOLATION The A2 Violation is abated. Non-compliance continues. TYPE B VIOLATION Based on observations, record reviews, and interviews the facility failed to obtain an electric wheelchair for 1 of 5 sampled residents as ordered by a licensed prescribing practitioner. (Resident #5.) The findings are: Review of Resident #5's current FL2 dated 12/7/16 revealed: -Diagnoses included cerebral vascular accident (stroke), chronic obstructive pulmonary disease, and encephalopathy. -Medication orders included aspirin 81mg daily and clopidogrel 75mg daily. (Both aspirin and	{D 273}		

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{D 273}	Continued From page 1 clopidogrel are medications used to prevent blood clots and secondary stroke. Per manufacturer's product information, both medications can cause easy bruising.) Review of Resident #5's Resident Register revealed an admission date of 10/7/13. Review of Resident #5's care plan dated 10/26/16 revealed: -Resident ambulated with a wheelchair. -Resident required limited assistance with ambulation. -Resident was paralyzed on his left side. Review of Resident #5's record revealed a physician's order for an electric wheelchair dated 7/27/16 from the facility's Family Nurse Practitioner (FNP). Observation of Resident #5 in the living room of the facility on 1/11/17 at 10:40am revealed: -Resident was sitting in a non-electric wheelchair. -The wheelchair had a torn left armrest. -The armrest had been repaired with foam pipe wrap and duct tape. -The duct tape had worn from the front edge of the armrest exposing bare metal on the armrest. -The top of Resident #5's left arm was badly bruised from just above the elbow to the wrist. Interview with Resident #5 on 1/12/17 at 9:05am revealed: -He was aware of the order for an electric wheelchair. -Someone came and took measurements for the electric wheelchair, (no time specified.) -The resident was not sure who took the measurements. -Since the measurements were taken, he had not	{D 273}		

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{D 273}	Continued From page 2	{D 273}		

heard anything else about the electric wheelchair.
-Someone from medicaid (unspecified) called and told Resident #5 he had been approved for an electric wheelchair.
-His left arm was weak and he had to pick it up with his right arm to place it on the left arm of the wheelchair.
-His "bad arm" hit the back of the left arm of the wheelchair on an exposed metal piece.
-He bruised easily and scratched the top of his left arm at times because it itched.
-He had used creams in the past for the itching.
-He was not sure if the left arm of the wheelchair had caused the bruising on his left arm, "it may have come from the scratching."
-The FNP had mentioned the bruising and scratching in the past.
-He had asked the facility's Supervisor about the electric wheelchair about a month ago.
-He was not sure if the supervisor did anything to follow-up with the order for the electric wheelchair.
-He propelled himself around the facility with his right arm only.
-He would really like to have the electric wheelchair or at least to get the regular wheelchair fixed.
-He believed the left arm of his old wheelchair had been torn and repaired with duct tape since he was admitted to the facility.
-A staff person made the repair to the left arm of the wheelchair with foam and duct tape "about a year ago, but I can't remember who did it."

Review of the FNP's progress notes for Resident #5 dated 1/4/17, 11/9/16, and 11/16/16 revealed:
-No bruising or bleeding.
-No rashes or skin breakdown.

Interview with the facility Business Office

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{D 273}	Continued From page 3 Manager (BOM) on 1/12/17 at 9:25am revealed: -She was not aware of any order for an electric wheelchair for Resident #5. -She was not aware the arm of Resident #5's old wheelchair was in disrepair. -She would be the one to order Durable Medical Equipment (DME) for Resident #5. -"We can get him (Resident #5) a new wheelchair today." Interview with the facility's nursing assistant (NA) on 1/12/17 at 9:40am revealed: -"We have tried to get Resident #5 an electric wheelchair in the past, but the insurance would not approve it." -The facility's Supervisor handled these DME orders. -She believed the order from 7/27/16 had been denied. -The only documentation they could find in Resident #5's record revealed an insurance denial for an electric wheelchair on 5/17/14. Interview with the facility's FNP on 1/12/17 at 10:58am revealed: -She recalled writing the order for Resident #5's electric wheelchair on 7/27/17. -She was not sure if the bruising on Resident #5's left arm came from the torn and repaired arm of his old wheelchair. -She was not sure about any itching on his left arm. -She had inquired about the status of his electric wheelchair about 3-4 weeks ago and was told by the facility staff they were working on it. -When she wrote an order for DME, she relied on the facility to follow-up on the order. -With the approval process for an electric wheelchair, the next step after writing the original order was to complete paperwork supplied from	{D 273}		

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{D 273}	Continued From page 4 the DME company. -She had not received any paperwork for Resident #5's electric wheelchair from any DME provider. Interview with a representative from the facility's DME provider on 1/12/17 at 11:20am revealed: -After an initial physician's order for an electric wheelchair, the next step would be to have a face to face meeting with the prescribing physician. -The resident's insurance would then be verified. -A form would then be sent to the physician for completion. -The home environment would be "assigned" to determine if use of the electric wheelchair was appropriate for the facility or home. -"We only have 45 days from the initial physician's order to complete all the requirements of obtaining an electric wheelchair." -They had not received any orders for an electric wheelchair for Resident #5 from the facility. Interview with the Resident Care Coordinator on 1/12/17 at 2:17pm revealed: -She was not aware Resident #5 had an order from 7/27/16 for an electric wheelchair. -Resident #5 seemed to be OK with the repairs made to the left arm of his wheelchair. -She believe the left arm of Resident #5's wheelchair had been in that condition for about 4 months. -The NA and Supervisors were responsible for ensuring physician's orders were faxed to the proper providers. Interview with the facility's Supervisor on 1/12/17 at 2:17pm revealed: -She believed Resident #5's order from 7/27/16 for an electric wheelchair had been faxed to the DME company.	{D 273}		

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{D 273}	Continued From page 5 -Someone from the DME company came out and took measurements from Resident #5 for an electric wheelchair. -She was not sure who faxed the order to the DME company. -The FNP had not asked her about the status of Resident #5's electric wheelchair. -She was not sure why the DME company did not have a record of the order for Resident #5's electric wheelchair. Interview with the BOM and Administrator on 1/12/17 at 2:45pm revealed the policy of the facility was for the medication aide on duty to fax orders to the appropriate provider. Per observation on 1/12/17 at 3:00pm, Resident #5 had been provided a newer non-electric wheelchair by the facility. _____ The facility failed to obtain an electric wheelchair ordered by the primary care provider for Resident #5. This failure made it difficult for Resident #5 to ambulate throughout the facility due to his left sided paralysis secondary to a prior stroke. In addition, the old wheelchair Resident #5 used was in disrepair and may have contributed to severe bruising of his left arm. The facility's failure to obtain an electric wheelchair for Resident #5 as ordered was detrimental to his health and well being and constitutes a Type B Violation. _____ Review of a Plan of Protection provided by the facility on 1/12/17 revealed: -The prescribing practitioner's order for Resident	{D 273}		

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{D 273}	Continued From page 6 #5's electric wheelchair will be faxed to the DME provider today. -All prescribing practitioner's orders will be reviewed weekly by the facility's Supervisor to ensure all healthcare services are acted upon in a timely manner. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 26, 2017. Surveyor: NC398	{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: Surveyor: 13264 Based on observations, record reviews, and interviews, the facility failed to provide care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations in the areas of health care referral and follow-up.	{D912}		

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{D912}	Continued From page 7 The findings are: Based on observations, record reviews, and interviews the facility failed to obtain an electric wheelchair for 1 of 5 sampled residents as ordered by a licensed prescribing practitioner. (Resident #5.) [Refer to D 273, 10A NCAC 13F .0902 (b) Health Care (Type B Violation.)] Surveyor: NC398	{D912}		