STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049003	A. BUILDING: _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PLACE ADULT LIVING CENTER	1372 EUFOLA ROAD STATESVILLE, NC 28677

(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 survey and complaint investigation on June 31, 2021 and July 1, 2021.	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 interviews and observations the facility failed to protect food from contamination by maintaining clean food storage areas. The findings are: Review of the county environmental and sanitation report dated 06/18/21 revealed: -A total score of 96. -A demerit under the food supplies and protection section related to food that was brought in by employees or visitors being handled properly. -The county inspector's comment on the report stated that employee's food was in the refrigerator with the resident's food. -Food that employees bring in must be stored separately, labeled with a name and dated. Observation of the refrigerator in the kitchen on 06/30/21 at 4:08pm revealed: -Two take-out containers with food inside that	D 283		

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D 283	Continued From page 1	D 283		

were not labeled or dated.
-One take-out box of fast food biscuit sandwiches that was not dated.
-A jar of applesauce, on the left side of the top shelf of the refrigerator, with mold that had grown in the jar.
-Clusters of mold on all of the refrigerator shelves, the walls and the vent.

Attempted telephone interview with the county health inspector on 07/01/21 at 10:52am and was unsuccessful.

Interview with the cook on 07/01/21 at 12:45pm revealed:
-He was responsible for keeping the refrigerator clean and disposing of expired foods.
-He typically checked the expiration date of items in the refrigerator once a week and disposed of expired foods.
-He cleaned the handles of the refrigerator daily and wiped out the inside of the refrigerator every 1-3 weeks depending on his schedule.
-He took the shelves out of the refrigerator once a month for a deep clean to scrub them and clean the walls of the refrigerator.
-The mold on the shelves of the refrigerator re-accumulated each month between deep cleanings.
-Sometimes staff would store their lunch in the refrigerator in the kitchen.

Interview with the Administrator on 07/01/21 at 12:38pm and at 1:23pm revealed:
-The refrigerator in the kitchen was for the residents' food only and there was a refrigerator in the medication room for the employees' food.
-The box of fast food biscuit sandwiches were purchased for the residents and the employees by the facility.

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D 283	Continued From page 2 -She was not sure who the two containers of take-out belonged to since the containers were not labeled. -The food provided by family was stored on the left side of the refrigerator and was monitored by the Administrator or the Resident Care Coordinator (RCC). -They checked expiration dates on food every 2-3 days and disposed of expired food. -She was not aware of the mold in the refrigerator. -She expected the cook to maintain a clean refrigerator and address any messes immediately.	D 283		
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 administer medications as ordered by a licensed prescribing practitioner for 2 of 4 residents (Resident #3 and #4), including a medication to treat anxiety (Resident #3), and a medication to decrease combative behavior (Resident #4). The findings are:	D 358		

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D 358	Continued From page 3 1. Review of Resident #3's current FL2 dated 04/06/21 revealed: -Diagnoses included early onset Alzheimer's Disease, anxiety disorder, and seizure disorder. -There was an order for mirtazapine 15mg (to treat anxiety disorder) one tablet at bedtime. Review of Resident #3's May 2021 medication administration record (MAR) revealed: -There was a computer-generated entry for mirtazapine 15mg one tablet at bedtime. -Mirtazapine 15mg was documented as administered at 8:00pm from 05/01/21 to 05/31/21. Review of Resident #3's June 2021 MAR revealed: -There was a computer-generated entry for mirtazapine 15mg one tablet at bedtime. -Mirtazapine 15mg was documented as administered at 8:00pm from 06/01/21 to 06/30/21. Observation of Resident #3's medications available for administration on 07/01/21 at 10:12am revealed there was no mirtazapine 15mg available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/01/21 at 10:37am revealed: -Resident #3's mirtazapine 15mg was not cycle filled because she was on hospice. -The pharmacy dispensed 15 days of medications at a time for Resident #3. -The facility needed to reorder Resident #3's mirtazapine 15mg every 15 days. -The pharmacy had dispensed mirtazapine 15mg, quantity 15 tablets on 04/23/21, 05/17/21, and	D 358		

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D 358	Continued From page 4 06/07/21. Interview with the Resident Care Coordinator (RCC) on 07/01/21 at 11:24am revealed: -The medication aides (MA) were responsible to reorder medications from the pharmacy when the medications needed refilled. -The MAs sometimes let her know when refills were needed, and she ordered them from the pharmacy. -She was not aware mirtazapine 15mg for Resident #3 needed reordered. Interview with a MA on 07/01/21 at 2:16pm revealed: -She worked second shift and administered mirtazapine 15mg to Resident #3. -She thought she gave the last mirtazapine 15mg tablet to Resident #3 the previous evening. -She did not remember a time she was out of Resident #3's mirtazapine 15mg. -It was the MA's responsibility to fax medication refills to the pharmacy. -She thought she faxed a reorder request to the pharmacy the previous evening. 2. Review of Resident #4's current FL2 dated 07/07/20 revealed: -Diagnoses included dementia and altered mental status. -An order for Haldol 0.5 ml once before bedtime. Review of Resident #4's May 2021 medication administration record (MAR) revealed: -An entry for Haldol 0.5 ml once daily before bedtime. -Haldol 0.5 ml was scheduled for administration at 8:00pm and was documented as administered	D 358		

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D 358	Continued From page 5 from 05/01/21- 05/31/21. Review of Resident #4's June 2021 MAR revealed: -An entry for Haldol 0.5 ml once daily before bedtime. -Haldol 0.5 ml was scheduled for administration at 8:00pm and was documented as administered from 06/01/21- 06/30/21. Review of medications on hand on 07/01/21 revealed: -A 15 ml bottle of Haldol that was approximately 10% full. -The fill date for the Haldol was 05/10/21. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/01/21 at 12:05pm revealed: -The pharmacy did not provide automatic refills and medication refills had to be requested by fax from the facility. -The last three fill dates for the 15 ml bottles of Haldol were: 10/07/20, 02/13/21 and 05/10/21. -The pharmacist expected the 15 ml bottle would provide a 30 day supply of medication if it was administered as prescribed. -Resident #4 had been prescribed to take 0.5 ml of Haldol once at night since 11/29/18. Interview with the second shift medication aide (MA) on 07/01/21 at 2:05pm revealed: -She was not sure why Resident #4 continued to receive the Haldol that was filled on 05/10/21. -Resident #4 was ocassionally combative when asked to take his night time medications. Telephone interview with a Registered Nurse at Resident #4's Primary Care Provider's (PCP) office on 07/01/21 at 2:48pm revealed:	D 358		

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D 358	Continued From page 6 -Resident #4 was prescribed Haldol 0.5 ml before bedtime due to his dementia and sundowning. -If Resident #4 was not administered the Haldol as prescribed then he could experience poor sleep and be combative. Based on observations, interviews and record reviews it was determined that Resident #4 was not interviewable.	D 358		