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
	HAL045113	A. BUILDING: _____ B. WING _____	C 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON'S ASSISTED LIVING	602 BROOKSIDE CAMP ROAD HENDERSONVILLE, NC 28792

(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 and the Henderson County Department of Social Services conducted an annual and follow-up survey on 06/05/19-06/06/19.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure the hot water temperatures were maintained between 100 - 116 degrees Fahrenheit (F) for 5 of 5 sampled sink fixtures. The findings are: Observations during the initial tour of the facility on 06/05/19 between 8:30am and 10:30am revealed: -At 8:45am, the hot water temperature at a common bathroom sink on the left side of a short hallway was 129 degrees F. -At 8:50am, the hot water temperature at the sink in room 8 was 130 degrees F.	D 113		

Reviewed and Accepted
Date: 08/15/19
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D 113	Continued From page 1 -At 9:20am, the hot water temperature at the sink in room 6 was 120 degrees F. -At 9:25am, the hot water temperature at the sink in room 9 was 118 degrees F. Observation with the maintenance staff on 06/05/19 at 9:30am revealed: -The surveyor checked the water temperature at the sink of the common bathroom at the entrance hallway and got a reading of 129 degrees F. -The maintenance staff checked the water temperature with his thermometer he used to check water temperatures in the same sink of the common bathroom at the entrance hallway and got a reading of 129 degrees F. Interviews with five residents on 06/05/19 during the initial tour revealed: -The water temperature in the sinks did get hot, but they could adjust it to warm. -The new maintenance staff had told the residents that he had been working on adjusting the water temperatures. -The staff would help them get "set up" for showers and help adjust the water. -Three of the three residents had not been burned by the hot water in the sinks in their rooms or in the common bathrooms. Review of the facility sanitation report dated 01/29/19 revealed the water temperature at the sink in a hallway restroom was 126 degrees F. Review of the facility's water temperature logs between 01/01/19 and 06/05/19 revealed: -There were 89 temperature readings of either the resident rooms or common hallway sinks / showers. -There were 86 water temperature readings which ranged between 100 degrees F to 116	D 113		

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D 113	Continued From page 2 degrees F. -There was 1 water temperature on 04/26/19 which was 118 degrees F. -There was 1 water temperature reading on 05/30/19 which was 127 degrees F. -There was 1 water temperature reading on 06/04/19 in room 9 which was 119 degrees F. Interview with the maintenance staff on 06/05/19 at 2:00pm revealed: -He had been working at the facility for 3 weeks. -When he started, the Executive Director told him that he needed to check the water temperatures every Monday and Friday. -He was also instructed to check at least two different rooms on opposite ends of the hallway. -He was changing a stem valve on 05/30/19 in one of the rooms faucets when he noticed that the water temperature felt hot and when he checked it it was 127 degrees F. -He did let the Executive Director know and she instructed him to start making more frequent water temperature checks. -On 05/30/19, he made an adjustment to the temperature regulator on the hot water boiler, and the water temperature went down to under 116 degrees F. Interview with the Executive Director on 06/06/19 at 10:30am revealed: -She had known that there had been intermittent temperature fluctuations with the hot water, but nothing that had continued. -She had instructed the maintenance staff to check the water temperatures more frequently and make sure they stayed in the temperature range of 100 degrees F to 116 degrees F. -No resident had ever said anything to her about the water temperatures being elevated. -The staff helped most of the residents get set up	D 113		

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D 113	Continued From page 3 for showers, or showered the residents who could not do for themselves. Interview with two personal care aides on 06/05/19 between 9:00am and 10:00am revealed they had never noticed the hot water being too hot. Telephone interview with the Administrator on 06/06/19 at 10:10am revealed: -He had not been made aware the facility water temperatures had been elevated at 126 degrees F on the sanitation report dated 01/29/19. -He had been made aware by the Executive Director water temperatures had been elevated when they were checked during the initial tour of survey on 06/05/19. -Maintenance staff were responsible for checking hot water temperatures in the facility on a weekly basis. -The maintenance staff would have been expected to communicate the issues with the hot water temperatures to him and the Executive Director. The facility's failure to ensure hot water temperatures were maintained between 100 and 116 degrees F at the sinks with hot water temperatures between 118 degrees F and 130 degrees F. This failure placed the residents at a potential risk for burns, which was detrimental to the health, safety and welfare of the residents, and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/05/19 for this Violation. THE CORRECTION DATE FOR THE TYPE B	D 113	6-5-19 When state notified director and maintenance that the water temperatures were out of range the day they were there, maintenance drained the hot water heater, removed the thermostats from the hot water heater. He then cleaned and adjusted the thermostat refilled the water tank and brought the water temps back into normal range by the evening of 6-5-19. 6-6-19 The director had a meeting with maintenance after exiting with the state, maintenance will be checking water temperatures daily for 30 days and recording them in a new water temperature notebook. If after 30 days there are no issues with the temperatures then maintenance will go back to check temperatures twice a week. The director will be checking to make sure water temperature are being checked correctly. If ever the hot water temperatures are not within in normal range maintenance will notify the director who will then notify the administrator. Maintenance will then immediately drain the hot water and adjust the thermostat to proper setting. If that does not work we will then try replacing the thermostat control valve.	

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D 113	Continued From page 4 VIOLATION SHALL NOT EXCEED JULY 21, 2019.	D 113		
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 assure medication was administered as ordered for 1 of 3 sampled residents (Resident #2) related to an antihypertensive medication. The findings are: Review of Resident #2's current FL2 dated 05/23/19 revealed: -Diagnoses included dementia and latent tuberculosis. -There was an order for lisinopril (used to treat	D 358		

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D 358	Continued From page 5 high blood pressure) 40mg 1 tablet daily. -There was an order for a monthly blood pressure checks. Review of Resident #2's physician order sheet dated 01/02/19 revealed there was an order for lisinopril 40mg daily. Review of Resident #2's March 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for lisinopril 40mg 1 tablet daily scheduled daily at 8:00am. -Lisinopril was documented as administered for 20 out of 31 opportunities from 03/01/19 to 03/31/19. -Lisinopril was not documented as administered from 03/20/19 to 03/29/19 and on 03/31/19 due to "awaiting RX/MD prior authorization." -There was a documented blood pressure of 94/56 on 03/20/19. Review of Resident #2's April 2019 eMAR revealed: -There was an entry for lisinopril 40mg 1 tablet daily scheduled daily at 8:00am. -Lisinopril was documented as administered for 22 out of 30 opportunities from 04/01/19 to 04/30/19. -Lisinopril was not documented as administered from 04/01/19 to 04/03/19 and 04/05/19 to 04/09/19 due to "awaiting RX/MD prior authorization." -There was a documented blood pressure of 124/68 on 04/20/19. Review of Resident #2's May 2019 eMAR revealed: -There was an entry for lisinopril 40mg 1 tablet daily scheduled daily at 8:00am.	D 358		

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D 358	Continued From page 6 -Lisinopril was documented as administered for 29 out of 31 opportunities from 05/01/19 to 05/31/19. -Lisinopril was not documented as administered on 05/22/19 and 05/27/19 due to "awaiting RX/MD prior authorization." -There were no documented blood pressures on the May eMAR. Review of Resident #2's June 2019 eMAR revealed: -There was an entry for lisinopril 40mg 1 tablet daily scheduled daily at 8:00am. -Lisinopril was documented as administered for 5 out of 5 opportunities from 06/01/19 to 06/05/19. -There were no documented blood pressures on the June eMAR. Observation of Resident #2's available medications on hand on 06/06/19 at 10:10am revealed: -There was one bottle of lisinopril 40mg tablets with five tablets remaining available for administration. -The dispense date on the bottle was 04/05/19. -The quantity dispensed was 30 tablets. Interview with the Executive Director on 06/05/19 revealed: -Resident #2 received lisinopril from a local clinic. -Lisinopril was the only medication she received through the clinic. -"It looked like we needed prior authorization from the doctor for the lisinopril." -She would have to "research" to find out what happened the lisinopril was not available for administration from 03/20/19 to 04/09/19. Telephone interviews with Resident #2's hospice nurse on 06/06/19 at 9:05am, 9:20am, and	D 358		

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D 358	Continued From page 7 11:50am revealed: -She visited Resident #2 on a weekly basis. -She performed blood pressure checks on the weekly visits. -On 03/18/19 the blood pressure was 122/74. -On 03/25/19 the blood pressure was 104/62. -On 04/08/19, the blood pressure was 120/70. -On 04/15/19, the blood pressure was 102/70. -The facility staff had told her during the time the resident had missed her lisinopril, they were having trouble getting the medication from the pharmacy. -Staff told her Resident #2 had not had the lisinopril for "a few days." Interview with the Executive Director on 06/06/19 at 9:36am revealed: -Resident #2's lisinopril supply was provided by a local clinic. -The Resident Care Coordinator (RCC) would have been responsible to call and tell the clinic the lisinopril needed to be refilled and then the RCC would go and pick it up from the clinic. -She had been unable to find any documentation of a call being made to the clinic to request a refill of lisinopril for Resident #2. -The RCC had left their employment as of 06/01/19. -The previous RCC had not informed her about the lisinopril being out for Resident #2 or any issues related to trying to get the refill of the medication from the clinic. -She did not know if the staff had requested a refill or if the clinic needed a new prescription from the physician. Telephone interview with the Administrator on 06/06/19 at 10:10am revealed: -It was the facility's policy if a medication was not in the facility for administration, staff should go	D 358		

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D 358	Continued From page 8	D 358		

pick up the medication from the pharmacy.
-It was his understanding, it was the facility's responsibility to provide the medication.
-He would have expected the staff to notify the prescribing physician the medication was unavailable and obtain a hold or an order to discontinue the medication.

Interview with a medication aide on 06/06/19 at 10:20pm revealed:
-Resident #2's lisinopril had to be reordered by the physician every month from the local clinic.
-As far as she knew that was the only time Resident #2 had been out of lisinopril.
-The RCC was responsible for reordering the lisinopril and getting the lisinopril "in the building."
-The RCC was also responsible for contacting the physician to get a new prescription if it was needed.

Telephone interview with Resident #2's physician on 06/06/19 at 10:45am revealed:
-Resident #2 was taking lisinopril because she had chronic high blood pressure.
-The Executive Director had notified him "last night" about the missed doses of lisinopril from 3/22/19 to 04/09/19.
-"I put the medication on hold yesterday, since the blood pressures have been okay without it."
-Resident #2 never really had "real high" blood pressure.

Attempted telephone interview with the local clinic which supplied Resident #2's lisinopril on 06/06/19 at 8:50am was unsuccessful.

Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.

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D912	Continued From page 9	D912		
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: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to hot water temperatures. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure the hot water temperatures were maintained between 100 - 116 degrees Fahrenheit (F) for 5 of 5 sampled sink fixtures. [Refer to Tag 113 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)].	D912	Response to med not being in the building: 6-7-19 On 6-7-19 the director had a meeting with all the medtechs and informed them that we should never be without a medicine for any reason. RCC is responsible for ordering all medicine and making it is in the facility at all times. If for some reason there is every a medicine not in the building medtechs and or RCC should notify the director. The director will then get the medicine in the building or contact the doctor for further instructions.	