Division of Health Service Regulation 3/31/17 received via email Tiffany Sewell

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070006	A. BUILDING: ______ B. WING ______	03/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE OF ELIZABETH CITY	100 TIMMERMAN DRIVE ELIZABETH CITY, NC 27909

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D 000	Initial Comments The Adult Care Licensure Section and the Pasquotank County Department of Social Services conducted an annual survey on March 9-10, 2017.	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: Based on interviews and record reviews, the facility failed to assure a resident's physician was notified for 1 of 5 sampled residents (#1) who did not receive nitroglycerin patches for heart problems as ordered. The findings are: Review of Resident #1's current FL2 dated 5/03/16 revealed: -Diagnoses included respiratory failure, acute hypoxia-resolved, acute sepsis secondary to pneumonia, hypokalemia, deep vein thrombosis (DVT), diabetes type II (DM T2), hypertension (HTN), and probable dementia - mental retardation. -There was a physician's order for nitroglycerin 0.1 mg/hr patch apply 1 patch daily. Review of the Resident Register for Resident #1 revealed the resident was admitted to the facility on 5/21/15. Review of the January 2017 Medication	D 273	A quality assurance staff meeting was held with all medication aides on March 14, 2017. The following policy was covered 1. If a medication is not in the medication cart Medicine Mart Pharmacy is to be contacted immediately to order medication from the local back up pharmacy for immediate delivery. 2. If the medication is not available locally the physician will be contacted immediately, made aware of the situation and orders requested. 3. The Health Service Director will be made aware of the missing medication within 24 hours for follow up with the pharmacy. 4. This policy will be monitored daily by Health Service Director with assistance from all Medication Aides.	03-14-17

POC reviewed and accepted. Tiffany Sewell RN

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D 273	Continued From page 1 Administration Record for Resident #1 revealed: -There was an entry for nitroglycerin 0.1 mg/hr patch to be applied daily with the old patch removed before applying a new patch. -On 1/08/17, nitroglycerin 0.1 mg/hr patch was documented as "waiting on medication." -On 1/09/17, nitroglycerin 0.1 mg/hr patch was documented as "medication not received." -On 1/10/17 and 1/11/17, nitroglycerin 0.1 mg/hr patch was documented as "waiting on pharmacy." Review of the February 2017 Medication Administration Record for Resident #1 revealed all doses of nitroglycerin 0.1 mg/hr patch were documented as administered as ordered by the physician. Review of March 1, 2017 through March 10, 2017 Medication Administration Record for Resident #1 revealed all doses of nitroglycerin 0.1 mg/hr patch were documented as administered as ordered by the physician. Interview with a Medication Aide (MA) on 3/10/17 at 9:26 a.m. revealed: -She was aware Resident #1 did not receive her nitroglycerin patch for four days in January 2017. -The evening shift removed Resident #1's patch each day and day shift staff applied it every morning. -She thought the primary care physician had been notified about the missed doses of nitroglycerin but she was not sure. -She did not notify the primary care physician that Resident #1 did not have any patches left on 1/08/17. -She thought the primary care physician was usually notified the next day by the Resident Care Coordinator (RCC) when a medication was missing from the medication cart.	D 273		

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D 273	Continued From page 2 -She had not notified the RCC or anyone regarding Resident #1 not having any nitroglycerin patches because she thought the facility was waiting on the pharmacy to send the medication. -When a medication was not available on the cart, she would wait until the medication came in the facility. -Resident #1 had not been given any pain medication in the meantime until the patches were received because she had not complained of any chest pain. -There was not a facility policy related to notifying the physician when residents missed medications. Interview with a second MA on 3/10/17 at 2:35 p.m. revealed: -She was not aware of the medication incident of Resident #1 not receiving her nitroglycerin patch for four days in January 2017. -When a medication was missing from the medication cart, she would enter that information on the medication administration record (MAR) and immediately contact the pharmacy. -If she could not reach the pharmacy because it was after hours, on a Friday, or on a weekend, she would immediately contact the backup pharmacy to get any missing medications that same day. -She did not notify the primary care physician unless the resident needed more refills. Telephone Interview with the Primary Care Physician for Resident #1 on 3/10/17 at 10:00 a.m. revealed: -He was not aware Resident #1 had not received her nitroglycerin patch for four days in January 2017. -The resident was last seen on 1/17/17 onsite at	D 273		

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D 273	Continued From page 3 the facility and no information was mentioned regarding Resident #1 having missed nitroglycerin patches or any other medications in January 2017. -He wanted to have been made aware immediately even after hours of the incident. -There was no record on the physician's office call log or answering service that the facility had called before, during, or after the medication event on 1/08/17 through 1/11/17 regarding Resident #1. -The nitroglycerin patches were required for Resident #1 to treat heart related problems and chest pain related to her diagnosis. -Resident #1 was unable to clearly express herself when in pain due to her cognitive and mental status and relied on staff to assist her. -He had not been made aware of any needed refills for Resident #1's nitroglycerin patches. -He wanted to be notified a week in advance of medications running out. Interview with the facility Pharmacist on 3/10/17 at 10:20 a.m. revealed: -The last refill order for the nitroglycerin patches was on 1/06/17. -When the facility called on a Friday, orders placed "could take a few days." -On 1/06/17, the order for nitroglycerin patches was placed but was not delivered to the facility until 1/10/17. -The pharmacy does have a 24-hour backup pharmacy that could have filled the nitroglycerin patch order the same day. -The 24-hour backup pharmacy was not contacted by the facility. -This was not the common practice of the facility and she was not sure why the pharmacy or the 24-hour backup pharmacy had not been contacted to obtain nitroglycerin patches for	D 273		

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D 273	Continued From page 4 Resident #1. Review of the January 2017 Vital Signs Log for Resident #1 revealed an undated entry of a reading for a blood pressure of 130/74, pulse of 72, and respirations of 20. Review of the February 2017 Vitals Signs for Resident #1 revealed an undated entry of a reading for a blood pressure of 138/72, pulse of 74, and respirations of 20. Review of the March 2017 Vitals Signs for Resident #1 revealed an undated entry of a blood pressure of 140/76, pulse of 72, and respirations of 24. Interview with the Resident Care Coordinator (RCC) for the facility on 3/10/17 at 3:15 p.m. revealed: -She was made aware Resident #1 had missed her nitroglycerin patch for four days in January 2017 after the incident had occurred. -She was told by a MA after the incident had occurred but was unable to specify when she was notified or the name of the MA who told her. -She expected the MAs to immediately contact the pharmacy when medications were not on the medication cart. -The backup pharmacy was to be immediately contacted by the MAs when medications were not readily available from the pharmacy to get missing medications that same day. -She had not contacted the physician for Resident #1 after being made aware of the incident because the resident had received her medications. -The pharmacy would contact the physician as needed for Resident#1 or any other resident who had missing medications.	D 273		

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D 273	Continued From page 5 -It was not the MAs responsibility to contact the resident's physician. -The facility did not have a policy addressing notifying the physician when a resident missed medications. Interview with the Administrator on 3/10/17 at 3:25 p.m. revealed: -She was made aware during the survey process by the RCC that Resident #1 had missed receiving her nitroglycerin patch for four days in January 2017. -The incident should not have happened and there was no excuse for it. -She had a meeting with the RCC on 3/09/17 regarding procedures to follow when medications were missing. -The primary care physician should have been immediately notified by the MAs and RCC when Resident #1's nitroglycerin patch was not available in the facility. -She would meet with the MAs to ensure that it did not occur again. -She expected the MAs to immediately contact the pharmacy or the backup pharmacy when medications were missing from the medication cart. -She wanted to be contacted by the MAs when the pharmacy or the backup pharmacy was not reachable. -She had a direct contact number for the pharmacist. Attempts to interview Resident #1 on 3/09/17 at 12:05 p.m. and on 3/10/17 at 9:30 a.m. were unsuccessful due to her cognitive mental status. Attempts to telephone interview the guardian of Resident #1 on 3/09/17 at 2:05 p.m. and on 3/10/17 at 10:00 a.m. were unsuccessful.	D 273		

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D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure four of four round ceiling vents, two of two large square ceiling vents, the kitchen door, and floor in the kitchen area were cleaned and free of contamination. The findings are: Observations of the ceiling above the food preparation areas in the kitchen on 3/09/17 at 11:05 a.m. revealed: -Four of four round ceiling vents were covered in black grime. -Four of four round vents had brown rust stains with dried food particles. -The ceiling areas around the four round ceiling vents had dark brown stains and food particles splattered around them. -The two large ceiling vents were covered in black grime with dirt particles hanging from them. -The two large ceiling vents had dried food particles stuck to them and were covered in a dark brown sticky substance. -The ceiling area around the two large ceiling vents had dark brown stains and food particles splattered around them. Observation of the kitchen door and floor in the kitchen area on 03/09/17 at 11:15 a.m. revealed:	D 282	At the time of this inspection the kitchen at Heritage Care had a 99 Health Grade from an inspection conducted 12/16. An inspection 3/17 also resulted in a 99 Health Grade. All vents and filters in the kitchen were cleaned immediately. The vent cover cited in this report was painted 03-17-17. The back door will be painted 03-31-17. All vents and filters in the kitchen will be cleaned by maintenance personnel weekly. This will be monitored by Administrator on a weekly basis.	03-31-17

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D 282	Continued From page 7 -Several dark brown rust stained areas were across the top and down the left interior side of the exit door. -Several dark brown rust stains were around the entire frame of the kitchen door, and on the kitchen door closest to the top left corner. -The kitchen door was covered with several black dirty marks. -Several long scraped, chipped paint areas were along the upper portion of the kitchen door and along the left interior of the kitchen door frame. -Nine floor tiles at the kitchen door interior threshold were chipped with black stains. Interview with the Dietary Aide on 3/09/17 at 11:30 a.m. revealed: -The kitchen areas were cleaned as needed daily by the end of their shifts. -She was not responsible for cleaning the ceiling vents or the kitchen door. -Maintenance was responsible for cleaning the ceiling vents and the kitchen door. -She was unaware of how long the ceiling vents and the kitchen door had been in that condition, but said it had been a long time. -She had not reported any repairs to the dietary manager or Administrator. Interview with the Cook on 3/09/17 at 11:40 a.m. revealed: -The kitchen areas were cleaned as needed daily by the end of their shifts. -She was not responsible for cleaning the ceiling vents or the kitchen door. -Maintenance was responsible for cleaning the ceiling vents and the kitchen door. -The kitchen door was used often as an entrance and exit to the kitchen especially when deliveries were made which may have caused the damage to the kitchen door.	D 282		

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D 282	Continued From page 8 -She had reported the kitchen door's condition to maintenance but was unsure of when she had reported it. -She was unaware of how long the ceiling vents and the kitchen door had been in that condition, but said it had been a long time. -She had not reported any repairs to anyone. Interview with the Dietary Manager on 3/10/17 at 11:57 a.m. revealed: -Cleaning occurred daily as needed by the kitchen staff. -She was not sure of how long the ceiling vents and kitchen door areas had been in that condition. -She monitored the cleaning of the kitchen areas on a weekly basis. -Maintenance was responsible for cleaning the ceiling vents. -Both of the large square ceiling vents needed to be replaced. -She had not been informed about the ceiling vents and kitchen door areas. -She expected to be informed by kitchen staff of any needed repairs or cleaning issues. Interview with the Housekeeping/Maintenance Supervisor on 3/09/17 at 11:57 a.m. revealed: -He was aware of the condition of the ceiling vents and kitchen door areas. -He only handled cleaning and not repairs in the kitchen. -He performed light maintenance tasks and cleaning. -He was responsible for cleaning the ceiling vents in the kitchen area, but he had been out of the facility for three months. -The Administrator addressed the "heavier" maintenance repairs. -He was aware the four round ceiling vents and	D 282		

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D 282	Continued From page 9 exit door areas needed cleaning. -The four round ceiling vents would be cleaned immediately and painted if deemed necessary. -The two large square ceiling vents needed to be replaced and had been that way for three months. -The ceiling vents and kitchen door areas were cleaned once a month. -He would follow up with the Administrator regarding the ceiling vents and kitchen door. Interview with the Administrator on 3/10/17 at 3:25 p.m. revealed: -The dietary manager was responsible for ensuring the kitchen areas were cleaned and were in working order. -She expected to be informed of any issues by the kitchen staff, dietary manager, or maintenance. -She was not aware of the condition or any issues with cleanliness of the ceiling vents and the exit door in the kitchen area. -Cleaning of the kitchen areas should occur every day as needed. -The Housekeeping/Maintenance Supervisor handled cleaning of kitchen vents and light maintenance work. -She had two staff she used to complete the heavier maintenance tasks for the facility. -The four round ceiling vents would be cleaned immediately and the two large square ceiling vents would be replaced as soon as possible. -The kitchen door could not be cleaned well enough and would be painted when the weather permitted.	D 282		