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
	HAL066012	A. BUILDING _____ B. WING _____	R 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON MANOR	320 BROUGHTON STREET GASTON, NC 27832

(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 and the Northampton County Department of Social Services conducted an annual survey, follow-up survey and complaint investigation on March 23, 2022 through March 24, 2022. The complaint investigation was initiated by the Northampton County Department of Social Services on February 23, 2022.	D 000	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.	
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 of health care needs for 2 of 5 sampled residents (#1 and #2) related to cardiology appointments (#2), podiatry referrals (#1, #2), and an eye clinic appointment (#1) were completed. The findings are: 1. Review of Resident #2's current FL-2 dated 02/03/22 revealed: -Diagnoses included Alzheimer's disease, vascular dementia, cerebral infarction, chronic obstructive pulmonary disease with hypoxia, systolic congestive heart failure, pacemaker, unsteady fall and continuous oxygen. -The resident was semi-ambulatory and intermittently disoriented. a. Review of Resident #2's hospital discharge paperwork dated 01/21/22 revealed Resident #2 had a cardiologist appointment scheduled for	D 273	10A NCAC 13F .0902(b) Health Care 1. 10A NCAC 13F .0902 Health Care The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. a. The facility will assure that all appointments are kept, refusals are documented, notification to the family, medical providers are documented in the resident's chart. b. The Resident Care Coordinator (RCC), the Special Care Coordinator (SCC) and the Transportation staff will review all appointments during daily stand up. Stand up is a meeting that is held each day with departments including managers and supervisors. Jennifer Ty - ED 4-25-22	5-6-22

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Reviewed and Acknowledged AST 05.04.22

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D 273	Continued From page 1 01/24/22 at 2:00pm and 02/01/22 at 1:00pm. Telephone interview with the nurse practitioner at the cardiologist's office on 03/24/22 at 8:30am revealed: -The resident was a "No Show" for medical appointments on 01/24/22 and 02/01/22. -The appointment on 01/24/22 was to see the cardiology nurse practioner and have an integration of her pacemaker. -The appointment on 02/01/22 was to see the cardiologist. -The facility was aware of both appointments. -He was concerned about the two missed appointments and requested the medical office reschedule with the facility staff. -On 12/28/21, it was determined that her pacemaker had only one to three months of battery life remaining. -Not attending cardiologist's appointments could be harmful to her health. -The pacemaker would begin to work when her heart rate started to drop. -If the battery for the pacemaker died, then the pacemaker would not work. Interview with Memory Care Manager (MCM) on 3/17/22 at 4:00pm revealed: -She was not sure why Resident #2 missed her cardiology appointments on 01/24/22 or 02/01/22. -The resident may have refused to attend the cardiology appointments. -She expected missed appointments and refusals to be documented. -There was no documentation to be found regarding the missed cardiology appointments. Interview with the facility transporter on 03/18/22 at 9:29am revealed: -She was hired on 01/18/22 to provide residents	D 273	c. The transportation staff and or care staff will document all appointments on the week appointment form and will give the RCC, SCC, Administrator and other staff copies of the appointment schedule to review. d. The transportation staff, RCC, SCC and or other care staff will document any residents' refusals to go to medical appointments in the resident's records. e. In the event a resident refuse to go to an appointment, the transportation staff, RCC, SCC and or care staff will notify the residents responsibility party or the Guardian, Power of Attorney by phone, or email and will be documented in residents' record. f. The transportation staff, RCC, SCC and or other care staff will call the residents primary care doctor and the referring agency should a resident refuse to go to their appointment and will be documented in residents' record.	

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D 273	Continued From page 2 with transportation to medical appointments. -She was not sure why Resident #2 missed her two cardiology appointments. -The resident may have refused. -The missed appointments were not documented. -She was aware that the resident was being seen by a cardiologist frequently to have her pacemaker monitored. -She was aware that the pacemaker was at least 10 years old and must be replaced. - She did not schedule either cardiology appointment on 01/24/22 or 02/01/22. Interview with the Administrator on 03/24/22 at 2:04pm revealed: -The resident refused to attend her appointment on 01/24/22 and 02/01/22. -It was expected that refusals were to be documented in the residents' notes. -There was no documentation regarding the two missed appointments found in the Resident #2's record. Attempted telephone interview with Resident #2's guardian on 03/22/22 at 12:07pm and 03/23/22 at 11:45am was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. Refer to the interview with the transporter on 03/18/22 at 9:29am. Refer to the interview with the Administrator on 03/24/22 at 2:04pm. b. Review of Resident #2's podiatrist summary dated 10/25/21 revealed: -Resident #2 was seen for a podiatry evaluation.	D 273	g. The RCC, SCC and or administrator will randomly audit residents' charts monthly to ensure all appointments, referrals are being met. h. The Administrator, RCC, SCC has in serviced the transportation staff along with other staff on the importance of knowing the exact location of resident's appointment to ensure no one gets lost. Recommendations were made to review locations with printing off directions, calling the office to ask questions on location of office. i. Administrator, RCC, SCC in serviced staff on the process of resident's refusals, notifications and interventions that may be used to encourage the resident to go their appointment.	3-24-22 3-25-22

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D 273	Continued From page 3 -This was her initial visit with this provider. -The resident complained of having painful toenails. -It was noted that the "Patient should be treated in 60 days for foot care due to systemic conditions or sooner should complications arise". Review of Resident #2's podiatrist summary dated 02/24/22 revealed: -Resident #2 was seen for a podiatry evaluation. -She was last seen on 10/25/21. -The resident complained of having painful toenails. -It was noted that the "Patient should be treated in 60 days for foot care due to systemic conditions or sooner should complications arise". -Resident #2 was not seen within 60 days. Review of document provided by the podiatrist dated 03/17/22 revealed: -The podiatrist could provide foot care services every sixty days per Medicare guidelines. -The podiatrist has found this schedule to be most effective. -Most patients required foot care at least every two months. Interview with Memory Care Manager (MCM) on 03/17/22 at 4:00pm revealed: -The podiatrist would only come to the facility quarterly. -She was not aware of a sixty-day follow up for Resident #2. -The podiatrist was not coming every sixty days. -The facility had COVID-19 in December 2021 and January 2022 and that could be why they did not come during that time. Review of notice provided by the podiatrist dated 03/17/22 revealed:	D 273		

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D 273	Continued From page 4 -The provider attempted to provide foot care for the residents of the facility on 01/10/22. -The facility had COVID-19 and the provider was instructed to return later once COVID-19 cases were resolved. -01/10/22 was beyond the sixty day follow up indicated on the previous podiatry evaluation. Interview with the Administrator on 03/24/22 at 2:04pm revealed: -The podiatrist would come to the facility every other month or every quarter. -The podiatrist came to the facility on 01/10/22 but would not stay as facility residents' and staff had COVID-19. -The Administrator was not aware of any missed podiatry appointments. -The facility did not have COVID-19 in the month of December 2021. -The podiatrist would make their own schedule and report to the facility when they will make their visits. -The Administrator had not followed up with the podiatrist regarding sixty-day podiatry needs. Attempted telephone interview with Resident #2's guardian on 03/17/22 and 03/23/22 was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Refer to the interview with the transporter on 03/18/22 at 9:29am. Refer to the interview with the Administrator on 03/24/22 at 2:04pm. 2. Review of Resident #1's current FL-2 dated	D 273		

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D 273	Continued From page 5 02/21/22 revealed: -Diagnoses included Alzheimer's disease, weight loss, diabetes without complications, acute kidney injury. -Resident #1 was semi-ambulatory with a wheelchair and constantly disoriented. a. Interview with Resident #1's family member on 03/22/22 at 11:23am revealed: -Resident #1 had an eye appointment on 02/09/22. -The facility staff took Resident #1 to the wrong medical office. -She missed her appointment. -The appointment was rescheduled for 03/30/22. -Resident #1 had a history of glaucoma and diabetes, which could affect her vision. -The missed appointment was reported to the Memory Care Manager that day (02/09/22). Interview with the facility's transporter on 03/18/22 at 9:29am revealed: -She took Resident #1 to the wrong doctor's office on 02/09/22. -She attempted to take the resident to the correct provider, but it had been more than 15 minutes, so the provider rescheduled the appointment. Interview with the Activity's Coordinator on 03/18/22 at 1:30pm revealed: -She assisted with facility transportation until the facility hired the transporter in the middle of January 2022. -The Memory Care Manager (MCM), Resident Care Coordinator (RCC) and residents would come directly to the transporter to report upcoming medical appointments. -The appointments would then be logged on the calendar. -The eye appointment for Resident #1 was	D 273		

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D 273	Continued From page 6 recorded with an accurate date, time and location on the calendar. -The facility's transporter took Resident #1 to the wrong location for her eye appointment, which caused the resident to miss her eye appointment. Interview with Memory Care Manager (MCM) on 03/18/22 at 9:00am revealed: -The eye appointment was set up for Resident #1, at a family member's request, because she was a diabetic and the family member thought that she might need glasses. -The MCM reported the eye appointment to the facility's transporter. -The transporter was responsible to contact the family/responsible party to inform of appointment and to get the resident to the appointment. -Resident #1's family member was notified of the appointment and went to the appointment. -The family member called the MCM to locate Resident #1. -The MCM called the facility's transporter who confirmed she was at the eye clinic. -The family member came to the facility upset because Resident #1 never made it to her scheduled appointment. -The MCM called the facility's transporter again and discovered that she took Resident #1 to the wrong medical office, which caused her to miss her appointment. Interview with the Administrator on 03/24/22 at 2:04pm revealed: -Resident #1 had an eye appointment and the transportation worker took the resident to the wrong medical office. -The transportation worker was new at the time and the eye providers were side by side. -She was not sure, when the appointment was rescheduled for or if the rescheduled appointment	D 273		

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D 273	Continued From page 7 had already passed. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Refer to the interview with the transporter on 03/18/22 at 9:29am. Refer to the interview with the Administrator on 03/24/22 at 2:04pm. b. Review of Resident #1's podiatrist summary dated 10/04/21 revealed: -Resident #1 was seen for a podiatry evaluation. -It was noted that the "Patient should be treated in 60 days for foot care due to systemic conditions or sooner should complications arise". Review of Resident #1's podiatrist summary dated 02/24/22 revealed: -Resident #1 was seen for a podiatry evaluation. -She was last seen on 10/04/21. -The resident complained of having painful toenails. -It was noted that Resident #2 should be treated in 60 days for foot care due to systemic conditions or sooner should complications arise. Review of notice provided by the podiatrist dated 03/17/22 revealed: -The podiatrist could provide foot care services every sixty days per Medicare guidelines. -The podiatrist has found this schedule to be most effective. -Most patients required foot care at least every two months. Interview with Memory Care Manager (MCM) on 03/17/22 at 4:00pm revealed:	D 273		

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D 273	Continued From page 8 -The podiatrist would only come to the facility quarterly. -She was not aware of a sixty-day follow up for Resident #1. -The podiatrist was not coming every sixty days. -The facility had COVID in December 2021 and January 2022 and that could be why they did not come during that time. Review of notice provided by the podiatrist dated 03/17/22 revealed: -The provider attempted to provide foot care for the residents of the facility on 01/10/22. -The facility had COVID-19 in the facility and the provider was instructed to return later once COVID-19 cases were resolved. -01/10/22 was beyond the sixty day follow up indicated on the previous podiatry evaluation. Interview with the Administrator on 03/24/22 at 2:04pm revealed: -The podiatrist would come to the facility every other month or every quarter. -The podiatrist came to the facility on 01/10/22, but would not stay as facility residents' and staff had COVID-19. -The Administrator was not aware of any missed podiatry appointments for Resident #2. -The facility did not have COVID-19 in the month of December 2021. -The podiatrist would make their own schedule and report to the facility when they will make their visits. -The Administrator had not reached out to the podiatrist regarding the notation to follow up with podiatry patients within sixty days. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.	D 273		

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D 273	Continued From page 9 Refer to the interview with the facility's transporter on 03/18/22 at 9:29am. Refer to the interview with the Administrator on 03/24/22 at 2:04pm. Interview with the facility's transporter on 03/18/22 at 9:29am revealed: -She was hired on 1/18/22 to provide residents with transportation to medical appointments. -She was trained for one week before she took over the role full time. -She kept a calendar to track all outside appointments. Interview with the Administrator on 03/24/22 at 2:04pm revealed: -She was not aware of any "intentional" missed medical appointments. -The facility had COVID-19 during the month of January and into February 2022. -In January 2022, she hired a new transporter to get residents to medical appointments. -The Memory Care Manager (MCM), Resident Care Coordinator (RCC), transporter and other assigned staff as needed would help with scheduling appointments. -The transporter would provide a weekly sheet to the MCM and the RCC informing them of upcoming appointments.	D 273	4-25-22	