

Division of Health Service Regulation

PRINTED: 02/03/2020
FORM APPROVED

RECEIVED

DATE SURVEY
COMPLETED

FEB 21 2020

01/17/2020

NAME OF PROVIDER OR SUPPLIER

CARTERET HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE
3020 MARKET STREET
NEWPORT, NC 28570
ADULT CARE LICENSURE SECTION
RALEIGH(X4) ID
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)ID
PREFIX
TAGPROVIDER'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 Carteret Department of Social Services of Social Services conducted an annual survey from January 15, 2020 - January 17, 2020.

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:
TYPE B Violation

Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 1 of 5 sampled residents (#2) related to a delay in reporting a reddened area of the resident's right hip that progressed to an open wound to the primary care provider (PCP).

The findings are:

Review of Resident #2's current FL-2 dated 11/25/19 revealed:
-Diagnoses included vascular dementia, history of traumatic hip fracture, muscle weakness, renal disease, and hypertension.
-The resident was non-ambulatory and

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D 273

Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.

It is the policy of Carteret House to assure referral and follow-up to meet the routine and acute health care needs of residents.

The resident's PCP was notified and orders were given for Home Health to evaluate and treat wound. Interim wound care orders were requested from PCP on 1/16/2020. Facility followed up with Home Health and requested an immediate assessment. Home Health assessment was completed on 1/17/2020. Home Health will exit with RCM or ED at completion of each visit to discuss status of wound healing.

1/16/20

1/17/20

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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The Plan of Correction has been reviewed by Linda Kirby and Nikia MozeH. The Plan of Correction has been accepted.
Nikia MozeH 03/04/20

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D 273	Continued From page 1 wheelchair bound. -The resident was incontinent of bowel and bladder. Review of Resident #2's care plan dated 12/03/19 revealed: -The resident was incontinent of bowel and bladder and required incontinence briefs. -The resident required extensive assistance with toileting, transfers, and bathing. Observation on 01/15/19 at 4:20pm revealed: -There was a red area over an old scar on Resident #2's right hip about the size of a half dollar bill. -There was an open area inside the red area about the size of a small pea. Review of an electronic progress note dated 01/01/20 at 10:57pm revealed: -Resident #2 had reddened a area on his right outer hip area. -The Resident Care Manager (RCM) was notified. Review of a second electronic progress note dated 01/09/20 at 10:31pm revealed: -It was reported to the RCM on 01/01/20 there was a reddened area on Resident #2's right hip. -At that time the reddened area was about the size of a dime. -The nurse did a visual assessment of the area. -The area was much larger and had a black dot on one part of it. -The black dot had a hard lump under the skin. -The area was cleaned with each [incontinence brief] change. The resident did not have an order for barrier cream to protect the skin from breakdown so regular lotion was applied. -The Executive Director (ED), the RCM, and the	D 273	Incontinent care for this resident was increased to every hour on 1/16/2020 to ensure resident remains clean and dry. Skin assessments are to be completed by care staff on designated shower days. Completed forms are to be placed in RCM box for review. ED or RCM will review and initial body assessment forms prior to filing, ensuring proper follow up with any identified issues.	1/16/20	

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Executive Director

2-20-2020

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D 273	Continued From page 2 nurse was notified Interview with 1st shift personal care aide (PCA) on 01/15/20 at 3:05pm revealed: -She was aware of a red area on Resident #2's right hip. -He had the red area on his right hip when he came to the facility in (November or December) 2019. -She did not know if the medication aides (MA) provided any wound care to the area. Interview with a second shift MA on 01/15/20 at 3:15pm revealed: -She became aware of the red area on Resident #3's right hip on 01/01/20. -She informed the facility's nurse and the Resident Care Director (RCD) of the red area on 01/01/20. -She documented her observations on electronic progress notes on 01/01/20 and 01/09/20. -There was not an order for wound care or barrier cream to treat the red area. -She reported the red area to the facility nurse, the RCD and the ED a second time about a week ago because the area was getting larger. -The facility's nurse came to the resident's room and looked at the red area and said she would follow-up with the resident's PCP. -She did not know if the nurse had followed up with the PCP because there were no orders to treat the red area. -She was not aware that there was an open wound to the right hip. -The RCD was responsible for notifying the PCPs of changes in residents' status, including skin breakdown. Interview with Resident #2's PCP on 01/15/20 at 4:00pm revealed:	D 273	An in-service was held with care staff and management pertaining to Healthcare Referral and Follow Up with emphasis on prompt and proper reporting of any skin issues on 1/15/2020 by the Divisional Director of Clinical Services. An additional in-service is scheduled for 2/21/2020 with care staff and management pertaining to maintenance of skin integrity and wound care. This in-service is being conducted by Kindred Home Health.	1/15/20	2/21/20

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Theresa Johnson - Executive Director

2-20-2020

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D 273	Continued From page 3 -Resident #2 had a history of right hip decubitus which had opened up and healed several times. -He had ordered home health to provide wound care in the past (when the resident was in another facility). -He was not sure if the facility had recently reported the resident had right hip wound or redness. -He would check his computer later this evening to confirm if the resident had any current wound care or home health orders. -The PCP expected the facility to contact him and report any skin changes such as redness or open wounds. -He did not know if the resident had an open wound on his right hip. Interview with a second PCA on 01/15/20 at 4:30pm revealed: -She provided personal care for Resident #2 which included incontinent care. -She was aware of the red area on the resident's right hip but was not aware of the open wound. -She did not know if the RCD or the MAs were aware of the open wound. Interview with a first shift MA on 01/16/20 at 8:25am revealed: -She noted a red area on Resident #2's right hip about 2 weeks ago. -She had planned to report the area to the resident's PCP but did not. -She reported the area to the RCD and the facility's nurse 2 weeks ago. -There were no current orders for treatment of the red area. -The RCD was responsible for notifying the PCP of resident changes. -She observed the area yesterday (01/15/20) and it remained red and the size was larger.	D 273			

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Theresa Johnson - Executive Director - 2 20 2020

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D 273	Continued From page 4 A second interview with Resident #2's PCP on 01/16/20 at 8:45am revealed: -He had a note dated 01/06/20 or 01/07/20 regarding an order for home health to look at Resident #2 right hip redness. -He did not know if there was a written order for home health because he was behind in his dictation on his computer. -The facility did not report the red area on Resident #2's right hip had opened up. -If the wound was opened, the resident was at risk for infection without wound care. -He did not know if home health had seen the resident because he did not have any home health wound care orders. Interview with the RCD on 01/16/20 at 11:30am revealed: -She was aware Resident #2 had a red area on his right hip. -Staff reported the red area in December 2019. -The facility's nurse looked at the resident's right hip and left the resident's PCP a note regarding the red area. -She did not remember if a MA informed her of any changes of the red area on the resident's right hip on 01/01/20. -The PCP ordered a referral to home health on 01/06/20, but the home health nurse did not come to facility to start wound care. -She was not sure if the home health agency recieved the referral because she did not follow-up with the home health agency. -The RCD faxed the referral to the home health agency on 01/06/20. -On 01/09/20, a MA informed her of a change in the red area on Resident #2's right hip. There was a black area on the hip. -She did not look at the area but reminded the MA	D 273			

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Deborah Johnson Executive Director 2-20-2020

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D 273	Continued From page 5 of the home health referral and to keep the resident positioned off his right side. -She did not report the change to the resident's PCP because she had been working third shift as a MA. -The last time she observed the wound on Resident #2's right hip was 2 days ago (01/14/20) and the area had increased redness but she did not observe an open wound. -Since there was a current order for home health (dated 01/08/20) she did not report the changes to the resident's PCP. -If a resident sustained redness to skin, the RCD contacted the PCP to obtain orders for a skin barrier cream to prevent skin breakdown, but she did not contact the resident's PCP to obtain this order for Resident #2, even though she was responsible for notifying PCPs of resident changes, including skin breakdown. -She was not aware there was an open wound to the resident's right hip. Interview with a supervisor from a local home health agency on 01/16/20 at 12:37pm revealed the agency did not have any orders/referrals for Resident #2. Review of a handwritten progress note documented by the facility's nurse dated 01/08/20 at 3:15pm revealed: -The medication aide (MA) "informed me that resident [Resident #2] had a reddened area on his right hip. -Upon assessment, the resident had an irregular oval shaped pink area with a dark red center that was non-blanchable on his right hip. -The MA states she will notify the RCD. Interview with the facility's nurse on 01/16/20 at 11:45am revealed:	D 273			

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Theresa Johnson Executive Director - 2-20-2020

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D 273	Continued From page 6 -She was aware Resident #2 had a red area on his right hip. -She was not aware of an open wound of the resident's right hip until today (01/16/20). -The RCD was made aware of the red area of the resident's right hip by a MA earlier this month (January 2020) and should have contacted the resident's PCP and reported the red area. Interview with the Executive Director (ED) on 01/16/19 at 12:40pm revealed: -She was not aware Resident #2 had an open wound on his right hip until today. -The RCD, the facility's nurse or the MAs were responsible for reporting resident changes, including skin problems/wounds, to the residents' PCP. -The RCD was responsible for sending home health referrals to the home health agencies, but since the RCD was new at her position she may not know or may have missed the order for the home health referral for Resident #2. The facility failed to notify Resident #2's PCP of an open wound of the resident's right hip. The facility's failure to report an open wound to the medical provider was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/16/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 02, 2020.	D 273	Weekly At Risk Meetings are held to identify at risk residents and follow up to ensure appropriate interventions are in place. Minutes may be found in the At Risk binder located in the ED office.		

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Theresa Johnson Executive Director - 2-26-2020

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D912	Continued From page 7	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, record reviews, and interviews, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 1 of 5 sampled residents (#2) related to a delay in reporting a reddened area of the resident's right hip that progressed to an open wound to the primary care provider (PCP). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912			

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Theresa Johnson - Executive Director 2-20-2020