| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL016018 | A. BUILDING: _____ B. WING _____ | R 12/01/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CARTERET HOUSE | 3020 MARKET STREET NEWPORT, NC 28570 |

| (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 |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an onsite follow-up and COVID-19 Focused Infection Control survey on 11/30/20-12/01/20. | D 000 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure the acute and routine health care needs were met for 1 of 5 residents sampled (#1) related to a missed dermatology referral for suspected melanoma.<br><br>The findings are:<br><br>1. Review of Resident #1's current FL-2 dated 07/16/20 revealed:<br>-Diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, macular degeneration, tobacco abuse, polymyalgia, rheumatica, iron deficiency and acute keratosis.<br>-The resident's level of orientation was not documented.<br><br>Observation of Resident #1 on 11/30/20 at 11:13am revealed she was sitting in her recliner with a scaly, raised, discolored, dime size lesion to her nose.<br><br>Review of Resident #1's Primary Care Provider (PCP) visit summary dated 10/20/20 revealed the | D 273 | | |

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resident had a concerning lesion on her nose and needed a dermatology referral "ASAP" for possible melanoma.

Telephone interview with Resident #1's responsible party on 11/30/20 at 4:59pm revealed:
-Resident #1 needed to see the dermatologist for the spot on her nose.
-Resident #1 was supposed to have a dermatology appointment scheduled to evaluate the area of concern on her nose.

Telephone interview with the representative dermatologist's office on 12/01/20 at 10:20am revealed:
-Resident #1 had an appointment scheduled for 12/03/20 at 2:00pm.
-There was no documentation of any previous attempts from the facility to schedule the appointment.

Interview with the Director of Resident Care (DRC) on 12/01/20 at 11:44am revealed:
-She was aware Resident 1's referral to dermatology needed to be made.
-She was responsible for scheduling appointments but Resident #1 would "sometimes" make her own appointments.
-She scheduled the dermatology appointment today and there were no other attempts to schedule the appointment prior to today.
-Resident #1 made "usually" her own appointments.

Interview with Resident #1 on 12/01/20 at 12:59pm revealed:
-The spot on her nose had been there for months; she did not know exactly how long.
-She mentioned the spot on her nose to her PCP

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during a visit a couple of months ago.
-She had a dermatology appointment scheduled on 12/03/20.
-The spot on her nose didn't hurt but "it feels like you could rub it right off."
-The spot didn't bother her.

Telephone interview with the representative from Resident #1's PCP office on 12/01/20 at 1:20pm revealed:
-The referral for the lesion on Resident #1's nose was sent to the dermatologist on 10/26/20 by the PCP office.
-It was the PCPs office responsibility to review Resident #1's record to ensure the appointment was made.
-The appointment was never made until today.

Telephone interview Resident #1's PCP on 12/01/20 at 1:24pm revealed:
-She saw Resident #1 on 10/20/20 and was made aware of the spot-on Resident #1's nose.
-The dermatology referral was sent to the dermatologist the same day.
-The dermatologist was supposed to contact the resident for an appointment.
-She would expect any orders or referrals to be followed.

Interview with a medication aide (MA) on 12/01/20 at 1:43pm revealed:
-She had noticed the area on Resident #1's nose.
-MAs did not get the visit summary after the resident's PCP visit.
-The DRC was responsible for reviewing paperwork and making the referrals and scheduling appointments.
-It was the responsibility of the Director of Resident Care to follow up on any referrals made to a specialist.

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-The DRC would then notify transport of the appointment.
-There was an appointment book in the office transportation used to track appointments.

Interview with a third MA on 12/01/20 at 2:00pm revealed:
-She was aware of the area on Resident #1's nose and it looked like a "scab."
-Resident #1 had not complained of pain or discomfort.
-She was not aware of any dermatology appointment for Resident #1 or referral being ordered.
-Transportation kept track of residents appointments.
-The DRC was responsible for obtaining the paperwork and making referrals.
-The MAs were made aware by the DRC of any order changes or newly scheduled appointments.
-She was not aware of any missed appointments for Resident #1.

Interview with the DRC on 12/01/20 at 2:06pm revealed:
-She had been employed with the facility since September 2020.
-They had a "bump in the road" with their transporter who usually kept up with appointments.
-The transporter was no longer there, and no one was keeping up with appointments.
-The Activity Director was currently filling in as the transporter.
-She did not know why Resident #1's dermatology appointment was not scheduled until today.
-Resident #1 used an outside provider and did not use the facility's PCP which made it difficult to coordinate appointments.
-Resident #1 did not come back to the facility with

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| D 273 | Continued From page 4<br>any paperwork the day of her appointment on 10/20/20.<br><br>Interview with Executive Director (ED) on 12/01/20 at 2:18pm revealed:<br>-She was not aware of the area on Resident #1's nose and had not been notified.<br>-The DRC was responsible for obtaining PCP office visit paperwork and scheduling appointments.<br>-The DRC made a copy of the paperwork and gave it to the transporter who placed the appointment in a book.<br>-She was not sure what happened with Resident #1's dermatology appointment but the appointment should have been made.<br>-She was concerned about the area on Resident #1's nose and that it would spread or potentially cause harm to the resident. | D 273 | | |