STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL018018	A. BUILDING: _____ B. WING _____	R-C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE OF CONOVER	3430 LESTER STREET CONOVER, NC 28613

(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 and follow-up survey on 08/28/19 to 08/29/19.	D 000		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure food being stored in the kitchen refrigerator was protected from contamination related to raw and uncooked foods being stored over fresh produce. The findings are: Review of the facility kitchen sanitation report dated 07/09/2019 revealed a score of 96.5. Observation of the inside of the refrigerator on 08/28/19 at 10:39am revealed: -There were 7 large egg crates containing raw eggs stacked on top of one another and stored above cut watermelon partially covered with plastic wrap on the shelf below. -There was an open box of uncooked breakfast sausage stored above boxes of fresh produce and cantaloupes. Interview with the cook/Dietary Manager on 08/28/19 at 2:40pm revealed:	D 283		

Reviewed and Accepted
Date: 09/12/19
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D 283	Continued From page 1 -She knew that uncooked meat and raw eggs could not be stored above fresh produce in the refrigerator. -She did not know that the raw sausage and eggs had been stored improperly in the refrigerator. -She did not know who improperly stored raw sausage and eggs above fresh produce in the refrigerator. -Third shift staff had been helping prepare breakfast foods by forming sausage patties and putting the eggs into a bowl. -Other facility staff had been helping to restock the pantry, refrigerator, and freezer when a shipment was delivered. -The Administrator trained all staff that worked in the kitchen. Interview with the Administrator on 08/26/19 at 4:39pm revealed: -He did not know that the raw meat and eggs were stored improperly in the refrigerator. -He did not know who had last stocked the refrigerator, "they know better than that". -There were laminated signs posted in the kitchen and at the refrigerator to remind staff of proper procedures for storing food. -The Dietary Manager knew how to properly store food in the kitchen refrigerator because "she has worked here for many years". -He trained all staff that would work in the kitchen during their orientation to the facility. -He expected all staff to adhere to the rules and regulations of properly storing food.	D 283	* Each employee is trained on Sanitation and safety upon hire. They each take a food handlers course administered by the administrator. On this occurrence a new employee got nervous due to the survey team being here. * The improper Storage was immediate Corrected And a review of food Storage policy with the employee responsible took Place. * Going forward we will stress the importance of taking time to ensure ~~food~~ storage is handled correctly even in stressful situations. The Kitch manager will check this after every meal. The cook will do so in absence of kitchen Mngr. We will ensure that all employees take food handling seriously.	8/28/19
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner	D 344		

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D 344	Continued From page 2 for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication orders were clarified with the prescribing practitioner for 3 of 6 sampled residents related to medications to control blood sugar (Resident #3), to prevent constipation (Resident #6), and to treat neuropathy (Resident #5). The findings are: 1. Review of Resident #3's current FL2 dated 05/23/19 revealed: -The diagnoses included diabetes mellitus type II, dementia, chronic kidney disease stage 3, congestive heart failure, atherosclerotic heart disease, coronary angioplasty implant/graft, anemia, hypotension, and muscle weakness. -There was an order to check fingerstick blood sugars (FSBS) monitoring before meals and at bedtime.	D 344		

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D 344	Continued From page 3 -There was an order for Novolog flex pen (used to control blood sugar) 100u/ml with sliding scale before meals and at bedtime. -There was no documented sliding scale for the Novolog insulin. Review of Resident #3's orders dated 05/01/19 revealed: -There was an order for FSBS monitoring before meals and at bedtime. -There was an order for Novolog flex pen 100u/ml before meals and at bedtime with the following scale: 0-60 initiate hypoglycemic protocol; 61-199=0u; 200-250=2u; 251-300=3u; 301-350=4u; 351-400=5u; >401=6u and call the primary care provider. Observation of the medication pass on 08/28/19 at 11:51am to 11:57am revealed: -Resident #3's FSBS was 230. -At 11:57am, Resident #3 was administered Novolog 2 units. Review of Resident #3's July and August 2019 electronic Medication Administration Records (eMARs) revealed: -There were entries for FSBS monitoring scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -There were entries for Novolog flex pen 100u/ml before meals and at bedtime with the following scale: 0-60 initiate hypoglycemic protocol; 61-199=0u; 200-250=2u; 251-300=3u; 301-350=4u; 351-400=5u; >401=6u and call the primary care provider scheduled at 7:30am, 11:30am, 4:30pm, and 8:00pm. -From 07/01/19 to 07/31/19, the Novolog insulin per sliding scale was documented as administered correctly for 14 occurrences out of 14 opportunites when insulin was required.	D 344	* RCC called the PA to Clarify 8/29/19 the order & update the records. She will ensure that going forward any new FL-2 and Care Plan match current orders so that there isn't a discrepancy. It was verified that the medication was administered per doctor's orders. The RCC will ensure that all records are up to date and FL-2's & Care Plans match anytime they are updated. The RCC will ensure that the pharmacy receives all new orders & FL-2's when sent and will review doctor's notes to ensure prescriptions are legible and any needed clarifications are obtained. RCC will also ensure medications entered by pharmacy match actual prescriptions. Additionally, the med tech on 3rd shift will Audit all new orders & scripts nightly.	

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D 344	Continued From page 4 Interview with the Resident Care Coordinator (RCC) on 08/28/19 at 3:56pm revealed: -Resident #3 had been on the same Novolog sliding scale "since she was admitted." -She did not know the Novolog sliding scale had been left off Resident #3's FL2. -She believed the Novolog sliding scale on the orders dated 05/01/19 were the orders the Physician's Assistant (PA) wanted the facility to administer. Review of Resident #3's verbal order dated 08/28/19 revealed: -There was an order for FSBS monitoring before meals and at bedtime. -There was an order for Novolog flex pen 100u/ml before meals and at bedtime with the following scale: 0-60 initiate hypoglycemic protocol; 61-199=0u; 200-250=2u; 251-300=3u; 301-350=4u; 351-400=5u; >401=6u and call the primary care provider. Telephone interview with Resident #3's Physician Assistant (PA) on 08/29/19 at 1:09pm revealed: -She wanted facility staff to continue to use the Novolog sliding scale order dated 05/01/19 and clarified on 08/28/19. -She would review the order again the next time she was at the facility. Telephone interview with the facility's contracted pharmacy on 08/29/19 at 3:11pm revealed: -Resident #3's order dated 05/01/19 was the last order they had received for the resident's Novolog sliding scale. -They had not received the FL2 dated 05/23/19. Interview with the Administrator on 08/29/19 at 3:30pm revealed:	D 344		

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D 344	Continued From page 5 -The facility had some issues with the phone lines to the facility being out of order "sometime between May and June." -If the phone lines had been out of order then "some of our faxes may not have gone through" to the pharmacy. -The RCC was responsible for ensuring FL2s were completed and signed by the primary care provider. -The RCC was responsible for ensuring all new FL2s and orders were sent to the pharmacy. -The RCC was responsible for ensuring orders which were not clear were clarified with the prescribing practitioner. Interview with the RCC on 08/29/19 at 4:25pm revealed: -She was responsible for ensuring FL2s were completed and signed by the primary care provider. -She was responsible for faxing all new FL2s and orders to the facility's contracted pharmacy. -The contracted pharmacy would then enter the orders into the eMAR system. -She approved new orders in the eMAR system. -She did not know she needed to update the eMAR medication list with new order changes before having the primary care provider sign the document to renew the orders. 2. Review of Resident #6's current FL2 dated 05/06/19 revealed: -Diagnoses included hypertension, anxiety, and depression. -There was no order for senna. Review of Resident #6's physician's order dated 05/01/19 revealed instructions to discontinue senna.	D 344		

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D 344	Continued From page 6 Review of Resident #6's physician's order dated 05/06/19 revealed instructions for senna 8.6mg 1 tablet two times a day for constipation. Observation of the medication pass on 08/29/19 at 8:29am revealed the resident did not receive senna. Review of Resident #6's August 2019 electronic Medication Administration Record (eMAR) revealed there was no entry for senna. Telephone interview with a representative from the facility's contracted pharmacy on 08/29/19 at 3:11pm revealed: -Resident #6 no longer had an active order to receive senna. -They had received an order dated 05/01/19 to discontinue the senna. -They had also received the medication order dated 05/06/19 for senna 8.6 mg 1 tablet two times a day and the FL2 dated 05/06/19. -They had gone by the order dated 05/01/19 and discontinued the senna. Telephone interview with Resident #6's Physician Assistant (PA) on 08/29/19 at 1:09pm revealed: -Resident #6 was seen in a face to face visit by the physician on 05/06/19. -There was no note or order to restart the senna for Resident #6 in the physician's notes after the order to discontinue on 05/01/19. Interview with the Administrator on 08/29/19 at 3:30pm revealed the RCC was responsible for ensuring orders which were not clear were clarified with the prescribing practitioner. Interview with the Resident Care Coordinator on 08/29/19 at 4:25pm revealed:	D 344		

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D 344	Continued From page 7 -She was responsible for faxing all new FL2s and orders to the facility's contracted pharmacy. -The contracted pharmacy would then enter the orders into the eMAR system. -She approved new orders in the eMAR system. -She did not know she needed to update the eMAR medication list with new order changes before having the primary care provider sign the document to renew the orders. 3. Review of Resident #5's current FL2 dated 07/17/19 revealed: -Diagnoses included diabetes, morbid obesity, chronic pain, depression, and hypertension. -There was a physician's order for gabapentin 800mg take 1 tablet by mouth four times a day. Review of a physician's order for Resident #5 dated 07/22/19 revealed: -A medication order for gabapentin 600mg by mouth three times per day for chronic neuropathy. -The medication order for gabapentin was difficult to read. Review of Resident #5's July 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for gabapentin 600mg take 1 tablet by mouth four times daily for chronic neuropathy. -Gabapentin 600mg was documented as administered at 7:00am, 12:00pm, 4:00pm, and 7:00pm from 07/23/19 to 07/31/19. Review of Resident #5's August 2019 eMAR revealed: -There was an entry for gabapentin 600mg take 1 tablet by mouth four times daily for chronic neuropathy.	D 344		

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D 344	Continued From page 8 -Gabapentin 600mg was documented as administered at 7:00am, 12:00pm, 4:00pm, and 7:00pm from 08/01/19 to 08/13/19. Review of a physician's order for Resident #5 dated 08/13/19 revealed to discontinue gabapentin. Interview with the Resident Care Coordinator (RCC) on 08/28/19 at 4:30pm revealed: -She read the physician order for Resident #5 as gabapentin 600mg take 1 tablet four times a day for chronic neuropathy. -Gabapentin 600mg three times per day was documented in Resident #5's physician's order from an emergency room visit dated 07/17/19. -She was responsible for calling the physician to clarify medication orders. -She did not call Resident #5's physician to clarify the medication order for gabapentin since she did not read the administration times correctly. Interview with the Administrator on 08/26/19 at 4:39pm revealed: -The RCC was responsible for checking physician's orders and clarify them "if need be". -The RCC was responsible for comparing new physician orders to the eMAR's. -The RCC should have called Resident #5's physician to clarify the order for gabapentin since the order was difficult to read. -He did not know why the RCC did not call to clarify Resident #5's gabapentin. Interview with a pharmacy technician from the facility's contracted pharmacy on 08/29/19 at 12:32pm revealed: -Once the pharmacy received new orders faxed from the facility, the pharmacy technician was responsible for entering physician's orders into	D 344		

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D 344	Continued From page 9 the computer for the Pharmacist to review for accuracy. -The medication orders entered into the computer generated the eMAR for the facility. -Resident #5's gabapentin order changed on 07/22/19 to 600mg by mouth four times per day. -She asked a couple of pharmacists on duty on 08/29/19 and the order was read as gabapentin 600mg by mouth four times per day for Resident #5. -No one from the facility's contracted pharmacy called the physician or the facility to clarify the gabapentin for Resident #5. Telephone interview with Resident #5's Physician's Assistant (PA) on 08/29/19 at 1:06pm revealed: -The physician had last seen Resident #5 on 07/22/19. -Resident #5's gabapentin had been changed to 600mg by mouth three times per day. -The facility did not call to clarify Resident #5's gabapentin order. -The pharmacy did not call to clarify Resident #5's gabapentin order. -There were no complications expected from Resident #5 receiving the incorrect dose of gabapentin since he had been taking a larger dosage of the medication.	D 344		