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
	HAL073018	A. BUILDING: _____ B. WING _____	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CANTERBURY HOUSE	1284 LEASBURG ROAD ROXBORO, NC 27573

(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 Licesensure Section and the Person County Department of Social Services conducted an annual survey on 01/05/22 - 01/06/22.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the facts alleged or conclusions, set forth in the statement of deficiencies, the plan of correction is perpared soley as a matter of compliance with the law.	02/14/2022
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: Based on interviews, and record reviews, the facility failed to ensure referral and follow-up for 1 of 5 sampled residents (Resident #1) related to a referral for an endocrinologist appointment. The findings are: Review of Resident #1's current FL-2 dated 09/08/21 revealed diagnoses included type 2 diabetes with hyperglycemia. Review of Resident #1's physician's visit report dated 11/17/21 revealed: -It was an electronic report. -The visit was with Resident #1's primary care provider (PCP) on 11/17/21. -The report was electronically signed by the PCP on 11/19/21. -Resident #1's HbA1c (Hemoglobin A1c) was 7.9 percent (an HbA1c test is a blood test that reflects an average blood glucose level over the past three months. An HbA1c level of 5.7 or lower was considered normal.). -There was not a date for the 7.9 percent HbA1c. -Additional lab work had been ordered for 11/19/21; including HbAlc.	D 273	10A NCAC 13F .0902(b) Health Care The community will assure all referral and follow-up to meet the routine and acute health care needs of the residents The Communtiy has implemented an "Order Processing System". Communities order processing system is utilized for health care referrals and needed follow-up. Community Resident Care Coordinator (RCC) and/or Assistant Executive Director (AED) are responisble for checking order processing system for all referral and health care follow-up. RCC and/or AED will check order processing system folders no less than 3 times a day to assure all items are followed-up on timely. Community ED will check order processing system weekly to assure items are followed-up on timely RCC and/or AED are responible for assuring all health care referral appointments are scheduled timely. RCC and/or AED will contact requested referral providers via phone no later than 72 hours from receipt of referral. Documention of all contact with PCP or any outside provider will be maintained in resident process notes	02/14/2022 02/14/2022 02/14/2022 02/14/2022 02/14/2022

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Geraldine Yancey — TITLE: EP Director — (X6) DATE: 2/4/22

Reviewed and acknowledged on 02/18/22

Janet Thornburg JT

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D 273	Continued From page 1 -A referral to a named endocrinology office was documented under the treatment section of the report. Review Resident #1's signed physician's order dated 11/19/21 revealed: -The order was handwritten and signed by the PCP on 11/19/21. -There was an order for a referral to an endocrinologist. -There were instructions to take Finger Stick Blood Sugar (FSBS) logs and medication administration records (MARs) to the appointment. Review of Resident #1's laboratory results dated 11/19/21 revealed Resident #1's HbA1c was 8.3 percent. Review of Resident #1's progress notes for November 2021 revealed a late entry on 11/21/21 for 11/17/21 for a referral for a named Endocrinology office. Review of a facsimile dated 11/22/21 revealed: -There was a cover sheet for a named endocrinology office with nine pages attached and the word referral in the comments section. -There was a facsimile confirmation page dated 11/22/21. Interview with Resident #1 on 01/06/22 at 8:43am revealed she used to see an endocrinologist but, she had not visited the named endocrinology office or an endocrinologist in one or two years. Telephone interview with Resident #1's PCP on 01/06/22 at 10:53am revealed: -She wrote the referral order to the endocrinologist for Resident #1.	D 273	Continued from page 1 Community ED, RCC and AED will review all referral request and upcoming resident appointments in Daily Stand-up meetings. Community RCC and AED have been in-serviced on referral follow-up, documention, the order processing system, and scheduling of appointoments	02/14/2022 01/27/2022

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D 273	Continued From page 2 -She referred Resident #1 to an endocrinologist because Resident#1 had poor diabetic management. -Resident #1 had gained weight, her HbA1c was high and she was not compliant with diet recommendations when she made personal food choices. -She requested Resident #1's FSBS logs and MARs to be taken to the endocrinologist appointment so they could be reviewed. -She expected the facility to make the appointment with the endocrinologist for Resident #1. -She thought a month was a reasonable length of time for the appointment to have been scheduled. Telephone interview with a representative from the endocrinologist office on 01/06/22 at 11:06am reveled: -She was responsible for scheduling appointments for the endocrinologist office. -A facsimile had been noted as received from the facility's Assistant Administrator on 11/22/21 but there was no documentation of what the facsimile was for. -No appointment had been scheduled for Resident #1 on 11/22/21 and there was no other documentation on 11/22/21. -A referral for Resident #1 had been faxed to the office on 01/06/22 at 10:16am. -After she received the referral on 01/06/22 she called the facility and requested lab results and additional information. -No appointment had been scheduled for Resident #1; an appointment could not be scheduled until the facility provided the additional information requested on 01/06/22. -Once the facility provided the remainder of the information the endocrinologist staff would call the facility with a date and time for an	D 273		

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D 273	Continued From page 3 appointment for Resident #1. -Usually scheduling an appointment only took about three days once the endocrinologist office had all the requested information sent to them. -The facility could always call to check on the status of a referral or to follow-up about an appointment. Interview with the Resident Care Coordinator (RCC) on 01/06/22 revealed: -She usually made physician's appointments for the residents; sometimes the Assistant Administrator faxed referrals as well. -The Assistant Administrator faxed Resident #1's referral to the endocrinologist on 11/22/21. -They waited for a call from the endocrinologist appointment to schedule the appointment but, the endocrinologist never called back with an appointment. -They usually waited for a week or maybe two for the physician's office to call back with a scheduled appointment date. -She or the Assistant Administrator should have called the endocrinologist office in a week or two, but they did not. - "This is one of those [appointments] that slipped through." -She had called the endocrinologist office that day and the office staff said they never received the fax dated 11/22/21. Interview with the Assistant Administrator on 01/06/22 at 2:52pm revealed: -She called the endocrinologist office to schedule the appointment for the referral for Resident #1 on 11/22/21. -The representative from the endocrinologist office told her to fax the referral and requested additional information for Resident #1. -The endocrinologist office said they would call	D 273		

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D 273	Continued From page 4 her back to schedule the appointment after they received the referral and the requested information. -She faxed the information on 11/22/21 but she never received a phone call from the endocrinologist with a scheduled appointment date. -She usually called the physicians' offices the following day to make appointments for referrals. -When a day or two went by she should have called the endocrinologist office to check on the appointment, but she failed to call them to follow-up. -She kept track of appointments and referrals with a folder, but she did not know what happened and why she did not follow-up for the referral for Resident #1. Interview with the Administrator on 01/06/22 at 3:23pm revealed: -The RCC was responsible for making physicians' appointments and referral appointments. -The Assistant Administrator made physicians' and referral appointments if the RCC had a lot going on and needed help. -She expected all referral appointments to be scheduled within two to three days after the referral was ordered by the PCP. -The RCC or the Assistant Administrator should have called to see about scheduling the appointment for Resident #1. -There should have been a follow-up call to the endocrinologist by the RCC or the Assistant Administrator to see why the appointment for Resident #1 was not made by the next Monday, (11/29/21). -The RCC and the Assistant Administrator had not forgotten about the appointment with the endocrinologist because they had mentioned it to her about one week ago; they said they needed	D 273		

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D 273	Continued From page 5 to see about the appointment. -She thought they had followed through with a telephone call to the endocrinologist. -Resident #1 had spoken to her last week about the appointment but she thought it had been scheduled.	D 273		
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 for 1 of 5 sampled residents (#1) by administering a discontinued medication to treat Alzheimer's. The findings are: Review of Resident #1's current FL-2 dated 09/08/21 revealed: -Diagnoses included type 2 diabetes with hyperglycemia and alcohol induced Korsakoff syndrome. -There was an electronically generated signed physicians order dated 09/08/21 attached to the FL-2. -The was an entry for memantine 10mg (memantine is used to treat dementia associated	D 358	10A NCAC 13F .1004(a) Medication Administration Community has implemented an order processing system to review and assure all medications are administered and/or discontinued as ordered by Providers. RCC and/or AED are responible for checking order processing system no less than 3 times daily to assure all medication orders are processed timely. RCC and/or AED conducted immediate medication cart audits to assure no discontinued medications remained on cart. RCC and/or AED will conduct medication cart audits twice weekly for 4 weeks then weekly there after. Community Executive Director will review all medication cart audits weekly to assure audits are completed and any discontinued medications are removed from cart.	2/14/2022 2/14/2022 2/14/2022 2/14/2022 2/14/2022

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D 358	Continued From page 6 with Alzheimer's disease) take once daily that had "discontinued" and "09/08/21" handwritten across the order. Review of Resident #1's electronic Medication Administration Record (eMAR) for November 2021 revealed: -There was an entry for memantine 10mg scheduled once daily at 8:00am. -Memantine 10mg was documented as administered 30 of 30 opportunities. Review of Resident #1's eMAR for December 2021 revealed: -There was an entry for memantine 10mg scheduled once daily at 8:00am. -Memantine 10mg was documented as administered 31 of 31 opportunities. Interview with Resident #1 on 01/06/22 at 8:43am revealed she was not familiar with memantine and did know what medications she was ordered or administered. Telephone interview with a representative from the facility's contracted pharmacy on 01/05/22 at 2:41pm revealed: -Resident #1 had an order dated 06/02/21 for memantine 10mg scheduled once daily. -Resident #1 had a second order for memantine 10mg scheduled once daily dated 12/17/21. -The orders were signed by two different primary care providers (PCPs). -The pharmacy had not received the FL-2 dated 09/08/21 with the discontinued memantine. -There was a signed physicians' order dated 12/17/21 for the memantine 10mg scheduled once daily. -The facility was responsible for faxing Resident #1's current FL-2 to the pharmacy to update	D 358	Continued from page 6 RCC and AED were in-serviced on proper medication cart audits and order processing system. Medication Staff have been in-serviced on proper process for discontinued medications	01/27/2022 01/27/2022

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D 358	Continued From page 7 orders. -Twenty-eight tablets of memantine 10mg were dispensed on 09/10/21. -Twenty-eight tablets of memantine 10mg were dispensed on 10/08/21. -Twenty-eight tablets of memantine 10mg were dispensed on 11/05/21. -Twenty-eight tablets of memantine 10mg were dispensed on 12/03/21. -Memantine was ordered for a diagnosis of Alzheimer's disease but Resident #1 did not have Alzheimer's listed as a diagnosis. -Memantine would usually be discontinued if it was not effectively slowing down or stabilizing Alzheimer's symptoms such as cognition. Telephone interview with Resident #1's PCP on 01/06/22 at 10:53am revealed: -She had only been Resident #1's PCP for about a month. -She did not know why Resident # 1's previous PCP had discontinued her memantine. -The facility should have followed the previous PCP's orders. -Resident #1 did not have a diagnosis of Alzheimer's disease but she did have alcohol induced dementia, so she had reordered the memantine 10mg scheduled once daily on 12/17/21. -She would monitor Resident #1 while on the memantine. Interview with a medication aide (MA) on 01/06/22 at 10:38am revealed: -She did not discontinue or remove medications from the eMAR; only the Resident Care Coordinator (RCC) and the Assistant Administrator could remove medications from the eMAR. -She did not have anything to do with faxing	D 358		

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D 358	Continued From page 8 orders to the pharmacy. -Discontinued medication would also be listed in progress notes and verbally communicated to the MAs. -If a medication had been discontinued, she would write it across the medication card and document on the eMAR that the medication had been discontinued. -She did not recall Resident #1's memantine 10mg being discontinued. Interview with the RCC on 01/06/22 at 9:51am revealed: -New FL-2s were faxed to the pharmacy to update medication orders for changes and discontinued medication. -The eMAR was updated by the RCC or the Assistant Administrator when a new FL-2 was signed by the PCP; discontinued medications would be discontinued on the eMAR as well. -When there was a signed physicians order attached to the FL-2 both documents would be faxed to the pharmacy. -Confirmations of faxes to the pharmacy were not kept by the facility; after a couple of months they were discarded. -She did not know why the pharmacy had not received Resident #1's current FL-2 dated 09/08/21 with the order to discontinue the memantine 10mg. -It must have fallen through the cracks. Interview with the Assistant Administrator on 01/06/22 at 2:52pm revealed: -She and the RCC were responsible for faxing new FL-2s to the pharmacy. -She did not recall if or who faxed Resident #1's FL-2 dated 09/08/21 to the pharmacy; confirmations for faxes were not kept after "so long".	D 358		

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D 358	Continued From page 9 -She or the RCC would have discontinued Resident #1's memantine on the eMAR. -She did not know why the PCP had discontinued Resident #1's memantine; the PCP never communicated why a medication was discontinued. -She did not know why Resident #1's FL-2 dated 09/08/21 was not faxed to the pharmacy so the memantine 10mg could be discontinued. -It was just overlooked or an oversite. Interview with the Administrator on 01/06/22 at 3:23pm revealed: -The RCC or the Assistant Administrator were responsible for ensuring FL-2s and medication orders with changes or discontinued medication were sent to the pharmacy via facsimile. -After the order for a discontinued medication was sent to the pharmacy the RCC or Assistant Administrator should discontinue the medication from the eMAR and then physically remove the medication from the medication cart. -She expected the RCC to fax Resident #1's current FL-2 dated 09/08/21 to the pharmacy and to ensure the memantine had been discontinued on the eMAR. -Resident #1's memantine 10mg should not have been administered from 09/08/21 to 12/17/21 if it had been discontinued by the PCP.	D 358		
D 611	10A NCAC 13F .1801 (b) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are	D 611	10A NCAC 13F .1801(b) Infection Prevention & Control Program Community will assure it follows all policies and procedures, CDC guidance, State and Local Health Department guidance regarding Infection Preventation and Control Program	1/7/2022

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D 611	Continued From page 10 hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following: (1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen;	D 611	Continued from page 10 Community Management Staff will review and discuss Infection Control in Daily Stand-Up meetings. Community ED, RCC, AED and/or other management team members will do rounds through out community to assure all staff are following proper infection control at all times. All staff and/or visitors shall remain in mask and follow all proper infection control procedures while in community unless in staff break room eating or drinking. All community staff have been in-serviced on proper Infection Control guidelines and community policies and procedures regarding infection control practices	01/7/2022 01/7/2022 01/7/2022 2/12/2022

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D 611	Continued From page 11 (4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures; (5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working; (6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak; (7) The annual review and update of the facility ' s IPCP to be consistent with published CDC guidance on infection control; and (8) a process for updating policies and procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human Services (NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to Assisted Living (AL) and Special Care Unit (SCU) residents during the global coronavirus (COVID-19) pandemic as related to the proper use of facemask (source	D 611		

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D 611	Continued From page 12 control) by staff. The findings are: Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 (COVID-19) spread in Nursing Homes and Long-Term Care Facilities dated 09/10/21 revealed staff should wear source control when they are in areas of the healthcare facility where they could encounter residents and facemask should not be worn under the nose or mouth. Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of COVID-19 in LTC facilities revealed all facility staff should wear a facemask while in the facility. Review of the facility's COVID-19 policy dated September 2021 revealed: -All staff were required to wear facemask while in the building. -Staff were only allowed to remove their facemask while eating and drinking in the breakroom. -Facemask must cover the staffs' nose and mouth. Observation of the facility staff on 01/05/22 at 7:41am revealed: -One staff did not have on a facemask as she walked down a hallway where residents resided. -The state survey team was greeted at the entrance to the facility and lead inside by a staff that did not have on a facemask. -There was a medication aide (MA) with her facemask under her chin while she administered	D 611		

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	HAL073018	A. BUILDING: _____ B. WING _____	01/06/2022

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D 611	Continued From page 13 medication. -A second MA pulled her facemask down and under her chin while she screened the state survey team; she identified herself as the person in charge. -The second MA was wearing her facemask under her chin as she walked around the facility while she was on the telephone. Observation of staff on 01/05/22 at 8:32am revealed: -She was conducting a medication audit on a medication cart with a second MA. -The first MA had her facemask under her chin. -A third staff entered the facility from an outside door and stopped at the medication cart to talk to the two MAs; the third staff did not have on a facemask. Observation of a MA on 01/05/22 at 9:34am revealed she was with a resident and a visitor having a conversation and standing about a foot away; the MA's facemask was under her chin. Observation of a two personal care aides (PCAs) on 01/05/22 at 9:39am and 12:54pm revealed: -One PCA was assisting residents in the hall; her mask was under her nose. -The second PCA was seated next to a resident and was assisting the resident with eating in the dining room. -She pulled her facemask under her chin to speak to the resident as she assisted the resident with eating. Observation of a PCA on 01/06/22 at 1:53pm revealed she pulled her facemask away from her face and spoke to a resident; the resident's face was less than six inches away from the PCA's face.	D 611		

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D 611	Continued From page 14 Interview with five residents on 01/05/22 from 7:50am to 8:40am revealed: -Staff quit wearing facemask months ago. -Staff wore their facemask some of the time. -Staff had not been wearing facemask and quit wearing facemask. -Staff did not always wear their facemask over their nose and mouth. Interview with a PCA on 01/06/22 at 1:53pm revealed: -She wore her facemask at all times while in the facility unless she was in designated break areas and eating or drinking. -Staff were required to wear their facemask over their mouth and nose. -She never saw other staff without their facemask unless they were eating. -She had pulled her facemask away from her face while she was speaking to a resident so the resident could understand her. Interview with a MA on 01/05/22 at 8:36am revealed: -She wore her facemask all the time while inside the facility. -The correct way to wear a facemask was over your nose and mouth. -Sometimes if she was talking to a resident or another staff and they could not understand her, she would step back and pull her facemask away from her face. -Sometimes she would move her facemask below her chin without realizing it; when she realized her facemask was below her chin, she would move it back up. -Sometimes she would see staff not wearing their facemask over their nose and mouth and she would remind them to pull their facemask over	D 611		

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D 611	Continued From page 15 their nose. -She had not had to tell anyone today, (01/05/22) to pull their facemask up over their nose. Interview with the Maintenance Director on 01/05/22 at 8:28am revealed: -There were strict rules for wearing facemask while inside the facility. -All staff were required to wear surgical facemask at all times; the facemask should cover their nose and mouth. -The only place staff could remove their facemask was when they were on their break and eating or drinking. -Staff had to keep their facemask over their nose and mouth when the talked. -He had never seen anyone without their facemask. Interview with the Assistant Administrator on 01/06/22 at 3:09pm revealed: -Staff were supposed to wear their facemask at all times while in the facility. -Staff were supposed to wear their facemask over their nose and mouth at all times. -Staff could remove their facemask when they were in the designated break areas and were eating. -Staff were not allowed to pull their facemask away from their face when they were speaking to a resident. -If a resident did not understand them then the staff would have to speak louder. -Facemasks were worn to prevent the spread of the [COVID-19] virus. -She had to reminded staff to pull their facemask over their nose in the past, but she had not had to remind anyone recently. Interview with the Administrator on 01/06/22 at	D 611		

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D 611	Continued From page 16 2:00pm revealed: -Staff were required to wear facemask at all times while in the facility unless they were in the breakroom eating or drinking. -If staff needed to take a break and breath without a facemask then they had to leave the facility and go outside. -The proper way to wear a facemask over the nose and mouth. -Staff were not allowed to wear their facemask under their nose or chin. -Staff were allowed to pull their facemask away from their face when speaking to a resident if the resident could not understand them. -There were "no droplets coming out" when the staff pulled their facemask away from their face to speak to a resident. -When staff had to pull their facemask away from their face to speak to a resident, they should be a few feet away from the resident's face. -She was disappointed staff were not properly wearing their facemask while in the facility.	D 611		