

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 and the Iredell DSS conducted a complaint investigation and annual survey on 11/08/22 to 11/10/22.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunization 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 2 of 3 sampled residents (#1 and #2) were tested for tuberculosis (TB) within one year of admission. The findings are: 1. Review of Resident #2's current FL2 dated 10/04/21 revealed: -Resident #2 was admitted to the facility from home. -Diagnoses included Alzheimer's Disease. Review of Resident #2's Resident Register revealed date of admission to the facility was 10/20/21. Review of Resident #2's record from 11/08/22 to	D 234	The Administrator/RCC/BOC/designee will utilize an admission checklist to verify that a TB test was completed prior to admission. Staff trainings with signed attendance sheets for the Admission checklist. Administrator along with the designee will sign. The administrator will be responsible for having a designee complete monthly audits on all resident records to ensure this was not overlooked	1/9/23

Division of Health Service Regulation

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

B. Clark

TITLE

Regional Director

(X6) DATE

1/9/23

STATE FORM

8898

FJM111

If continuation sheet 1 of 77

Reviewed and acknowledged on 01/25/23 by

DMS

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 234	Continued From page 1 11/10/22 revealed there was no documentation of TB testing. Refer to the telephone interview with the Resident Care Coordinator (RCC) on 11/10/22 at 4:34pm. Refer to the interview with the Administrator on 11/10/22 at 5:27pm. 2. Review of Resident #1's current FL2 dated 09/02/21 revealed: -Resident #1 was admitted to the facility from another Special Care Unit (SCU). -Diagnoses included dementia. Review of Resident #1's Resident Register revealed date of admission to the facility was 07/29/20. Review of Resident #1's record from 11/08/22 to 11/10/22 revealed there was no documentation of TB testing. Refer to the telephone interview with the RCC on 11/10/22 at 4:34pm. Refer to the interview with the Administrator on 11/10/22 at 5:27pm. Telephone interview with the RCC on 11/10/22 at 4:34pm revealed: -She and the Administrator were responsible for ensuring that residents had TB testing within the first year of admission. -They did not use a tracking tool to keep track of due dates or audit resident records. -She was not aware that Resident #1 and Resident #2 did not have documentation of TB testing.	D 234		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 234	Continued From page 2 Interview with the Administrator on 11/10/22 at 5:27pm revealed: -The RCC was responsible for collecting all clinical documentation prior to the residents' admission to the facility. -She and the RCC met several weeks ago to discuss job responsibilities and she gave the RCC a tracking tool, which included TB testing, to ensure all documents were present on admission. -She was ultimately responsible for making sure the new residents' records were complete prior to admission. -She started in September 2022 and had not completed any chart audits for residents that were admitted prior or after her arrival. -She was not aware that Resident #1 and Resident #2 did not have documentation of TB testing.	D 234		
D 235	10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter. (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:	D 235	The Administrator/RCC/BOM or staff designated staff will utilize an admission checklist to verify if the medical examination was completed and signed by a physician prior to admission. The Administrator/RCC will utilize a tracking tool for all residents for monitoring when residents require updated FL2s or when the resident's annual FL2 will expire. Staff trainings with signed attendance sheets for the Admission checklist and Tracking tool for FL2 (Initial and annual) will be signed by the administrator, RCC, BOM, and any staff designee. The administrator will be responsible for having a designee complete monthly audits on all resident profiles to ensure this was not overlooked.	1/9/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 235	Continued From page 3 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure an annual FL2 was completed for 3 of 3 sampled residents (#1, #2 and #3). The findings are: 1. Review of Resident #1's current FL2 dated 09/02/21 revealed: -An admission date of 07/29/20. -Diagnoses included dementia. Review of Resident #1's Resident Registrar revealed an admission date of 07/29/20. Review of Resident #1's record revealed there was not an updated FL2 completed or signed by the primary care provider (PCP) after 09/02/21. Review of Resident #5's record from 11/08/22 to 11/10/22 revealed there was not an FL2 dated after 09/02/21. Refer to the telephone interview with the Resident Care Coordinator (RCC) on 11/10/22 at 4:34pm. Refer to the interview with the Administrator on 11/10/22 at 5:27pm. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 11/09/22 at 3:23pm was unsuccessful. 2. Review of Resident #2's current FL2 dated 10/04/21 revealed:	D 235		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 235	Continued From page 4 -An admission date of 10/20/21. -Diagnoses included Alzheimer's Disease. Review of Resident #2's record revealed there was not an updated FL2 completed or signed by the primary care provider (PCP) after 10/04/21. Review of Resident #2's Resident Registrar revealed an admission date of 10/20/21. Refer to the telephone interview with the RCC on 11/10/22 at 4:34pm. Refer to the interview with the Administrator on 11/10/22 at 5:27pm. Attempted telephone interview with Resident #2's PCP on 11/10/22 at 3:39pm was unsuccessful. 3. Review of Resident #3's current FL2 revealed: -It was not signed or dated. -Diagnoses included type 2 diabetes and vitamin B12 deficiency. Review of Resident #3's Resident Registrar revealed an admission date of 09/02/22. Review of Resident #3's record revealed there was not an updated FL2 completed or signed by the primary care provider (PCP) after 09/02/22. Telephone interview with the RCC on 11/10/22 at 4:34pm revealed: -She obtained Resident #3's FL2 from the facility he was living in prior to his admission. -She typically checked the FL2 to ensure the resident had a diagnosis of dementia or Alzheimer's disease and that it was signed by a provider no earlier than a month prior to admission.	D 235		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 235	Continued From page 5 -She was not aware that Resident #3's FL2 was not dated or signed by a provider. Refer to the telephone interview with the RCC on 11/10/22 at 4:34pm. Interview with the Administrator on 11/09/22 at 11:00am and on 11/10/22 at 5:27pm revealed: -The RCC was responsible for ensuring a current FL2 was signed by a provider and dated no more than a week before the resident's admission. -She was ultimately responsible for making sure the new residents' records were complete prior to admission. -Resident #3 was admitted around the time that she started working at the facility and she did not help process his admission paperwork. -She was not aware that his FL2 was not signed or dated. Refer to interview with the Administrator on 11/10/22 at 5:27pm. Attempted telephone interview with Resident #2's PCP on 11/10/22 at 3:39pm was unsuccessful. Telephone interview with the Resident Care Coordinator on 11/10/22 at 4:34pm revealed: -In September 2022, she learned she and the Administrator were responsible for ensuring residents had an FL2 before admission and a FL2 that was updated yearly. -Prior to September 2022, she thought only the Administrator was responsible for tracking and updating resident's FL2s. -A tracking tool had not been implemented to monitor when residents required updated FL2s. -The RCC looked in resident's records to see when they needed an updated FL2. -She was not aware Resident #1 and Resident #2	D 235		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 235	Continued From page 6 had expired FL2s. Interview with the Administrator on 11/10/22 at 5:27pm revealed: -The RCC was responsible for ensuring updated FL2s were signed for the residents annually. -A couple of weeks ago, she gave the RCC a tracking sheet to write down the due dates of several documents and the FL2 was on that list. -She was not aware Resident #1 and Resident #2 had expired FL2s.	D 235		
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 record reviews and interviews, the facility failed to ensure health care referral and follow up for 2 of 4 sampled residents (#1 and #6) related to a resident who had diarrhea for 5 days, and used an as needed (PRN) medication to treat diarrhea for 24 days (#1) and report of a fall with injuries of a resident (#6) to hospice. The findings are: 1. Review of Resident #1's current FL2 dated 09/02/21 revealed: -Diagnoses included dementia, atrial fibrillation, chronic obstructive pulmonary disease, frequent urinary tract infections and lumbar stenosis. -An order for dicyclomine (a medication used to treat diarrhea) 20mg two times a day PRN for	D 273	Staff (MA/RCC) will utilize the rounding sheets or 'Shift Report' to indicate the number of days the resident had diarrhea. Therefore, the Medication Aide (MA)/ Resident Care Coordinator (RCC) will notify the resident's physician, albeit; Primary Care Physician (PCP) or Hospice Provider regarding any acute changes and document in the progress note of this intervention. MA/RCC will be responsible for following up/notifying with resident's PCP/Hospice provider regarding usage of any PRN medications for more than 5 consecutive days. The RCC will be responsible for obtaining this information via daily Stand-up meetings with staff as well as through daily checks from the Shift Report. These issues should be reported in the Shift Report as well as documented in the progress notes. Progress notes and Shift Report documents will be utilized and monitored daily by the RCC.	1/9/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 273	Continued From page 7 diarrhea. Review of Resident #1's subsequent signed physician orders dated 09/09/22 revealed an order for dicyclomine 20mg 2 times a day PRN for diarrhea. Review of Resident #1's October 2022 Medication Administration Record (MAR) revealed: -An entry for dicyclomine 20mg two times a day to be administered PRN for diarrhea and documented as administered from 10/01/22 to 10/24/22 once daily. -There was no documentation on the exception page related to the dicyclomine 20mg. Interview with the hospice Registered Nurse (RN) on 11/08/22 at 10:24am revealed: -On 09/14/22, Resident #1 developed diarrhea after 7 days of antibiotic use, so she told the medication aide (MA) to use the PRN dicyclomine 20mg two times a day and to notify her if the diarrhea continued after day. -On 09/19/22, she visited Resident #1 and Resident #1's diarrhea had not resolved, and her bottom and the backs of her legs were "excoriated" (lesions of the skins surface) from the diarrhea. -She was not notified by staff the diarrhea continued. -She was not notified by staff Resident #1 continued to receive dicyclomine 20mg on a daily basis for 24 days or that Resident #1 continued to have diarrhea several times during the month of October 2022. -She expected staff to notify her Resident #1 required the on-going use of dicyclomine because the resident continued to have diarrhea, developed skin breakdown that could lead to	D 273	Staff trainings with signed attendance sheets for the following will occur: 1. Shift Reports 2. Progress notes The Administrator/RCC will be responsible to train staff regarding these implemented forms. RCC will be responsible for monitoring the shift reports and progress notes daily to ensure any acute issues or status changes can and/or will be addressed. In order to ensure all residents have been checked; the RCC/staff will go over each resident to discuss current issues, follow up, document and proceed with ongoing procedures as stated.	1/9/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 273	Continued From page 8 infection, and delayed any testing that would have determined the cause of the diarrhea. Interview with a personal care aide (PCA) on 11/10/22 at 12:30pm revealed: -She alerted the Resident Care Coordinator (RCC) or the Administrator if she had concerns about any of the resident's skin. -When hospice was aware of Resident #1's skin breakdown, she did not document it on the rounding sheet. Interview with a second PCA on 11/10/22 at 12:45pm revealed: -If a resident had diarrhea, she alerted the medication aide (MA) and documented Resident #1's bowel movements the resident had on the rounding sheet. -She told the MA if she had concerns about Resident #1's skin but did not document it on the rounding sheet since there was not a specific spot to write it down. Telephone interview with the RCC on 11/10/22 at 4:49pm revealed: -She was the only MA from 10/01/22 to present. -Resident #1 developed diarrhea after she received antibiotic and her bottom became excoriated. -She did not call the hospice nurse because she treated the diarrhea with the PRN dicyclomine. -It was her responsibility to notify the hospice RN with any concerns including the diarrhea continuing more than three days. Interview with the Administrator on 11/10/22 at 12:22pm revealed: -She trained the MA to notify the physician or hospice of any concern with the residents, including a PRN medication for diarrhea used	D 273			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 273	Continued From page 9 more than 3 days in a row and skin break down. -The MA's were responsible for notifying the physician, the RCC, the hospice RN and documenting in the residents' progress notes. -The RCC was responsible for checking the progress notes daily for completion of the physician notification. -The RCC was responsible for notification to her in the daily standup meetings. -She was not aware hospice was not notified of Resident #1's daily use of the PRN dicyclomine daily for 24 days in October. -She was not aware hospice was not notified of Resident #1's amount of diarrhea causing Resident #1's skin to break down on her bottom. 2. Review of Resident #6's current FL2 dated 08/11/22 revealed: -Diagnoses included senile degeneration of the brain. -Resident #6 was intermittently confused and semi-ambulatory. Telephone interview with the hospice Registered Nurse (RN) on 11/10/22 at 10:44am revealed: -On 08/29/22, Resident #6 fell causing a laceration to her bottom lip. -On 08/30/22 a family member notified her of Resident #6's fall and that Resident #6 was not sent out to the emergency room (ER) for evaluation. -On 08/30/22, she arrived at the facility to assess Resident #6 and found a 1-2cm "gaped open" laceration to her bottom lip. -Staff reported Resident #6 did not lose consciousness at time of the fall and Resident #6 was not sent to the ER for evaluation of the lip laceration. -A lip laceration should be repaired within 6-8	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 273	Continued From page 10 hours to decrease the risk of infection, restore function to the tissue in a timely manner, and achieve optimal cosmetic results with minimal scarring. -On 08/29/22, she did not receive a call from the facility staff about Resident #6's fall. -On 08/29/22, she expected facility staff to notify her of the fall. -On 08/29/22, if she received the notification of the fall with Resident #6 hitting her face sustaining a laceration to her bottom lip, she would have directed the facility to send Resident #6 out to the ER for evaluation and repair of the laceration to the bottom lip. Telephone interview with the RCC on 11/10/22 at 4:34pm revealed: -When a resident fell the personal care aide (PCA) was expected to notify a medication aide (MA). -The MA was expected to check on the resident and inform her of the situation. -She was responsible for contacting the provider to inform them of the fall. -She was not working when Resident #6 fell on 08/29/22. -Since she was not in the building, the Administrator should have been contacted to notify the PCP. -She was aware Resident #6's fall resulted in a bloody cut on her lip. -She was not aware that the hospice provider was not contacted about Resident #6's fall. Interview with the Administrator on 11/10/22 at 12:22pm revealed: -The MA was responsible for notifying to the physician, documenting notification in the progress notes and notifying the RCC. -The RCC was responsible for checking the	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 273	Continued From page 11 progress notes daily for completion of the physician notification; however, the MAs had not been documenting in the progress notes. -On 09/03/22, Resident #6's daughter her informed her that Resident #6 fell on 08/29/22. -She was not aware Hospice was not notified of Resident #6's fall that resulted in a laceration to the bottom lip. The facility failed to ensure the PCP was contacted for a resident who developed episodes of diarrhea resulting in Resident #1's bottom and the backs of her legs to become excoriated putting her at risk for infection, and delayed any testing that would have determined the cause of the diarrhea (#1), and to notify hospice about a fall that resulted in 1-2 cm a lip laceration which increased the risk of infection and a delay in the restored function to the lip tissue due to not receiving emergency medical care (#6). This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-21 on October 10, 2022 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 25, 2022.	D 273	As stated in this facility's POC: The medication aides are responsible for contacting the resident's physician as soon as a health concern(s) is made aware as well as to make the RCC aware. The RCC will be responsible for documentation related to health care/notifications. The administrator will monitor this process weekly to ensure completion.	1/9/23
D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (a) An adult care home shall assure that an appropriate licensed health professional	D 278		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 278	Continued From page 12 participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer	D 278	The Administrator/RCC will be utilizing a LHPS tracking tool to verify the resident's need for assessment (initial and quarterly). The contracted LHPS professional will complete and sign, and RCC will be responsible these documents are kept in the resident's profile. The Administrator/RCC will be trained on how to identify residents with the need for assessment. The Administrator/RCC will be responsible for ensuring that the resident's personal care tasks will be evaluated as well as training staff by the LHPS professional will be completed with a signed attendance sheet.	1/9/23	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 278	Continued From page 13 subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule); (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure an updated licensed health professional support (LHPS) evaluation had been completed by an appropriate licensed professional for 2 of 3 sampled residents	D 278		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 278	Continued From page 14 (Resident #1, #3) with LHPS tasks of transferring a non-ambulatory resident and ambulation assistance with an assistive device (#1) fingerstick blood sugar (FSBS) and injection of insulin (#3). The findings are: 1. Review of Resident #1's current FL2 dated 09/02/21 revealed: -Diagnoses included dementia. -She was non- ambulatory with the use of a wheel chair. -She was intermittently disoriented. Review of Resident #1's record on 11/08/22 revealed a current LHPS completed 04/12/22. Refer to the telephone interview with the Resident Care Coordinator (RCC) on 11/10/22 at 4:34pm. Refer to the interview with the Administrator on 11/10/22 at 5:27pm. 2. Review of Resident #3's current FL2 revealed: -It was not dated or signed by a provider. -Diagnoses included type 2 diabetes. Review of Resident #3's physician's orders dated 08/31/22 revealed: -An order for fingerstick blood sugar (FSBS) before meals and before bedtime. -An order for Humalog 100 unit/mL sliding scale insulin (SSI). Review of Resident #3's September 2022 and October 2022 medication administration records (MAR) revealed: -An entry to check FSBS before each meal and at bedtime, scheduled for 7:30am, 11:30am, 4:30pm	D 278		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 278	Continued From page 15 and 8:00pm. -An entry to inject Humalog 100 unit/mL SSI after checking FSBS. Review of Resident #3's October 2022 and November 2022 electronic medication administration records (eMAR) revealed: -An entry to check FSBS before each meal and at bedtime, scheduled for 7:30am, 11:30am, 4:30pm and 8:00pm. -An entry to inject Humalog 100 unit/mL SSI after checking FSBS. Review of Resident #3's record on 11/09/22 revealed there was no Licensed Health Professional Support (LHPS) evaluation completed. Refer to the telephone interview with the Resident Care Coordinator (RCC) on 11/10/22 at 4:34pm. Refer to the interview with the Administrator on 11/10/22 at 5:27pm. Telephone interview with the RCC on 11/10/22 at 4:34pm revealed the Administrator was responsible for ensuring residents with tasks had an LHPS evaluation. Interview with the Administrator on 11/10/22 at 5:27pm revealed: -The RCC was responsible for contacting the contracted Registered Nurse on a quarterly basis to complete Licensed Health Professional Support (LHPS) evaluations. -Several weeks ago, she met with the RCC to discuss job responsibilities and gave the RCC a tool to track due dates of documents. -The LHPS was on the list of documents. -She was not aware that Resident #1 and	D 278			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 278	Continued From page 16 Resident #3 did not have up to date LHPS evaluations.	D 278			
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide table service utensils consisting of a knife, fork and spoon used to assist the residents in eating their meals. The findings are: Review of the posted dietary menu for the breakfast meal on 11/09/22 revealed an English muffin, scrambled eggs, bacon, grits, juice, coffee and milk. Observation of the dining room on 11/09/22 at 8:17am revealed: -The tables were preset with a napkin, fork and spoon for each resident. -There were not any knives at the resident's	D 287	This facility has made a place setting diagram that is posted in the kitchen. The staff (both clinical and dietary staff) have been trained regarding table settings consisting of knives, forks, spoons for every meal unless exceptions made on an individual basis. Administrator will be responsible for training all dietary and clinical staff regarding table service/set-up for all meals with a signed attendance sheet. This will be completed prior to 12/25/22 Administrator/RCC/Lead Cook will be responsible for monitoring the place settings daily.	1/9/23	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 287	Continued From page 17 tables. Observation of the breakfast meal on 11/09/22 from 8:17am to 8:25am revealed: -One resident used a spoon to scoop butter out of a container and tried to use the spoon to spread the butter on an English muffin. -Another resident used a spoon to cut open an English muffin. -A third resident attempted to rip open an English muffin with her hands then tried to cut open the English muffin with a fork. Interview with the Activity Director on 11/08/22 at 11:55am revealed she had worked at the facility for two weeks and never witnessed residents using knives. Interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 11/08/22 at 11:50am revealed: -The residents were not given knives to use at mealtime. -"It would not be a good idea to give memory care residents knives". Interview with the Administrator on 11/10/22 at 5:27pm revealed: -She started in September 2022 and noticed residents were not given knives at mealtime. -She was told by multiple staff at the facility that they did not offer knives to residents, and she did not pursue the issue any further. -She was aware that the rule stated residents should be provided a fork, spoon and knife with meals.	D 287		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service	D 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 296	Continued From page 18 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure there were matching therapeutic diet menus for 2 of 2 sampled residents (#3 and #6) who had physician ordered therapeutic diets. The findings are: Observation of the kitchen during initial tour on 11/08/22 at 9:05am revealed: -A diet list which included residents on regular, mechanical soft, pureed, no added salt and no concentrated sweets diets was posted on the wall. -No therapeutic diet menus were available for reference by dietary staff. 1.Review of Resident #3's current FL2 revealed: -It was not signed or dated by a provider. -Diagnoses included type 2 diabetes. -There was an order for a cardiac diet. Review of the facility's therapeutic diet list revealed Resident #3 was on a no concentrated sweets (NCS) diet. Refer to interview with the cook on 11/08/22 at 9:28am.	D 296	The Administrator/Lead cook will be responsible for ensuring the cooks/kitchen staff has the binders for therapeutic diet menus for all physician-ordered therapeutic diets that the dietician set up.This will be completed by posting up updated therapeutic diet orders in the kitchen for the kitchen staff can view it while preparing the food. The Administrator/RCC will be responsible for utilizing the audit tool to ensure that there are diet orders from physicians are matching the current FL2 and diet list from the kitchen. Administrator/RCC will be responsible for updating the diet list/ menu binders established by the dietician. These audits will be monthly.	1/9/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 296	Continued From page 19 Refer to interview with the Administrator on 11/10/22 at 5:27pm. 2. Review of Resident #6's current FL2 revealed: -Diagnoses included senile degeneration of the brain. -There was an order for a regular diet. Review of Resident #6's physician's order dated 10/20/22 revealed diet as tolerated, ok to feed pureed meals. Review of the facility's therapeutic diet list revealed Resident #6 was on a regular diet. Interview with the cook on 10/08/22 at 9:23am revealed the therapeutic diet list had not been updated in a while and Resident #6 was on a pureed diet. Refer to interview with the cook on 11/08/22 at 9:28am. Refer to interview interview with the Administrator on 11/10/22 at 5:27pm. Interview with the cook on 11/08/22 at 9:28am revealed: -He cooked and served the meals. -The therapeutic diet menus were not in the binder and he did not know where else they would be. -Since he did not have the therapeutic diet menus, he relied on his previous therapeutic diet knowledge to prepare the meals. Interview with the Administrator on 11/10/22 at 5:27pm revealed: -At the beginning of October 2022, she added the fall/winter menus to the binder in the kitchen and	D 296		

Division of Health Service Regulation

STATE FORM

6899

FJM111

If continuation sheet 20 of 77

Division of Health Service Regulation
STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 310	Continued From page 21 Review of Resident #6's physician's order dated 10/20/22 revealed diet as tolerated, ok to feed pureed meals. Review of the therapeutic diet list posted in the kitchen on 11/08/22 revealed Resident #6 was on a regular diet. Interview with the cook on 10/08/22 at 9:23am revealed the therapeutic diet list had not been updated in a while and Resident #6 was on a pureed diet. Review of the posted dietary menu for the lunch meal on 11/08/22 revealed a pork chop, rice and mixed vegetables with a beverage of choice. Observation of the cook preparing lunch on 11/08/22 at 11:10am revealed: -He placed a pork chop into the high-powered blender and blended the meat. -When he took the pork out of the blender, he stated that it was pureed and scooped a portion of pork onto a plate. -The pork was partially pureed but had some stringy pieces of meat. Observation of the lunch meal service for Resident #6 on 11/09/22 at 11:30am revealed: -She ate in her room. -A personal care aide (PCA) delivered the meal to her room and called for someone to assist Resident #6. -Two other PCAs arrived and one of the PCAs started assisting Resident #6 with lunch. -Resident #6 was given a spoonful of pork and moved the food around in her mouth for a minute. -The PCA pulled a stringy piece of pork out of Resident #6's mouth.	D 310	Administrator will be responsible for ensuring that all cooks are trained regarding all specialty/therapeutic diets to ensure the residents are in fact receiving the appropriate prepared meals they have orders for. Administrator and dietary cooks/servers will have the weekly menus; therapeutic diet menus; and the recipes will be kept in binders in the kitchen. The Administrator/Lead cook will be responsible for ensuring menus and binders are kept in working order by checking monthly or when a new revised seasonal menu is created.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 310	Continued From page 22 -At 11:36am Resident #6 stated she was finished eating. Interview with the PCA that assisted Resident #6 at lunch on 11/08/22 at 11:32am revealed she did not know Resident #6's diet order since she did not typically work as a PCA. Interview with the PCA that delivered Resident #6's lunch meal tray on 11/08/22 at 11:40am revealed: -She looked at Resident #6's meal before she left it in the room. -She thought all of the food on the plate was pureed. Review of the posted dietary menu for the breakfast meal on 11/09/22 revealed an English muffin, scrambled eggs, bacon, grits, juice, coffee and milk. Observation of the cook preparing breakfast on 11/09/22 at 7:36am revealed: -He placed three handfuls of cooked bacon into the high-powered blender and blended the meat. -After blending the bacon, he scooped some onto a plate. -The bacon was chopped into small pieces of meat that stuck together. -He did not puree the grits and they were not smooth. Interview with the cook on 11/09/22 at 7:36am revealed: -The grits were not pureed since they are already soft. -The bacon was an appropriate texture for a pureed diet. Observation of the breakfast meal service for	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 310	Continued From page 23 Resident #6 on 11/09/22 at 7:50am revealed: -Resident #6 ate in her room. -A PCA assisted her with breakfast and she ate a couple bites of pureed English muffin and pureed scrambled eggs. Interview with the cook on 11/08/22 at 9:28am revealed: -He did not know where the therapeutic diet menus were for the current fall/winter menu cycle. -He did not have any recipes on how to modify regular texture food into a pureed consistency. -He relied on his previous therapeutic diet training to puree food. Telephone interview with the Registered Dietitian at the facility's contracted menu company on 11/09/22 at 3:19pm revealed: -She reviewed the facility's menus for the nutritional content and diet accuracy for therapeutic diets. -She generally did not recommend pureeing bacon since it is very difficult to achieve a pureed texture, instead she recommended a different meat. -Pureeing bacon required a high-powered blender with the addition of a liquid, bread and thickener. -Pureed meat should not have any chunky or stringy pieces in it. -Pureed food was smooth with a pudding consistency. Interview with the Administrator on 11/10/22 at 5:27pm revealed: -She expected the kitchen to prepare the residents food according to their diet orders. -She thought the cook could puree food from the regular diet menu without needing a recipe. -She expected the pureed food to be the consistency of applesauce.	D 310		

Division of Health Service Regulation

STATE FORM

6899

FJM111

If continuation sheet 24 of 77

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 310	Continued From page 24 Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 11/10/22 at 3:39pm was unsuccessful.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure residents were treated with dignity related to a resident whose cell phone was taken away by the staff because she called 911 to get assistance (#1). The findings are: Review of Resident #1's current FL2 dated 09/02/21 revealed diagnoses of dementia, atrial fibrillation, chronic obstructive pulmonary disease, frequent urinary tract infections and lumbar stenosis. Review of Hospice Registered Nurse (RN) visit notes revealed: -On 09/22/22, Resident #1 stated her cell phone was taken away by the staff on Monday due to calling 911 and she was going to ask for it back since she was good for about a week. -On 10/26/22, Resident #1 was upset because she could not call Hospice and the staff told her that her phone did not have minutes on it. -On 10/31/22, Resident #1 was upset that no one would come when she called for assistance and	D 338	Training all staff on the community's resident rights form by the Administrator and/or Ombudsman and will have a signed attendance sheet completed on or prior to 12/25/22. This training will include resident's personal items (including cell phone) should not be removed for punitive purposes as well as staff should follow up with any resident request to see their physician/health care provider. The administrator/BOM will utilize the audit tool to verify that all staff have this training in their personnel file, monthly. All new employees will obtain this training within the first week of hire. The administrator will be responsible for ensuring that all staff are trained.	1/9/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 338	Continued From page 25 when they did they would have an attitude with her. -On 10/31/22, Resident #1 would often ask the staff to call Hospice because the staff took her cell phone and no one from Hospice would come so she believed the staff did not call Hospice. -On 11/07/22, Resident #1 was frustrated that her cell phone had no minutes on it. Interview with Resident #1 on 11/10/22 at 3:45pm revealed: -Around the middle of September 2022, she called the police because she thought the residents were in jeopardy. -She had a urinary tract infection at that time and was very confused. -The police did not talk to her and afterwards that night the Resident Care Coordinator (RCC) took her phone from her. -She was told by the RCC, she could not have her phone because she called the police and that it was not allowed. -She was admitted to the hospital after that and did not have her phone so she was not able to speak to her sister while she was in the hospital because her sister's number was programmed into her phone. -Without her phone she felt "stranded", and afraid. -Her phone was her security and a way to talk to the person she trusted and that was her sister. -She also used her phone to call hospice for help when she did not receive the care and medications she was supposed to. -She talked with her sister frequently about concerns and decisions. -She just got her phone back on 11/10/22 and the social worker had to reconnect it. Telephone interview with the RCC on 11/10/22 at	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 338	Continued From page 26 4:49pm revealed: -She was the only medication aide (MA) in October 2022 and November 2022. -Resident #1 called the police in September 2022 because she was in fear the staff was in danger. -Resident #1 was confused. -The night shift MA took Resident #1's cell phone to keep her from calling the police again. -She gave Resident #1 back her cell phone the next day. -The morning she gave Resident #1 back her cell phone, Resident #1 was diagnosed with a urinary tract infection. -She always checked in on Resident #1 and called Hospice anytime Resident #1 requested to speak with the Hospice RN. Interview with the Administrator on 11/10/22 at 5:27pm revealed: -Resident #1 had the right to have their personal cell phone in her room. -It was reported by the RCC, that the RCC removed Resident #1's cell phone because Resident #1 called the police. -Resident #1 was calling for help because she thought there was no one in the building. -She informed the RCC she could not do that and to return the cell phone to Resident #1. -She was not sure how long the phone was removed.	D 338			
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:	D 358	The Administrator will be responsible for the Medication Administration policy to be implemented. Trainings for the Medication Administration Policy will be completed by 12/25/22. The Administrator will be responsible for having all MAs trained and to have a signed attendance sheet be completed and filed.	12/25/22	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 27 (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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered prescribed by a licensed prescriber for 5 of 5 sampled residents (#1, #3, #5, #7 and #8) related to a medication used to treat high blood pressure, hypothyroidism, shortness of breath, treat nerve pain, pain, probiotic and diarrhea (#1), control elevated blood sugar (#3), chronic severe pain and one for mild pain and seizures (#5), mood stabilizer (#7) and depression (#8). The findings are: The medication error rate was 6.25% based on the observation of 2 errors out of 32 opportunities during the 7:00am medication pass on 11/09/22. 1. Review of Resident #1's current FL2 dated 09/02/21 revealed: -A diagnosis of dementia, lumbar stenosis, frequent urinary tract infections, atrial fibrillation, and chronic obstructive pulmonary disease. -An order for diltiazem (a medication used to treat high blood pressure) 120mg every day. -An order for levothyroxine (a medication used to treat hypothyroidism) 88mcg every day. an order for Symbicort inhaler (a medication used to treat shortness of breath) 160-4.5 INH Aero 120, inhale two puffs 2 times a day. Review of Resident #1's physician's orders dated	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 28 09/06/22 revealed: -An order for diltiazem 120mg every day. -An order for levothyroxine 88mcg every day. -An order for Symbicort inhaler 160-4.5 INH Aero 120, inhale two puffs 2 times a day. -An order for gabapentin 300mg at bedtime. Review of Resident #1's signed physician orders dated 09/09/22 revealed an order for gabapentin (a medication used to treat nerve pain) 100mg every morning and at noon. Review of Resident #1's signed physician orders dated 09/16/22 revealed an order for acetaminophen (a medication used to treat pain) 325mg, two tablets every 8 hours. Review of Resident #1's signed physician orders dated 09/19/22 revealed: -An order for lactobacillus acidophilus (a probiotic) every day. -An order for Lomotil (a medication used to treat diarrhea) 0.025mg-2.5mg, two tablets 4 times a day for 10 days Review of Resident #1's September 2022 Medication Administration Record (MAR) revealed: -An entry for diltiazem 180mg every day documented as administered from 09/01/22 to 09/30/22 at 8:00am. -The diltiazem 120mg every day was not documented as administered from 09/06/22 to 09/30/22. -An entry for levothyroxine 100mcg every day was documented as administered from 09/01/22 to 09/22 at 8:00am. -The levothyroxine 88mcg every day was not documented as administered from 09/06/22 to 09/30/22.	D 358	This will be the responsibility of the Administrator/RCC to have the MAs trained. A nurse will complete trainings for medication administration signed attendance sheet to be attached and completed by 12/25/22. All staff will be trained on the importance of Medication Administration. The RCC/MAs will review all orders for accuracy when new orders come in. Staff will be trained monthly during monthly staff meetings by pharmacy of medication administration, practices and procedures. RCC will conduct weekly cart audits to ensure medications are available to ensure medication labels match physician's orders. A Medication cart audit tool will be created and implemented for weekly audits by the RCC/designated MAs. The Administrator will be responsible for trainings of the RCC/MAs for utilization of the Medication cart audit tool. A signed attendance sheet will be attached and completed by 12/25/22.	12/25/22	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 358	Continued From page 29 -An entry for Symbicort inhaler 160-4.5 INH Areo 120, inhale 2 puffs 2 times a day was documented as administered from 09/01/22 to 09/30/22 at 8:00am and 5:00pm. -An entry gabapentin 300mg, 3 times a day for 30 days documented as administered from 09/06/22 to 09/30/22 at 8:00am, 2:00pm and 8:00pm. -The gabapentin 300mg at bedtime was not documented as administered from 09/06/22 to 09/30/22. -There was not an entry for acetaminophen 325mg, two tablets every 8 hours. -The acetaminophen 325mg was not documented as administered 09/16/22 to 09/30/22. -There was not an entry for lactobacillus acidophilus every day. -The lactobacillus was not documented as administered from 09/19/22 to 09/30/22. -An entry for Lomotil 2.50-0.25mg 4 times a day. -The Lomotil 2.50-0.25mg, two tablets 4 times a day was not documented as administered from 09/19/22 to 09/29/22. Review of Resident #1's October 2022 MAR revealed: -An entry for diltiazem 180mg every day documented as administered from 10/01/22 to 10/24/22 at 8:00am. -There was not an entry for diltiazem 120mg every day. -The diltiazem 120mg every day was not documented as administered form 10/01/22 to 10/24/22. -There was not an entry for . -The levothyroxine 88mcg every day was not documented as administered from 10/01/22 to 10/24/22. -An entry for Symbicort inhaler 160-4.5 INH Areo 120, inhale two puffs 2 times a day was documented as administered from 10/01/22 to	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 30 10/24/22 at 8:00am and 5:00pm. -There was not an entry gabapentin 300mg at bedtime. -The gabapentin 300mg at bedtime was not document as administered 10/01/22 to 10/24/22. -There was not an entry for acetaminophen 325mg, two tablets every 8 hours . -The acetaminophen 325mg was not documented as administered 10/01/22 to 10/24/22. -There was not an entry for lactobacillus acidophilus every day. -The lactobacillus acidophilus was not documented as administered 10/01/22 to 10/24/22. Review of Resident #1's October 2022 electronic Medication Administration Record (eMAR) revealed: -An entry for diltiazem 180mg every day. -The diltiazem 180mg was not documented as administered on 10/25/22 at 8:00am. -There was not an entry for diltiazem 120mg every day. -The diltiazem 120mg every day was not documented as administered form 10/25/22 to 10/31/22. -There was not an entry for levothyroxine 88mcg every day. -The levothyroxine 88mcg documented as administered 10/25/22 to 10/31/22. -There was not an entry for Symbicort inhaler 160-4.5 INH Areo 120, inhale two puffs 2 times a day was documented as administered. -There was not an entry gabapentin 300mg at bedtime. -The gabapentin 300mg was not document as administered 10/25/22 to 10/31/22. -There was not an entry for acetaminophen 325mg, two tablets every 8 hours . -The acetaminophen 325mg was not documented	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 358	Continued From page 31 as administered 10/25/22 to 10/31/22. -There was not an entry for lactobacillus acidophilus every day. -The lactobacillus acidophilus was not documented as administered 10/25/22 to 10/31/22. documented as administered. Review of Resident #1's November 2022 eMAR revealed: -An entry for diltiazem 180mg every day. -There was not an entry for diltiazem 120mg every day. -The diltiazem 120mg every day was not documented as administered form 11/01/22 to 11/08/22. -There was not an entry for Symbicort inhaler 160-4.5 INH Areo 120, inhale two puffs 2 times a day was documented as administered. -There was not an entry gabapentin 300mg at bedtime. -The gabapentin 300mg was not document as administered 11/01/22 to 11/08/22. -There was not an entry for acetaminophen 325mg, two tablets every 8 hours . -The acetaminophen 325mg was not documented as administered 11/01/22 to 11/08/22. -There was not an entry for lactobacillus acidophilus every day. -The lactobacillus acidophilus was not documented as administered 11/01/22 to 11/08/22. documented as administered. Review of Resident #1's medications available for administration on 11/10//22 at 11:16am revealed: -A bottle of diltiazem 120mg with a printed label indicating 90 tablets were dispensed on 07/29/22 and approximately 45 tablets remaining on the medication cart. -A bubble pack of acetaminophen 325mg with a printed label indicating 30 tablets were dispensed	D 358		

Division of Health Service Regulation

STATE FORM

6899

FJM111

If continuation sheet 32 of 77

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 32 on 09/16/22 and 8 tablets remaining on the medication cart. -A full bottle of gabapentin 300mg with a printed label indicating 90 tablets were dispensed on 08/16/22 and 90 tablets remaining in the closet in the medication room. -A bottle of levothyroxine 88mcg with a printed label indicating 90 tablets were dispensed on 07/21/22 and approximately 60 tablets remaining in the closet in the medication room. -Two Symbicort inhalers 160-4.5 INH Aero 120 with a printed label indicating 120 inhalations each dispensed on 08/22/22 and 10/17/22 with 120 inhalation each in the closet in the medication room. -There was no lactobacillus acidophilus, and Lomotil available for administration. Telephone interview with the contracted facility pharmacy technician on 11/10/22 at 3:07pm revealed: -The diltiazem 120mg, lactobacillus acidophilus and levothyroxine 88mcg were never dispensed only placed on the resident's profile. -Symbicort 160-4.5 INH Aero 120 was dispensed on 08/22/22 and 10/17/22, (30-day supply) each. -The gabapentin 300mg at bedtime was last dispensed on 05/12/22 with a quantity of 30. -The acetaminophen 325mg, 2 tablets every 8 hours was last dispensed on 09/16/22 with a quantity of 30, (5-day supply). -The Lomotil 0.025mg-2.5mg, 2 tablets 4 times a day for 10 days was dispensed on 09/20/22 with a quantity of 80 (10-day supply). Telephone interview with Resident #1's Hospice RN on 11/08/22 at 10:24am revealed: -Resident #1 reported to her in September 2022, she was not receiving her daily medications correctly.	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 33 -On 09/09/22, an order was given for gabapentin 100mg every morning and at noon and she reviewed all medications with the Resident Care Coordinator (RCC) and the Administrator because Resident #1 complained about not receiving all her daily medications. -The RCC stated that she thought the gabapentin 100mg every morning and at noon was a PRN medication. -She reviewed Resident #1's gabapentin with the RCC and showed her it was scheduled not PRN. -She continued to review Resident #1's medications twice monthly to clarify them, but Resident #1 continued to report she wasn't getting them as ordered. -Resident #1 was ordered gabapentin and acetaminophen for pain and Resident #1 complained many times in September, October and November about an increase of pain. -If Resident #1 did not get gabapentin and acetaminophen every day as ordered, then she could have increased pain. -The diltiazem was for high blood pressure and if Resident #1 was not receiving that medication daily could increase her blood pressure and harder to keep the blood pressure under control and increased risk of heart attack. -The levothyroxine was for hypothyroidism and if Resident #1 was not receiving the medication as ordered could cause the thyroid to drop even more and over time could cause obesity, joint pain, and heart disease and Resident #1 was already dealing with all those issues. -The Symbicort inhaler was ordered because Resident #1 was having some shortness of breath with her chronic obstructive disease and if she did not receive that medication as ordered Resident #1 could have increased shortness of breath.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 34 Telephone interview with the RCC on 11/10/22 at 4:34pm revealed: -She was the only mediation aide (MA) from 10/01/22 to 11/10/22. -The MAs were expected to reorder medication when they were five to seven doses left. -Medications can be reordered through the eMAR. -MAs are expected to complete a medication cart audit once per week where they review the medications on the medication cart and compare it to the medication listed on the eMAR. -She had been working as the only MA in the facility for the last month and completed a medication cart audit on 10/28/22. -She did not document the findings of her medication cart audit but she did tell the Administrator the results. -If any medication needed to be reordered then she would do it while completing the audit. Interview with the Administrator on 11/10/22 at 12:22pm: -She began working at the facility as the Administrator 2 months ago. -She was not aware of a medication administration policy at the facility. -The RCC was responsible for faxing all orders to the pharmacy. -The RCC was responsible for medication cart audits on a weekly basis which included comparing the eMARs, orders and the medications to check for accuracy and completion of the orders. -The RCC was the only MA since October 1, 2022. -She was responsible for medication cart audits on a weekly basis as a second audit which included comparing the eMARs, orders and the medications to check for accuracy and	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 358	Continued From page 35 completion of the orders. -The Hospice RN reviewed some orders with her and the RCC for clarification sometime in September 2022 and the RCC should have caught the medication errors during the weekly medication cart audits. -She was not aware the audits were not completed. -She did not complete the second weekly medication cart audits and did not have a reason as to why. 2. Review of Resident #5's current FL2 dated 04/01/22 revealed: -Diagnoses included early onset Alzheimer's disease, pre-senile dementia, anxiety disorder, and seizure disorder. -An order for hydrocodone/APAP (a medication used to treat chronic sever pain) 5/325mg every day. Review of Resident #5's subsequent physician's order dated 08/08/22 revealed an order for hydrocodone/APAP 5/325mg two times a day. Review of Resident #5's subsequent physician's order dated 09/22/22 revealed an order for hydrocodone/APAP 5/325mg four times a day. Review of Resident #5's subsequent physician's order dated 10/27/22 revealed an order for hydrocodone/APAP 5/325mg every 6 hours. Review of Resident #5's signed physicians order dated 10/10/22 revealed an order for lorazepam 0.5mg four times a day. Review of Resident #5's September 2022 MAR revealed: -An entry for hydrocodone/APAP 5/325mg 2 times	D 358		

Division of Health Service Regulation

STATE FORM

6899

FJM111

If continuation sheet 36 of 77

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 36 a day. -Hydrocodone/APAP 5/325mg two times a day was documented as administered from 09/01/22 to 09/30/22. -There was no entry for hydrocodone/APAP 5/325mg every 6 hours, Review of Resident #5's October 2022 MAR revealed: -An entry for hydrocodone/APAP 5/325mg four times a day was blank from 10/01/22 to 10/24/22 at 8:00am, 1:00pm, 5:00pm and 8:00pm. -There was no entry for lorazepam 0.5mg four times a day documented from 10/10/22 to 10/24/22. Review of Resident #5's October eMAR 2022 revealed: -An entry for hydrocodone/APAP 5/325mg every 6 hours. -There was no documentation hydrocodone/APAP 5/325mg every 6 hours was administered on 10/28/22, 10/29/22, 10/30/22 and 10/31/22 at 12:00am, and documentation was left blank on 10/24/22, 10/25/22 and 10/26/22 at 12:00am, 6:00am, 12:00pm and 6:00pm, and on 10/27/22 at 12:00am, 6:00am and 12:00pm. -An entry for lorazepam 0.5mg four times a day. -There was no documentation lorazepam 0.5mg four times a day was administered on 10/25/22 at 8:00am, 1:00pm, 5:00pm and 8:00pm. Review of Resident #5's November 2022 eMAR revealed: -An entry for hydrocodone/APAP 5/325mg every 6 hours. -There was no documentation hydrocodone/APAP 5/325mg every 6 hours was administered on 11/01/22 to 11/08/22 at 12:00am.	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 37 -An entry for lorazepam 0.5mg four times a day. -There was no documentation lorazepam 0.5mg four times a day was administered on 11/08/22 at 8:00am, 1:00pm, 5:00pm and 8:00pm. Telephone interview with the contracted facility pharmacy technician on 11/10/22 at 3:07pm revealed: -Lorazepam 0.5mg four times a day, 60 doses, (15 day supply) was dispensed on 10/11/22 and would need a refill on 10/25/22. -Lorazepam 0.5mg 4 times a day, 60 doses, (15 day supply) was dispensed on 10/31/22 and would need a refill on 11/14/22. -Hydrocodone/APAP 5/325mg every 6 hours, 56, (15 day supply) was dispensed on 09/22/22 and would need to be refilled on 10/06/22. -Hydrocodone/APAP 5/325mg every 6 hours, 120, (30 day supply) was dispensed on 10/27/22 and would need to be refilled on 11/26/22. Review of Resident #5's medications available for administration on 11/10/22 at 11:16am revealed: -A bubble pack of hydrocodone/APAP 5/325mg with a printed label indicating 120 tablets were dispensed on 10/27/22 and 2 tablets remaining on the medication cart. -There was a bubble pack of lorazepam with a printed label indicating 60 tablets were dispensed on 10/31/22 and 3 tablets remaining on the medication cart. -There were four bubble packs of hydrocodone/APAP 5/325mg with a printed label indicating 120 tablets were dispensed on 11/08/22 and 120 tablets remaining in the closet in the medication room. Telephone interview with Resident #5's Hospice RN on 11/08/22 at 10:24am revealed:	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 38 -Resident #5 had hydrocodone/APAP ordered for pain due to Resident #5 showing non-verbal signs of pain which included facial grimacing, her right arm tightening up and moaning. -She ordered scheduled doses of the hydrocodone/APAP and PRN acetaminophen/APAP 5/325mg suppository due to the fact Resident #5 was non-verbal in order to keep the pain under control. -When Resident #5 did not receive the hydrocodone/APAP as ordered then Resident #5 would have increased pain and it would be harder to get her pain back under control. -She ordered the scheduled and PRN doses of lorazepam to decrease the duration and amount of seizures and if Resident #5 did not receive the medications as ordered then Resident #5 could have increased duration of seizures. Telephone interview with the RCC on 11/10/22 at 4:49pm revealed: -She was the only MA since 10/01/22 to 11/10/22. -She completed weekly medication cart audits by comparing the medications on the medication cart to the MAR. -She did not compare the medications and the MARs to the physician orders. -If the medication was not listed on the MAR then she did not know to administer the medication. Interview with the Administrator on 11/10/22 at 12:22pm: -She began working at the facility as the Administrator 2 months ago. -She was not aware of a medication administration policy at the facility. -The RCC was responsible for faxing all orders to the pharmacy. -The RCC was responsible for medication cart audits on a weekly basis which included	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 39 comparing the eMARs, orders and the medications to check for accuracy and completion of the orders. -If the RCC did not compare the medications on the medication cart with the MAR and the physician orders then medication orders could be missed or administered incorrectly. -The RCC was the only MA since October 1, 2022. -She was responsible for medication cart audits on a weekly basis as a second audit which included comparing the eMARs, orders and the medications to check for accuracy and completion of the orders. -The Hospice RN reviewed some orders with her and the RCC for clarification sometime in September 2022 and the RCC should have caught the medication errors during the weekly medication cart audits. -She was not aware the audits were not completed. -She did not complete the second weekly medication cart audits and did not have a reason as to why. 3. Review of Resident #7's current FL2 dated 12/02/21 revealed a diagnosis of dementia Alzheimer's type, dementia and mixed hyperlipidemia. Review of Resident #7's subsequent orders dated 02/23/22 revealed risperidone (a mood stabilizer 0.5mg every morning. Review of Resident #7's subsequent orders dated 02/23/22 revealed risperidone 0.25mg every morning. Observation during the medication pass on 11/09/22 at 7:00am revealed risperidone 0.5mg	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 40 was administered to Resident #7. Review of Resident #7's November 2022 eMAR revealed an entry for risperidone 0.5mg every morning was documented as administered on 11/09/22 at 8:00am. Telephone interview with the contracted facility pharmacist on 11/10/22 at 3:07pm revealed: -Risperidone 0.5mg every morning was last filled on 10/21/22 for 28 doses. -The did not have the order dated 03/31/22 for risperidone 0.25mg every morning. -It was the facility's responsibility to fax over orders for all medications. -If Resident #7 received too much risperidone along with the PRN dose, it could cause increased sedation. Telephone interview with the RCC on 11/10/22 at 4:49pm revealed: -She was the only MA since 10/01/22 to 11/10/22. -She completed weekly medication cart audits by comparing the medications on the medication cart to the MAR. -She did not compare the medications and the MARs to the physician orders. -If the medication was not listed on the MAR then she did not know to administer the medication. Interview with the Administrator on 11/10/22 at 12:22pm: -She began working at the facility as the Administrator 2 months ago. -She was not aware of a medication administration policy at the facility. -The MA/RCC was responsible for faxing all orders to the pharmacy. -The MA/RCC was responsible for medication cart audits on a weekly basis which included	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 358	Continued From page 41 comparing the eMARs, orders and the medications to check for accuracy and completion of the orders. -The MA/RCC was the only MA since October 1, 2022. -She was responsible for medication cart audits on a weekly basis which included comparing the eMARs, orders and the medications to check for accuracy and completion of the orders. -She was not aware the audits were not completed. -She did not complete the weekly medication cart audits and did not have a reason as to why. 4. Review of Resident #8's current FL2 dated 05/13/22 revealed a diagnosis of myocardial infarction, type 2 diabetes, muscle weakness, lack of coordination, cognitive communication deficit, and seizures. Review of Resident #7's subsequent orders dated 10/31/22 revealed sertraline (a medication used to treat depression) 100mg every day. Observation during the medication pass on 11/09/22 at 7:23am revealed sertraline 100mg, 1-1/2 tablet was administered to Resident #8. Review of Resident #8's November 2022 eMAR revealed an entry for sertraline 100mg, 1-1/2 tablet every morning was documented as administered on 11/09/22 at 8:00am. Telephone interview with the contracted facility pharmacist on 11/10/22 at 3:07pm revealed: -Sertraline 100mg every day was last filled on 10/31/22 for 25 doses. -If Resident #8 received too much sertraline, and because Resident #8 was taking a sleep medication, it could cause insomnia, stomach	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 42 ache, headache, bad dreams and mood swings. Telephone interview with the RCC on 11/10/22 at 4:49pm revealed: -She was the only MA since 10/01/22 to 11/10/22. -She completed weekly medication cart audits by comparing the medications on the medication cart to the MAR. -She did not compare the medications and the MARs to the physician orders. -If the medication was not listed on the MAR then she did not know to administer the medication. Interview with the Administrator on 11/10/22 at 12:22pm: -She began working at the facility as the Administrator 2 months ago. -She was not aware of a medication administration policy at the facility. -The MA/RCC was responsible for faxing all orders to the pharmacy. -The MA/RCC was responsible for medication cart audits on a weekly basis which included comparing the eMARs, orders and the medications to check for accuracy and completion of the orders. -If the RCC did not compare the medications on the medication cart with the MAR and the physician orders then medication orders could be missed or administered incorrectly. -The MA/RCC was the only MA since October 1, 2022. -She was responsible for medication cart audits on a weekly basis which included comparing the eMARs, orders and the medications to check for accuracy and completion of the orders. -She was not aware the audits were not completed. -She did not complete the weekly medication cart audits and did not have a reason as to why.	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 43 5. Review of Resident #3's current FL2 revealed: -It was not signed or dated by a provider. -Diagnoses included type 2 diabetes. Review of Resident #3's physician's orders dated 08/31/22 revealed: -An order to check fingerstick blood sugar (FSBS) four times daily, before meals and before bed. -An order to administer Humalog 100 unit/mL insulin (a short-acting form of insulin used to control elevated blood sugar), per the sliding scale: FSBS 0-199= 0 units; FSBS 200-250= 2 units; FSBS 251- 300= 4 units; FSBS 301-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units; if blood sugar is greater than 450 give 12 units and repeat FSBS in 30 minutes, if blood sugar remains over 400 call the physician. Review of Resident #3's September 2022 medication administration record (MAR) revealed: -There was an entry to check FSBS four times daily, scheduled at 7:30am, 1:30am, 4:30pm and 8:00pm. -There was an entry for Humalog 100 unit/mL insulin per the sliding scale: FSBS 0-199= 0 units; FSBS 200-250= 2 units; FSBS 251- 300= 4 units; FSBS 301-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units; if blood sugar is greater than 450 give 12 units and repeat FSBS in 30 minutes, if blood sugar is still over 400 call the physician. -The documented FSBS ranged from 120 to 380. -There was no documentation Humalog 100 unit/mL was administered from 09/09/22 to 09/30/22. Review of Resident #3's September 2022 FSBS history from the glucometer (a device used to measure the concentration of glucose in the	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 44 blood) revealed: -The time setting on the glucometer was inaccurate. -The FSBS ranged from 93 to 366. -There were not any FSBS results from 09/11/22 to 09/14/22. Review of Resident #3's October 2022 MAR revealed: -There was an entry to check FSBS four times daily, scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was an entry for Humalog 100 unit/mL insulin per the sliding scale: FSBS 0-199= 0 units; FSBS 200-250= 2 units; FSBS 251- 300= 4 units; FSBS 301-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units; if blood sugar is greater than 450 give 12 units and repeat FSBS in 30 minutes, if blood sugar remains over 400 call the physician. -Resident #3's FSBS was documented from 10/01/22 at 7:30am to on 10/24/22 at 7:30am. -The documented FSBS ranged from 138 to 402. -There was no documentation Humalog 100 unit/mL was administered from 10/01/22 to 10/24/22. Review of Resident #3's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS four times daily, scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm and inject Humalog 100 unit/mL insulin per the sliding scale: FSBS 0-199= 0 units; FSBS 200-250= 2 units; FSBS 251- 300= 4 units; FSBS 301-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units; if blood sugar is greater than 450 give 12 units and repeat FSBS in 30 minutes, if blood sugar remains over 400 call the physician.	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 358	Continued From page 45 -There was not a space to enter the FSBS. -There was not a space to enter the units of sliding scale insulin that were administered. -There was documentation of the medication aide's (MA) initials from 10/26/22 to 10/31/22 at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was a note documented on 10/31/22 at 4:46pm and 8:05pm that read "out of facility". -There were not any notes with FSBS results or the amount of sliding scale insulin administered. Review of Resident #3's October 2022 FSBS history from the glucometer revealed: -The time setting on the glucometer was inaccurate. -The FSBS ranged from 128 - 402. -There were not any FSBS results for 10/08/22, 10/16/22 to 10/21/22, 10/23/22 to 10/28/22 and 10/30/22 to 10/31/22. Review of Resident #3's November 2022 eMAR revealed: -There was an entry to check FSBS four times daily, scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm and inject Humalog 100 unit/mL insulin per the sliding scale: FSBS 0-199= 0 units; FSBS 200-250= 2 units; FSBS 251- 300= 4 units; FSBS 301-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units; if blood sugar is greater than 450 give 12 units and repeat FSBS in 30 minutes, if blood sugar remains over 400 call the physician. -There was not a space to enter the FSBS. -There was not a space to enter the units of sliding scale insulin that were administered. -There was documentation of the MA's initials from 11/01/22 at 7:30am to 11/02/22 at 4:30pm, 11/03/22 at 7:30am to 11/06/22 at 4:30pm, 11/07/22 at 4:30pm and 11/08/22 for 7:30am, 11:30am, 4:30pm and 8:00pm.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 46 -There was not any documentation on 11/02/22 at 8:00pm and on 11/07/22 at 8:00pm. -There was a note that Resident #3 was out of the building on 11/06/22 and 11/07/22. Review of Resident #3's November 2022 FSBS history from the glucometer revealed: -The time setting on the glucometer was inaccurate. -There were not any FSBS results from 11/01/22 to 11/07/22. -Resident #3's FSBS ranged from 153 to 293 on 11/08/22. Observation of the medication aide (MA)/Resident Care Coordinator (RCC) on 11/08/22 at 11:31am revealed: -She used a glucometer to check Resident #3's FSBS. -The glucometer read 293 and she administered 4 units of insulin in the back of his right arm. -There was not a dedicated space to record the FSBS or units of insulin administered on the eMAR so she wrote a note in the eMAR system stating Resident #3's FSBS was 293 and 4 units of insulin was administered. Observation of the medication cart on 11/10/22 at 3:28pm revealed: -Resident #3 had a box with his name on it in the top drawer of the medication cart. -Inside the box was a glucometer, a Lantus insulin pen (a long-acting modified form of insulin used to control elevated blood sugar) and a Humalog insulin pen. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/10/22 at 4:06pm revealed: -If Resident #3 did not receive the correct amount	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 47 of sliding scale insulin it could cause abnormal FSBS. -Elevated FSBS could cause Resident #3 to be shaky, irritable, sweaty or experience vision changes. -He would start to be concerned if Resident #3's FSBS were consistently in the high 200's or 300's and the prescribed sliding scale insulin regimen would need to be reevaluated. Telephone interview with the RCC on 11/10/22 at 4:34pm revealed: -She was the only MA that worked in the facility for the last thirty days. -She administered sliding scale insulin to Resident #3 based on the scale on the MAR but did not document how much insulin was administered in September 2022 or October 2022 because there was not a spot on the MAR. -She did not document Resident #3's FSBS or the amount of sliding scale insulin that was administered for the end of October 2022 or November 2022 because there was not a spot on the eMAR. -She did not know why days of FSBS results were missing from Resident #3's glucometer since she only used that meter for him. Interview with the Administrator on 11/10/22 at 11:30am and 5:27pm revealed: -She was not aware the FSBS readings in Resident #3's glucometer did not match the MAR/eMAR and did not know which value the RCC used to administer the sliding scale insulin. -The RCC should have checked the FSBS with a glucometer, recorded the reading on the glucometer on the MAR/eMAR, referred to the scale to determine how much insulin to administer then record the units of sliding scale insulin administered on the MAR/eMAR.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 358	Continued From page 48 -The pharmacy put the medication orders on the MAR/eMAR and the facility did not audit them. -She expected all medication orders to be followed. Attempted telephone interview with Resident #3's Primary Care Provider on 11/10/22 at 3:39pm was unsuccessful. The facility failed to ensure residents medications were administered as ordered for a resident with chronic pain and uncontrolled diarrhea with skin breakdown at risk for infection (#1), and a resident with an order for sliding scale insulin and FSBS that were inaccurately obtained putting the resident at risk for elevated FSBS and uncontrolled diabetic symptoms (#3). This failure was detrimental to the health of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/10/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 25, 2022.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered;	D 367	The Administrator will be responsible to ensure that the RCC/MAs be trained in proper medication administration and documentation in the eMARs especially (diabetic training) related to finger stick blood sugars (FSBS) and recording sliding scale insulin (SSI) administration.	12/25/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 367	Continued From page 49 (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure the medication administration records (MAR) and electronic medication administrator records (eMAR) were accurate for 1 of 3 sampled residents (#3) related to the documentation of finger stick blood sugars (FSBS) and recording of sliding scale insulin (SSI) administered. The findings are: Review of Resident #3's current FL2 revealed: -It was not signed or dated by a provider. -Diagnoses included type 2 diabetes. Review of Resident #3's physician's order dated 08/31/22 revealed: -An order to check FSBS before each meal and at bedtime then inject Humalog KwikPen 100 unit/mL per SSI: FSBS 0-199= 0 units; FSBS 200-250= 2 units; FSBS 251- 300= 4 units; FSBS 301-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units; if FSBS is greater than 450 give 12 units and repeat FSBS in 30 minutes, if	D 367	A review/refresher in-service training for all MAs will be completed in reviewing Medication administration procedures/ review of properly reviewing the MARs. The resident's medication administration record (MAR) shall be accurate. If a MA continues to not follow the guidelines and fails to follow the regulations, corrective action will occur.	1/9/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 367	Continued From page 50 FSBS remains over 400 call physician. Review of Resident #3's September 2022 MAR revealed: -There was an entry to check FSBS four times daily, scheduled at 7:30am, 1:30am, 4:30pm and 8:00pm. -There was an entry for Humalog 100 unit/mL per SSI: FSBS 0-199= 0 units; FSBS 200-250= 2 units; FSBS 251- 300= 4 units; FSBS 301-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units; if FSBS is greater than 450 give 12 units and repeat FSBS in 30 minutes, if FSBS remains over 400 call physician. -The documented FSBS ranged from 120 to 380. -There were not any FSBS results on 09/12/22 at 1:30am or 09/13/22 at 1:30am. -There was no documentation Humalog 100 unit/mL was administered from 09/09/22 to 09/30/22. Review of Resident #3's September 2022 FSBS history from the glucometer (a device used to measure the concentration of glucose in the blood) revealed: -The time setting on the glucometer was inaccurate. -The FSBS ranged from 93 to 366. -There were not any FSBS results from 09/11/22 to 09/14/22. Review of Resident #3's October MAR revealed: -There was an entry to check FSBS four times daily, scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was an entry for Humalog 100 unit/mL per SSI: FSBS 0-199= 0 units; FSBS 200-250= 2 units; FSBS 251- 300= 4 units; FSBS 301-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units; if FSBS is greater than 450 give 12 units	D 367	This will be the responsibility of the Administrator/RCC to have the MAs trained. A nurse will complete trainings for medication administration signed attendance sheet to be attached and completed prior to 12/25/22. Medication cart audits will be completed weekly; MAR audits will be completed monthly. The Administrator/RCC will be responsible for ensuring these audits are completed.	1/9/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 367	Continued From page 51 and repeat FSBS in 30 minutes, if blood FSBS over 400 call physician. -Resident #3's FSBS was documented from 10/01/22 at 7:30am to 10/24/22 at 7:30am. -The documented FSBS ranged from 138 to 402. -There was no documentation Humalog 100 unit/mL was administered from 10/01/22 to 10/24/22. Review of Resident #3's October electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS four times daily, scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was an entry for Humalog 100 unit/mL per SSI: FSBS 0-199= 0 units; FSBS 200-250= 2 units; FSBS 251- 300= 4 units; FSBS 301-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units; if FSBS is greater than 450 give 12 units and repeat FSBS in 30 minutes, if FSBS remains over 400 call physician. -There was not a space to enter the FSBS. -There was not a space to enter the units of SSI that were administered. -There was documentation of the medication aide's (MA)/Resident Care Coordinator's (RCC) initials from 10/26/22 to 10/31/22 at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was a note documented on 10/31/22 at 4:46pm and 8:05pm that read "out of facility". -There were not any notes with FSBS results or the amount of SSI administered. Review of Resident #3's October 2022 FSBS history from the glucometer revealed: -The time setting on the glucometer was inaccurate. -The FSBS ranged from 128-402. -There were not any FSBS results for 10/08/22,	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 367	Continued From page 52 10/16/22 to 10/21/22, 10/23/22 to 10/28/22 and 10/30/22 to 10/31/22. Review of Resident #3's November 2022 eMAR revealed: -There was an entry to check FSBS four times daily, scheduled at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was an entry for Humalog 100 unit/mL per SSI: FSBS 0-199= 0 units; FSBS 200-250= 2 units; FSBS 251- 300= 4 units; FSBS 301-350= 6 units; FSBS 351-400= 8 units; FSBS 401-450= 10 units; if FSBS is greater than 450 give 12 units and repeat FSBS in 30 minutes, if FSBS remains over 400 call physician. -There was not a space to enter the FSBS. -There was not a space to enter the units of SSI that were administered. -There was documentation of the RCC's initials from 11/01/22 at 7:30am to 11/02/22 at 4:30pm, 11/03/22 at 7:30am to 11/06/22 at 4:30pm, 11/07/22 at 4:30pm and 11/08/22 for 7:30am, 11:30am, 4:30pm and 8:00pm. -There was not any documentation on 11/02/22 at 8:00pm and on 11/07/22 at 8:00pm. -There was a note that Resident #3 was out of the building on 11/06/22 and 11/07/22. Review of Resident #3's November 2022 FSBS history from the glucometer revealed: -The time setting on the glucometer was inaccurate. -There were not any FSBS results from 11/01/22 to 11/07/22. -Resident #3's FSBS ranged from 153 to 293 on 11/08/22. Interview with the Administrator on 11/09/22 at 3:40pm and 11/10/22 at 11:30am revealed: -She was working as the MA today (11/09/22)	D 367			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 367	Continued From page 53 since the RCC was sent home. -She was not able to identify how many units of SSI Resident #3 received by looking at the September 2022 or October 2022 MARs. -The facility switched over to an eMAR system at the end of October 2022 and she had to write a note in the system to document Resident #'s FSBS and units of SSI administered since there was not a spot on the eMAR. -She was not able to locate any documentation in the eMAR system of Resident #3's FSBS or units of SSI administered from 10/26/22 to 11/07/22. -She did not know why the FSBS readings in Resident #3's glucometer did not match the September 2022 or October 2022 MARs. -She sent a text message to the RCC to inquire if Resident #3 had another glucometer that they used, the answer was "no". Telephone interview with the RCC on 11/10/22 at 4:34pm revealed: -She was the only MA for October 2022 and November 2022. -She was the only MA that worked in the facility for the last thirty days. -She did not document how much SSI was administered to Resident #3 in September 2022 or October 2022 because there was not a spot on the MAR. -She did not document Resident #3's FSBS or the amount of SSI that was administered for the end of October 2022 or in November 2022 because there was not a spot on the eMAR. -She did not know why days of FSBS results were missing from Resident #3's glucometer since she only used that meter to test his blood sugar. -She was not aware that some of Resident #3's FSBS in his glucometer were different from the FSBS documented on the MAR/eMAR.	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 367	Continued From page 54 Interview with the Administrator on 11/10/22 at 5:27pm revealed: -She expected Resident #3's FSBS and amount of SSI administered to be documented on the eMAR. -The RCC did not tell her there was not a spot to document the FSBS or amount of SSI administered on the eMAR for Resident #3. -The MARs had not been audited since she arrived in September 2022 and she was not aware that the amount of SSI administered was not being documented on the paper MAR.	D 367			
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances was maintained for 1 of 4	D 392	The Administrator will assure all MAs and RCCs be trained regarding documenting and utilizing the CSCS appropriately as well as for documenting on eMARs and CSCS. Training for the CSCS will be completed by 12/25/22 and have an attached signed attendance sheet. The RCC will monitor the CSCS weekly. The MAs will complete audits to ensure accurate reconciliation of the receipt, administration and the disposition of controlled substances are being maintained. The RCC will review the MAs audits to ensure completion. The administrator/RCC will be responsible for ensuring that CSCS audits are being done weekly to ensure counts are correct and for any discrepancies be reported to the administrator to be follow up. If a MA continues to not follow the guidelines and fails to follow the regulations, corrective action will occur.	1/9/23	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 392	Continued From page 55 sampled residents (#5). The findings are: Observation during the medication pass with the Administrator on 11/09/22 at 8:04am revealed: -Resident #5 controlled substance count sheet (CSCS) did not match the hydrocodone/APAP 5/325mg on hand. -The CSCS documented there were 12 doses of hydrocodone/APAP 5/325mg remaining and the bubble pack containing the hydrocodone/APAP 5/325mg count was 2 doses remaining. Review of Resident #5's current FL2 dated 04/01/22 revealed diagnoses included early onset Alzheimer's disease, pre-senile dementia, anxiety disorder, and seizure disorder. Review of Resident #5's subsequent physician's order dated 08/08/22 revealed an order for hydrocodone/APAP 5/325mg 2 times a day. Review of Resident #5's subsequent physician's order dated 09/22/22 revealed an order for hydrocodone/APAP 5/325mg 4 times a day. Review of Resident #5's subsequent physician's order dated 10/27/22 revealed an order for hydrocodone/APAP 5/325mg every 6 hours. Review of Resident #5's September 2022 MAR revealed: -An entry for hydrocodone/APAP 5/325mg 2 times a day documented as administered 09/01/22 to 09/30/22 at 8:00am and 8:00pm. -There was not an entry for hydrocodone/APAP 5/325mg 4 times a day documented as administered 09/22/22 to 09/30/22. -The hydrocodone/APAP 5/325mg 4 times a day	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 392	Continued From page 56 was not administered for 18 out of 18 doses. Review of Resident #5's October 2022 MAR revealed: -An entry for hydrocodone/APAP 5/325mg 4 times a day was blank and "rewritten" was documented across the page 10/01/22 to 10/24/22 at 8:00am, 1:00pm, 5:00pm and 8:00pm. -There was no documentation the hydrocodone/APAP 5/325mg 4 times a day was administered 96 out of 96 doses. Review of Resident #5's October eMAR 2022 revealed: -An entry for hydrocodone/APAP 5/325mg every 6 hours was documented as administered 10/27/22 at 6:00pm, 10/28/22 at 6:00am, 12:00pm and 6:00pm, 10/29/22 at 6:00am, 12:00pm and 6:00pm, 10/30/22 at 6:00am, 12:00pm and 6:00pm, 10/31/22 at 6:00am, 12:00pm and 6:00pm, documented as not administered on 10/28/22, 10/29/22, 10/30/22 and 10/31/22 at 12:00am, and documentation was left blank on 10/24/22, 10/25/22 and 10/26/22 at 12:00am, 6:00am, 12:00pm and 6:00pm, and on 10/27/22 at 12:00am, 6:00am and 12:00pm. Review of Resident #5's November 2022 eMAR revealed: -An entry for hydrocodone/APAP 5/325mg every 6 hours was documented as administered 11/01/22 to 11/08/22 at 6:00am, 12:00pm and 6:00pm, and documented as not administered 11/01/22 to 11/08/22 at 12:00am. -The hydrocodone/APAP 5/325mg every 6 hours was not administered for 8 out of 32 doses. Review of Resident #5's medication on hand revealed there was a bubble pack of hydrocodone/APAP 5/325mg every 6 hours,	D 392			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 392	Continued From page 57 containing 120 doses dispensed on 10/27/22, with 2 out of 30 left located in the medication cart. Review of Resident #5's CSCS for hydrocodone/APAP 5/325mg every 6 hours on 10/27/22 revealed: -On 10/27/22 at 6:00pm hydrocodone/APAP 5/325mg was documented on the eMAR as administered but not on the CSCS. -On 10/28/22 at 12:00am hydrocodone/APAP 5/325mg was documented as not administered on the eMAR and on the CSCS. -On 10/28/22 at 6:00am hydrocodone/APAP 5/325mg was documented on the eMAR and at 8:00am on the CSCS. -On 10/28/22 at 12:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 10/28/22 at 6:00pm hydrocodone/APAP 5/325mg was documented on the eMAR as administered at 8:00pm on the CSCS. -On 10/29/22 at 12:00am hydrocodone/APAP 5/325mg was documented as not administered on the eMAR and on the CSCS. -On 10/29/22 at 6:00am hydrocodone/APAP 5/325mg was documented on the eMAR and at 8:00am on the CSCS. -On 10/29/22 at 12:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 10/29/22 at 6:00pm hydrocodone/APAP 5/325mg was documented on the eMAR as administered at 8:00pm on the CSCS. -On 10/30/22 at 12:00am hydrocodone/APAP 5/325mg was documented as not administered on the eMAR and on the CSCS. -On 10/30/22 at 6:00am hydrocodone/APAP 5/325mg was documented on the eMAR and at 8:00am on the CSCS. -On 10/30/22 at 12:00pm hydrocodone/APAP	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 392	Continued From page 58 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 10/30/22 at 6:00pm hydrocodone/APAP 5/325mg was documented on the eMAR as administered at 8:00pm on the CSCS. -On 10/31/22 at 12:00am hydrocodone/APAP 5/325mg was documented as not administered on the eMAR and on the CSCS. -On 10/31/22 at 6:00am hydrocodone/APAP 5/325mg was documented on the eMAR and at 8:00am on the CSCS. -On 10/31/22 at 12:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and at 2:00pm on the CSCS. -On 10/31/22 at 6:00pm hydrocodone/APAP 5/325mg was documented on the eMAR as administered at 8:00pm on the CSCS. -On 11/01/22 at 12:00am hydrocodone/APAP 5/325mg was documented as not administered on the eMAR and on the CSCS. -On 11/01/22 at 6:00am hydrocodone/APAP 5/325mg was documented on the eMAR and at 8:00am on the CSCS. -On 11/01/22 at 12:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and at 2:00pm on the CSCS. -On 11/01/22 at 6:00pm hydrocodone/APAP 5/325mg was documented on the eMAR as administered at 8:00pm on the CSCS. -On 11/02/22 at 12:00am hydrocodone/APAP 5/325mg was documented as not administered on the eMAR and on the CSCS. -On 11/02/22 at 6:00am hydrocodone/APAP 5/325mg was documented on the eMAR and at 8:00am on the CSCS. -On 11/02/22 at 12:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and at 2:00pm on the CSCS. -On 11/02/22 at 6:00pm hydrocodone/APAP 5/325mg was documented on the eMAR as	D 392			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 392	Continued From page 59 administered at 8:00pm on the CSCS. -On 11/03/22 at 12:00am hydrocodone/APAP 5/325mg was documented as not administered on the eMAR and on the CSCS. -On 11/03/22 at 6:00am hydrocodone/APAP 5/325mg was documented on the eMAR and at 8:00am on the CSCS. -On 11/03/22 at 12:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 11/03/22 at 12:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 11/03/22 at 6:00pm hydrocodone/APAP 5/325mg was documented on the eMAR and no as administered on the CSCS. -On 11/04/22 at 12:00am hydrocodone/APAP 5/325mg was documented as not administered on the eMAR and on the CSCS. -On 11/04/22 at 6:00am hydrocodone/APAP 5/325mg was documented on the eMAR and not on the CSCS. -On 11/04/22 at 12:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and at 2:00pm on the CSCS. -On 11/04/22 at 6:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 11/05/22 at 12:00am hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 11/05/22 at 6:00am hydrocodone/APAP 5/325mg was documented on the eMAR and not on the CSCS. -On 11/05/22 at 12:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 11/05/22 at 6:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and as administered at 8:00pm on the	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 392	Continued From page 60 CSCS. -On 11/06/22 at 12:00am hydrocodone/APAP 5/325mg was documented as not administered on the eMAR and on the CSCS. -On 11/06/22 at 6:00am hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 11/06/22 at 12:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 11/06/22 at 6:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 11/07/22 at 12:00am hydrocodone/APAP 5/325mg was documented as not administered on the eMAR and on the CSCS. -On 11/07/22 at 6:00am hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 11/07/22 at 12:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 11/07/22 at 6:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 11/08/22 at 12:00am hydrocodone/APAP 5/325mg was documented as not administered on the eMAR and on the CSCS. -On 11/08/22 at 6:00am hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 11/08/22 at 12:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 11/08/22 at 6:00pm hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -On 11/09/22 at 12:00am hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS.	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 392	Continued From page 61 -On 11/09/22 at 6:00am hydrocodone/APAP 5/325mg was documented as administered on the eMAR and not on the CSCS. -The ending count on the CSCS was documented as 12 remaining hydrocodone/APAP 5/325mg. Telephone interview with the contracted facility pharmacy technician on 11/10/22 at 3:07pm revealed: -Hydrocodone/APAP 5/325mg every 6 hours, containing 56, a 15 day supply, was dispensed on 09/22/22 and would need to be refilled on 10/06/22. -Hydrocodone/APAP 5/325mg every 6 hours, containing 120, a 30 day supply, was dispensed on 10/27/22 and would need to be refilled on 11/26/22. -This was a new order so the medication was dispensed, and a new Controlled Substance Count Sheet (CSCS) as sent with the new order and should have been used. Review of Resident #5's October and November eMAR, CSCS, mediations on hand and the interview with the contracted facility pharmacy technician, Resident #5 should have 71 doses of hydrocodone/APAP 5/325mg remaining but only had 2 on hand. Telephone interview with the MA/RCC on 11/10/22 at 4:49pm revealed: -She was the only MA administering medications since 10/01/22. -There was no shift change controlled substance count performed at the end of every shift because she was the only MA. -She documented the controlled substances on the MAR and CSCS and may have missed a few on the CSCS. -She was not aware the controlled substance	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 392	Continued From page 62 medications counts did not match the corresponding CSCS. Interview with the Administrator on 11/09/22 at 8:20am revealed: -She administered medications until 9:30pm and completed the medication controlled substances count with the night shift MA. -The count for Resident #5's hydrocodone/APAP 5/325mg did not match the CSCS. -She informed the night shift MA that the counts were off and there was nothing that could be done at that time. -There was no policy on what to do in case of controlled substances medications count not matching the CSCS and she was unsure what to do.	D 392			
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21);	D 433	This ACH will establish and maintain Resident Records according to NCAC 13F .1201 Resident Records contents by ensuring the list of contents is posted on the inside of each resident record for staff to follow. The Administrator/RCC will complete a Resident Record audit tool which will contain the list provided above. The Administrator/RCC will be responsible for having the audits completed quarterly. This ACH will ensure the 3rd Party provider progress notes are submitted by the 3rd party provider, so that this documentation can be placed in the resident's record accordingly. The Administrator/RCC will be responsible for ensuring these documents are being submitted from our providers as well as filing them in the Resident Record appropriately.	1/9/23	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 433	Continued From page 63 (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain residents records in an orderly manner and readily available for review for 3 of 3 sampled residents (#1, #2 and #3) who resided in the facility and were available for review. The findings are: 1. Review of Resident #1's Resident Register revealed date of admission to the facility was 07/29/20. Review of Resident #1's record on 11/08/22 revealed:	D 433	This ACH will create a general progress note for documentation to be kept in the Resident Record. This ACH will create a section of the Resident Record to ensure the facility receives and keeps records of the following: hospital records, physician notes, physician orders, LHPS evaluations, diet orders, labs, current/updated FL2 and current care plans. Trainings to discuss all forms and the procedures for completion of resident records will be the responsibility of the Administrator. A signed attendance sheet will be completed prior to 12/25/22. A resident record audit tool will be created and utilized monthly by designated staff but would be the responsibility of the Administrator to ensure this gets completed. This ACH will create a separate binder for all Incident/Accident Reporting to keep track of. This ACH will create personal care rounding sheets to verify what services were completed during the shift.	1/9/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 433	Continued From page 64 -There was no tuberculosis (TB) immunizations record. -There was no documentation of staff progress notes. -There was no documentation of physician or third-party notes. -There was no documentation of hospital records. -There was no documentation of current FL2's after 09/02/21. -There was no documentation of current licensed health professional support (LHPS). -There was no documentation of current Resident Profiles. -There was no documentation of current physician orders. -There was no documentation of Incident/Accident Reports. -There was no documentation of personal care rounding sheets. Refer to the interview with the Administrator on 11/09/22 at 8:25am. Refer to the telephone interview with the Resident Care Coordinator (RCC) on 11/10/22 at 4:34pm. Refer to the interview with the Administrator on 11/10/22 at 5:27pm. 2. Review of Resident #2's current FL2 dated 10/04/21 revealed: -Diagnoses included Alzheimer's disease. -Documented level of orientation was constantly disoriented. -The diet order section was blank. Review of Resident #2's resident register revealed her date of admission was 10/20/21. Review of Resident #2's record from 11/08/22 to	D 433			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 433	Continued From page 65 11/10/22 revealed: -There was no TB immunization record. -There was no documentation of staff progress notes. -There was no documentation of physician visit notes. -There was no documentation of a diet order. -Resident #2's current FL2 was dated 10/04/21, there was no documentation of a current FL2. -Resident #2's last Special Care Unit (SCU) Resident Profile was dated 04/11/22, there was no documentation of a quarterly SCU Resident Profile. Refer to the interview with the Administrator on 11/09/22 at 8:25am. Refer to the telephone interview with the RCC on 11/10/22 at 4:34pm. Refer to the interview with the Administrator on 11/10/22 at 5:27pm. 3. Review of Resident #3's current FL2 revealed: -It was not signed or dated by a provider. -Diagnoses included a vitamin B12 deficiency and type 2 diabetes. Review of Resident #3's resident register revealed an admission date of 09/02/22. Interview with the RCC on 11/08/22 at 9:00am revealed Resident #3 was sent to the hospital on 11/06/22 due to choking on food. Review of Resident #3's record from 11/09/22 to 11/10/22 revealed: -There was no documentation of staff progress notes. -There was no documentation of physician visit	D 433		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 433	Continued From page 66 notes. -There was no documentation of hospital records. -The current FL2 was not signed or dated, there was no documentation of current FL2. -There was no documentation of a Licensed Health Professional Support (LHPS) evaluation. -There was no documentation of an initial Special Care Unit (SCU) Resident Profile. -There was no documentation of Incident/Accident Reports. Refer to the telephone interview with the RCC on 11/10/22 at 4:34pm. Refer to the interview with the Administrator on 11/09/22 at 8:25am and 11/10/22 at 5:27pm. Telephone interview with the RCC on 11/10/22 at 4:34pm revealed: -She was responsible for ensuring physician visit notes, hospital notes and physician's orders were in the residents' records. -She was not sure why Resident #2 was missing a diet order and thought it was on the FL2. -At the beginning of September 2022, she became aware that she was responsible for ensuring the updated FL2s were in the residents' records. -She was told by the facility's Regional Representative that the SCU Resident Profiles were not required so she did not complete any of them. -She and the Administrator made sure all of the residents had documented TB testing. -The Administrator was responsible for ensuring the LHPS evaluation was completed and in the residents' records. -She did not have a tracking tool or complete resident record audits to ensure the documents were in the record and up to date.	D 433			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 433	Continued From page 67 -She was not sure why the documents that she was responsible for were not in the residents' records. Interview with the Administrator on 11/10/22 at 5:27pm revealed: -The staff did not write progress notes on the residents, she did not believe the staff knew that they were supposed to. -The facility contracted with a new Primary Care Provider (PCP) and she had not left any visit notes at the facility. -The PCP visited the facility weekly and saw a couple of residents each time so each resident should have had at least one visit with the PCP as of 11/09/22. -The RCC was responsible for ensuring the necessary documentation was in the residents' records. -She was not sure if the RCC used tracking tool or completed audits of the residents' records. -A couple of weeks ago, she made a chart to help the RCC track certain documents. -The documents on the chart included: first and second TB, Care Plan, FL2, Physician's orders, LHPS and diet order. -She had not completed an audit of the residents' records and was not aware of the missing documentation until the surveyors started to request it on 11/08/22.	D 433		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.	D 438	This ACH will create and implement a policy of Incident/accident reporting. The Administrator/RCC will be responsible for ensuring any and all incident/accident reports are documented, filed appropriately and submitted in a timely manner to AHS.	12/25/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 438	Continued From page 68 This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry (HCPR) report within 24 hours of knowledge of (Staff A) slapped the hand and arm of a resident (#2). The findings are: Review of Staff A's, Medication Aide (MA), personnel file revealed: -Date of hire: 07/08/21. -Staff A's position title was MA. -There was an HCPR dated 05/16/22 with no substantial findings. Review of Staff A's timecard reports dated 10/24/22 to 11/08/22 revealed Staff A did have a timecard for review. Review of email confirmation dated 11/04/22 at 11/04/22 revealed an email from the Adult Home Specialist to the Administrator with a subject containing HCPR copies. Interview with the Administrator on 11/08/22 at 2:51pm revealed: -On 11/03/22, the Adult Home Specialist (AHS) informed her of the complaint regarding Staff A allegedly slapping the hand and arm of Resident #2. -She did not complete the HCPR 24 hour report, start the investigation and did not send Staff A home until the investigation was completed because she was waiting on the AHS to complete their investigation.	D 438	This ACH will follow the procedures outlined for completing a Health Care Personnel Registry (HCPR) report within 24 hours of knowledge of any allegations of physical abuse of staff towards residents. The alleged staff member will be placed on suspension pending investigation results. The Administrator will complete the investigation of the 5 day report, documentation of written statements, schedules, and any pertinent information will be kept separately from Resident Profile. An Incident/Accident report will be completed, submitted to AHS within 24 hours. If the results of the investigation is substantiated; the staff involved will be terminated. The Administrator will be responsible for training all MAs and RCC regarding incident and/or accident reporting, documentation and communication with the AHS, physician providers and family members. This training will be completed prior to 12/25/22 with an attached signed attendance sheet. The Administrator and/or RCC will monitor the incident/accident report daily. They will be able to monitor it via the shift report, progress notes, daily Stand-Up meetings.	1/9/23	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE PLACE

**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 438	Continued From page 69 -Staff A did not have a timecard because she was considered management and worked when needed and as scheduled. Telephone interview with Staff A on 11/10/22 at 4:34pm revealed: -She was the only MA in the facility for the last thirty days and worked everyday. -She changed Resident #2's clothes after Resident #2 had an accident on the weekend of October 16, 2022. -She was not asked to give a statement on the reported incident from the weekend of October 16, 2022. Interview with the Administrator on 11/08/22 at 2:51pm revealed: -She was not aware of a facility policy related to reporting a staff member to the HCPR after an allegation was reported. -In her experience she would take the report of the allegation and check on the resident named in the allegation. -If there was staff named then that staff member was to be sent home until after the investigation was completed. -She was responsible for notification to the owners and report the allegations to the HCPR within 24-hours. -She was responsible for completing the 5 day report which included her investigation of the allegation. -On 11/03/22, the Adult Home Specialist (AHS) informed her of an allegation evolving Staff A and a resident. -She did not complete the 24-hour report with in 24-hours because she did not feel Staff A was capable of the allegations. -She did not initiate the investigation and she did not fill out the 5-day report.	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 438	Continued From page 70 Review of the HCPR 24-hour report revealed it was filled out and faxed into the HCPR on 11/07/22 at 7:38pm. There was no required 5-day report completed by the facility prior to exit on 11/10/22. Based on interviews and observations it was determined that Resident #2 was not interviewable. The facility failed to ensure allegations of physical abuse was reported to the HCPR resulting in Staff A continuing to work with residents. This failure resulted in Staff A continuing to work with 30 Special Care Unit residents without being investigated putting residents at risk of physical abuse which was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 11/08/22. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 25, 2022.	D 438			
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a	D 451	This ACH will implement the policy of Incident/accident reporting. The Administrator will be responsible for ensuring any and all incident/accident reports are documented, filed appropriately and submitted in a timely manner to AHS. The Administrator will train the RCC/lead MA regarding incident/accident reporting and will have this training completed and signed by 12/25/22	12/25/22	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 451	Continued From page 71 resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to notify the county department of social services of any accident or incident requiring any medical treatment other than first aid for 2 of 3 sampled residents (#1 and #3). The findings are: 1. Review of Resident #1's current FL2 dated 09/02/21 revealed diagnoses of dementia, atrial fibrillation, chronic obstructive pulmonary disease, frequent urinary tract infections and lumbar stenosis. Review of a hospital discharge dated 08/26/22 revealed: -Resident #1 presented to the emergency room on 08/22/22 with complaints of weakness and discharged from the hospital on 08/26/22. -Documentation Resident #1 was recently discharged from the hospital on 08/12/22 after being treated for chronic obstructive pulmonary disease exacerbation, urinary tract infection, heart failure and atrial fibrillation. Review of Resident #1's incident/accident reports on 11/09/22 revealed: -There was not a report generated for Resident #1's 08/22/22 to 08/26/22 hospital stay. -There was not a report generated for Resident #1's discharge of 08/12/22 after a hospital stay. Refer to interview with the Adult Home Specialist (AHS) on 11/08/22 at 10:00am.	D 451	The Administrator/RCC will ensure that the facility will notify the county department of social services of any accident or incident requiring any medical treatment other than first aid by having Stand-up meetings daily, and for RCC/Lead MAs to report such incidents. The RCC/MAs will be trained/in-serviced on how we will address hospitalizations that are not the result of an accident/injury and how it is reported, documented and who it is reported to.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 451	Continued From page 72 Refer to the telephone interview with Resident Care Coordinator (RCC) on 11/10/22 at 4:34pm. Refer to the interview with the Administrator on 11/10/22 at 2:22pm. 2. Review of Resident #3's FL2 revealed: -It was not dated or signed by a provider. -Diagnoses included chronic obstructive pulmonary disease (COPD), type 2 diabetes and hypertension. Review of Resident #3's hospital discharge summary dated 11/07/22 revealed: -Resident #3 presented to the emergency room (ER) after a choking episode that was resolved with an abdominal thrust. -The ER provider planned to discharge Resident #3 back to the facility on 11/06/22 but he had orthostatic hypotension (a condition where blood pressure drops when standing up or sitting down) and was held overnight. -Resident #3 discharged back to the facility on 11/07/22. Review of Resident #3's incident/accident reports on 11/09/22 revealed there was not a report generated for Resident #3's 11/06/22 to 11/07/22 hospital stay. Refer to interview with the Adult Home Specialist (AHS) on 11/08/22 at 10:00am. Refer to the telephone interview with the RCC on 11/10/22 at 4:34pm. Refer to the interview with the Administrator on 11/10/22 at 2:22pm.	D 451			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 451	Continued From page 73 Interview with the AHS on 11/08/22 at 10:00am revealed the facility had not submitted any Incident/Accident reports since June 2022 for any of the residents in the facility. Telephone interview with the RCC on 11/10/22 at 4:34pm revealed: -The MA was responsible for filling out an Incident/Accident report when a resident required more than first aid for an injury. -The report should have been filled out immediately after the incidents or accidents occurred. Interview with the Administrator on 11/10/22 at 2:22pm revealed: -An Incident/Accident report was to be filled out after every incident or accident requiring the resident to be sent out to the hospital for evaluation. -The MAs were responsible for completing the incident/accident reports. -The RCC was responsible for faxing a copy of the report to the Department of Social Services (DSS). -The RCC was responsible for daily audits of the incident/accident reports and for notification to her the next day in the morning meetings.	D 451		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special	D 464	This ACH will develop and maintain an SCU resident profile, Initial assessment, resident care plan and for those plans to be updated on a quarterly basis. The Administrator will be responsible for ensuring these documents are obtained, updated, completed and kept in the resident profiles appropriately by utilizing the audit tools created and used monthly.	1/9/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 464	Continued From page 74 care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 3 of 3 sampled residents (#1, #2 and #3) had an initial Special Care Unit (SCU) resident profile (#3) and SCU resident profiles updated on a quarterly basis (#1 and #2). The findings are: Review of Resident #1's current FL2 dated 09/02/21 revealed: -Diagnoses included dementia. -Resident #1 required total care assistance for bathing and dressing. -Documented level of orientation was intermittently disoriented. Review of Resident #1's Resident Register revealed an admission date of 07/29/20. Review of Resident #1's record on 11/08/22 revealed a SCU resident profile dated 04/27/22. Refer to the telephone interview with the Resident	D 464	The Administrator/RCC will be responsible for ensuring the FL2s are completed; followed up on with any corrections needed; along with it signed by the physician/provider prior to the resident's admission to the facility. This can be accomplished by utilizing the admission checklist each time prior to any new resident is admitted. The RCC will monitor the FL2's expiration, completion, and signature via a tracking system for all residents. The RCC will complete monthly audits.	1/9/23	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 464	Continued From page 75 Care Coordinator (RCC) on 11/10/22 at 4:34pm. Refer to the interview with the Administrator on 11/09/22 at 11:00am. 2. Review of Resident #2's current FL2 dated 10/04/21 revealed: -Diagnoses included Alzheimer's disease. -Resident #2 required total care for bathing, feeding and dressing. -Documented level of orientation was constantly disoriented. Review of Resident #2's Resident Register revealed an admission date of 10/20/21. Review of Resident #2's record on 11/08/22 revealed a SCU resident profile dated 04/11/22. Refer to the telephone interview with the RCC on 11/10/22 at 4:34pm. Refer to the interview with the Administrator on 11/09/22 at 11:00am. 3. Review of Resident #3's current FL2 revealed: -It was not dated or signed by a provider. -Diagnoses included vitamin B12 deficiency. -Resident #3 required limited assistance with bathing, toileting and dressing. -Documented level of orientation was constantly oriented. Review of Resident #3's record on 11/09/22 revealed there was not a SCU resident profile. Refer to the telephone interview with the RCC on 11/10/22 at 4:34pm. Refer to the interview with the Administrator on	D 464		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/10/2022
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 464	Continued From page 76 11/09/22 at 11:00am. Telephone interview with the RCC on 11/10/22 at 4:34pm revealed: -She did not complete the SCU resident profiles because the facility's Regional Representative told her they were not required. -She was not aware there was a rule that required all residents in a SCU to have an initial resident profile and quarterly resident profiles. Interview with the Administrator on 11/09/22 at 11:0am revealed: -The RCC was responsible for completing the SCU resident initial and quarterly profiles. -Several weeks ago, she and the RCC discussed job responsibilities and the RCC was not aware that she was responsible for the SCU resident profiles. -She was not sure if the RCC had completed any SCU resident profiles since that discussion.	D 464			



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor

KODY H. KINSLEY • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

Certified Mail and Electronic Mail
7021 0950 0000 9786 7171

December 6, 2022

Essie Nikouyea, Executive Officer
Omega Investment, Inc, Licensee
Heritage Place Adult Living Center
P.O. Box 903
Statesville NC, 28687

Email: nnikouveh@gmail.com

**Re: Annual and Complaint Investigation completed November 10, 2022 (ASPEN Event ID FJM111 /Complaint Intake Reference NC00194356)
Type B Violation(s)**

Facility: Heritage Place Adult Living Center
Licensure Number: HAL-049-003
County: Iredell

Dear Ms. Nikouyea:

Thank you for the cooperation and courtesy extended during the survey completed November 10, 2022 by staff with the Adult Care Licensure Section and the Iredell County DSS.

Based on the survey findings, 1 of 2 complaint allegations were substantiated resulting in deficiencies 10A NCAC 13F .0909 Resident Rights.

Enclosed you will find all violations/deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with the state regulations. You must provide an acceptable Plan of Correction for each violation/deficiency cited in the left column. In the spaces to the right of the form, state your plan for correcting the problem and the completion date by which you will correct each violation/deficiency identified and return it to our office within 15 working days of receipt of this letter. Below you will find what to include in the Plan of Correction for all deficiencies; and, if violations were identified, details of the type of violation(s) and the time frame(s) for compliance are also provided below.

Type B Violation(s)

- Type B rule violation(s) are cited for **10A NCAC 13F .1205 Health Care Personnel Registry, 10A NCAN 13F .0902(b) Health Care and 10A NCAC 13F .1004(a) Medication Administration.**
- Type B Violation(s) must be corrected within 45 days from the exit date of the survey, which is December 25, 2022.

**NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION
ADULT CARE LICENSURE SECTION**

LOCATION: 801 Biggs Drive, Brown Building, Raleigh, NC 27603
MAILING ADDRESS: 2708 Mail Service Center, Raleigh, NC 27699-2708
<https://info.ncdhhs.gov/dhsr/> • TEL: 919-855-3765 • FAX: 919-733-9379

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

As set forth in G.S. § 131D-34 where a facility has failed to correct a Type B Violation, the Department shall assess the facility a civil penalty in the amount of up to \$400.00 for each day that the violation continues beyond the time specified for correction.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.)
- Indicate what measures will be put in place to prevent the problem from occurring again
- Indicate who will monitor the situation to ensure it will not occur again
- Indicate how often the monitoring will take place
- Completion dates by which the plan of correction will be completed. The completion dates must be acceptable to the State.
- Sign and date the bottom of the first page of the State Form.

Return the signed and dated Statement of Deficiencies form within 15 working days from the date of receipt of this letter. We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is **SIGNED AND DATED** or it will not be accepted. A response to the plan of correction will be sent **ONLY** if the plan of correction is not accepted. Please retain a copy for your files.

Staff Training

Pursuant to G.S. § 131D-34 (g1), the agency may consider training completed by the facility in lieu of some or all of the penalty and if the following criteria are met:

- Training was completed after identification of the violation(s), is specific to the violation(s) and,
- The Department has determined the facility corrected the violation(s) and continues to remain in compliance with the regulation(s) cited.

Instruction for Submission of Training:

- Complete the appropriate cover page(s) for each rule area to be considered.
 - The cover page is available in the "Provider Forms" section of the Adult Care License Section's webpage: <https://info.ncdhhs.gov/dhsr/acls/pdf/penaltytraining.pdf>.
- Submit the training with cover page(s) within 30 calendar days of this notice via e-mail to: DHRS.Adultcare.PenaltyTrainingSubmission@dhhs.nc.gov.
- Training should include:
 - The date and time of the training.
 - Sign in sheet(s) showing the names and titles of the attendees.
 - Name, title, and resume of the individual(s) who conducted the training.
 - The training agenda and general outline of information covered in the training.

All resident names and confidential information must be redacted from any training materials sent to the agency. Documents that include residents' names or confidential information will not be accepted. Training submitted without the designated cover page(s) will not be accepted.

**NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION
ADULT CARE LICENSURE SECTION**

LOCATION: 801 Biggs Drive, Brown Building, Raleigh, NC 27603
MAILING ADDRESS: 2708 Mail Service Center, Raleigh, NC 27699-2708
<https://info.ncdhhs.gov/dhsr/> • TEL: 919-855-3765 • FAX: 919-733-9379

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

As set forth in G.S. § 131D-34, the penalty recommendation and any training submitted by the facility will be forwarded for review by the Section Chief of the Adult Care Licensure Section, who will make the final decision regarding the imposition of an administrative penalty. If no training information is submitted or is received after 30 calendar days, the penalty recommendation will be forwarded to the Section Chief for imposition without consideration of training.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to dispute cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by **December 30, 2022**. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by **December 30, 2022**. You must submit 2 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: IDR Coordinator, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: <http://www.ncdhhs.gov/dhsr/acsls/idr.html>.

If you have questions about the enclosed Statement of Deficiencies or the violations, please contact me at 704-594-0203. Questions regarding submission of staff training to be considered in lieu of some or all of a penalty should be directed to DHSR.AdultCare.QualityandCompliance@dhhs.nc.gov. A follow up survey will be conducted to determine compliance in all areas cited. If this agency can be of any assistance in providing consultation relative to licensure rules, please let us know.

Sincerely,



Diana Spalding RN, BSN, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosures: Statement of Deficiencies

cc: Ms. Jimmi Anne Johnson, Supervisor/Designee, Iredell County DSS
Ms. Mary Agena, Team Supervisor, West 2 Region, Adult Care Licensure Section
Quality and Compliance Unit, Adult Care Licensure Section
Star Rating
Facility File

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION
ADULT CARE LICENSURE SECTION

LOCATION: 801 Biggs Drive, Brown Building, Raleigh, NC 27603
MAILING ADDRESS: 2708 Mail Service Center, Raleigh, NC 27699-2708
<https://info.ncdhhs.gov/dhsr/> • TEL: 919-855-3765 • FAX: 919-733-9379

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

