Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043036	A. BUILDING: _____ B. WING _____	R-C 02/02/2023

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 000	Initial Comments The Adult Care Licensure Section and Iredell County DSS conducted a follow-up and complaint investigation survey on 01/31/23 - 02/02/23. The complaint investigation was initiated by the Iredell County Department of Social Services on 01/12/23.	D 000	RCC was provided a training check list that must be completed prior to RN, check off. Administrator to QA employee files monthly	
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 1 of 3 medication aides (Staff A) who administered medications independently had completed the 5-hour medication aide training. The findings are: Review of Staff A, medication aide (MA) personnel record revealed:	D 125	5/26/23 D125 Addendum per email with Ms. Jayme Shatley on 5/23/23. Jennifer Fender, RN / jbf	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 05/05/23

STATE FORM 6899 If continuation sheet 1 of 16

The plan of correction with addendums was reviewed and acknowledged on 05/23/23. Refer to addendums on pages 1, 3, 7, and 14 to add completion date of 05/26/23 to all rule areas of this Statement of Deficiencies. Jennifer Fender, RN / jbf

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D 125	Continued From page 1 -She was hired on 01/24/23. -She completed her MA competency validation clinical skills checklist on 01/24/23. -She passed the written MA examination on 12/10/2019. -There was no documentation of a 5-hour MA training. Review of the schedule for January 2023 revealed Staff A worked as a MA on 01/27/23, 01/30/23 and 01/31/23. Interview with the Business Office Manager (BOM) on 02/02/23 at 1:19pm revealed: -The Regional Director and the Resident Care Coordinator (RCC) were responsible for scheduling staff training. -She was responsible for making sure all staff records were complete and included training documentation. -She did not have the training form for Staff A's 5-hour MA training. -She was aware that some training documentation was missing from staff records. -She was not aware that Staff A did not have the 5-hour MA training completed. Interview with the RCC on 02/02/23 at 1:00pm revealed: -She was responsible to supervise the MAs in the facility and ensure training requirements were met. -She and the Regional Director were responsible for scheduling staff training. Telephone interview with the Administrator on 02/02/23 at 1:45pm revealed: -She was responsible to schedule required MA training since September 2022. -The Regional Director was responsible to ensure	D 125		

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D 125	Continued From page 2 training requirements were met and to schedule MA training going forward. -The BOM and RCC were responsible for making sure all personnel records were complete. -She was not aware that Staff A did not have the 5-hour MA training completed. Attempted telephone interview on 02/02/23 at 1:10pm with Staff A was unsuccessful.	D 125		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration.	D 164	AL MT's will have a refresher training on Diabetes with Southern Pharmacy RN. Training prior to administering medications. and skills checklist to be completed to assure understanding and compliance. D164 Addendum per email with Ms. Jayme Shatley on 5/23/23. Jennifer Fender, RN / JBF	5/26/23

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D 164	Continued From page 3	D 164		

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure that 3 of 3 sampled medication aides (Staff A, B, and C) had completed training on the care of diabetic residents prior to the administration of insulin.

The findings are:

1. Review of Staff A, medication aide (MA) personnel record revealed:
-She was hired on 01/24/23.
-She completed her MA competency validation clinical skills checklist on 01/24/23.
-She passed the written MA examination on 12/10/2019.
-There was no documentation of the 5-hour MA training.
-There was no documentation of training on the care of diabetic residents.

Review of the schedule for January 2023 revealed Staff A worked as a MA on 01/27/23, 01/30/23 and 01/31/23.

Attempted telephone interview on 02/02/23 at 1:10pm with Staff A was unsuccessful.

Refer to interview with the Business Office Manager (BOM) on 02/02/23 at 1:19pm.

Refer to interview with the RCC on 02/02/23 at 1:00pm.

Refer to telephone interview with the Administrator on 02/02/23 at 1:45pm.

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D 164	Continued From page 4 2. Review of Staff B, medication aide (MA) personnel record revealed: -She was hired on 01/16/23. -She completed her MA competency validation clinical skills checklist on 11/09/22. -There was no documentation of a medication aide test. -There was no documentation of training on the care of diabetic residents. Review of the schedule for January 2023 revealed Staff B worked as a MA on 01/16/23 to 01/18/23, 01/20/23 to 01/23/23, 01/26/23, 01/27/23, and 01/30/23. Attempted telephone interview on 02/02/23 at 1:13pm with Staff B was unsuccessful. Refer to Interview with the Business Office Manager (BOM) on 02/02/23 at 1:19pm. Refer to Interview with the RCC on 02/02/23 at 1:00pm. Refer to telephone interview with the Administrator on 02/02/23 at 1:45pm. 3. Review of Staff C, medication aide (MA) personnel record revealed: -She was hired on 01/05/23. -She completed her MA competency validation clinical skills checklist on 01/06/23. -There was no documentation of a medication aide test. -There was no documentation of training on the care of diabetic residents. Review of the schedule for January and February 2023 revealed Staff C worked as a MA on 01/2023, 01/29/23, 01/30/23, and 02/01/23.	D 164		

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D 164	Continued From page 5	D 164		

Attempted telephone interview on 02/02/23 at 1:15pm with Staff C was unsuccessful.

Refer to interview with the Business Office Manager (BOM) on 02/02/23 at 1:19pm.

Refer to interview with the RCC on 02/02/23 at 1:00pm.

Refer to telephone interview with the Administrator on 02/02/23 at 1:45pm.

Interview with the Business Office Manager (BOM) on 02/02/23 at 1:19pm revealed:
-The Regional Director and the Resident Care Coordinator (RCC) were responsible for scheduling staff training.
-She was responsible for making sure all staff records were complete and included training documentation.
-She did not have the documentation for the diabetic care training.
-She was aware that some training documentation was missing from staff records.
-She was not aware the MAs did not have the diabetic care training completed.

Interview with the RCC on 02/02/23 at 1:00pm revealed:
-She was responsible to supervise the MAs in the facility and ensure diabetic care training requirements were met.
-She and the Regional Director were responsible for scheduling staff training.

Telephone interview with the Administrator on 02/02/23 at 1:45pm revealed:
-She was responsible to schedule required MA

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D 164	Continued From page 6 training since September 2022. -The Regional Director was responsible to ensure training requirements were met and to schedule MA training going forward. -The BOM and RCC were responsible for making sure all personnel records were complete. -She was not aware that Staff A did not have the diabetic care training completed. -MA training on the care of diabetic residents was provided by a contracted RN on 12/15/22.	D 164		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as prescribed for 3 of 7 sampled residents (#5, #7, and #8) related to a medication used to control elevated blood sugar (#5), a medication to treat glaucoma (#7), and a medication to treat high blood pressure (#8). The findings are: The medication error rate was 7.14% based on the observation of 2 errors out of 28 opportunities during the 9:00am medication pass on 01/31/23.	D 358	The RCC will be responsible for education and training with MT.s. regarding medication storage, keeping carts clean, neat, organized to locate all ordered medications. RCC will monitor weekly during cart audits. Training sheets will be completed and placed in employee file and Administrator to review monthly. 5/24/23 D358 Addendum per email with Ms. Jayme Shatley on 5/23/23. Jennifer Fender, RN / jbb	

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D 358	Continued From page 7 Review the the facility's undated Medication Administration policy revealed: -Staff were to administer medications according to the prescribing practitioner's orders. -Staff were to document medications administered on the resident's Medication Administration Record (MAR). -Omissions and refusals of medications and the reason for omissions were to be documented on the MAR. 1. Review of Resident #5's current FL2 dated 01/25/2022 revealed diagnoses included unspecified dementia, diabetes mellitus, hypertension and congestive heart failure. Review of Resident #5's current signed physician orders dated 12/13/2022 revealed Humalog Kwikpen 100 units, check fingerstick blood sugar (FSBS) before each meal and at bedtime and inject per sliding scale: FSBS: 0-199 = 0 units, 200-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-450 = 10 units, greater than 450 give 12 units repeat in one half hour and if still above 400, call the medical doctor. Review of Resident #5's December 2022 electronic Medication Administration Record (eMAR) revealed: -His FSBS on 12/27/22 at bedtime was 268 and he received 8 units of Humalog Kwikpen 100 units, when the order stated he should have received 4 units. -His FSBS on 12/30/22 before lunch was 260 and he received 2 units of Humalog Kwikpen 100 units, when the order stated he should have received 4 units. Interview with the medication aide (MA) on	D 358		

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D 358	Continued From page 8 02/02/23 at 1:19pm revealed: -She always looked at the sliding scale order written above the screen on the computer because the order was always there. -All staff should be doing the same thing but we had agency in here and they may not have been paying attention. -If you checked the sliding scale order each time you put the FSBS in the computer you would not make an error. Interview with the Resident Care Coordinator (RCC) on 02/02/23 at 1:31pm revealed: -She did not have the time to review the eMAR's. -Her goal was to review the eMAR's daily. -She did not know there were errors in Resident #5's sliding scale insulin. Review with the Administrator on 02/02/23 at 1:45pm revealed: -She did not know there were errors on Resident #5's sliding scale insulin. -She did not look at the eMAR's. -She expected the RCC to be auditing the eMAR's on Monday, Wednesday and Friday. -If there was a medication error, the process was to make the RCC aware, make the Administrator aware and the medical doctor would be notified. Attempted interview with Resident #5's primary care provider (PCP) on 02/02/23 at 1:00pm was unsuccessful. 2. Review of Resident #7's current FL2 dated 12/20/22 revealed: -Diagnoses included Alzheimer's Disease, restlessness and agitation, and colon cancer. -There was an order for dorzolamide/timolol 22.3-6.8 mg/ml, one drop twice daily to the right eye.	D 358		

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D 358	Continued From page 9 Observation during the medication pass on 01/31/23 at 9:36am revealed dorzolamide/timolol 22.3-6.8 mg/ml one drop was administered to both eyes of Resident #7. Interview with the MA on 01/31/23 at 9:36am revealed: -She placed one drop of the eye medication in both eyes of Resident #7. -She was not paying attention and should have only placed one drop in Resident #7's right eye. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/01/23 at 3:26pm revealed: -Dorzolamide/timolol eye drops were used to treat glaucoma. -Resident #7 was to be administered dorzolamide/timolol eye drops, one drop to the right eye twice daily. -If the medication was placed in a non-affected eye it could cause blurred vision, burning of the eye, or changes in the sense of taste. Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable. Interview with the RCC on 02/02/23 at 10:56am revealed: -She expected the MAs to notify her of any medication errors when they occurred. -The MAs were responsible to notify the RCC and the resident's PCP of medication errors. Refer to the telephone interview with the Administrator on 02/02/23 at 1:45pm. 3. Review of Resident #8's current FL2 dated	D 358		

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D 358	Continued From page 10 01/10/23 revealed: -Diagnoses included primary hypertension and dementia. -There was an order for lisinopril (a medication to treat high blood pressure) 10mg, one tablet daily. Observation during the medication pass on 01/31/23 at 9:50am revealed: -Each resident had a designated location in the cart for their medications. -The MA pulled the blister packs of medications for Resident's #8 from the cart. -She did not have a blister pack for Resident #8's lisinopril 10mg. -She checked the order history on Resident #8's electronic Medication Administration Record (eMAR) to determine if it was on order from the pharmacy. -She did not look in other locations of the medication cart for the lisinopril. -She did not administer lisinopril 10mg to Resident #8. -She documented the resident's lisinopril was not administered on the eMAR. Interview with the MA on 01/31/23 at 9:50am revealed: -She checked the reorder history for Resident #8's lisinopril 10mg. -It was reordered on 01/29/23 and was not delivered yet. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/31/23 at 3:34pm revealed: -Resident #8 had an order for lisinopril 10mg, one tablet daily. -Lisinopril 10mg, 28 tablets was dispensed for Resident #8 on 01/13/23.	D 358		

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D 358	Continued From page 11 Observation with the RCC of the medication cart on 01/31/23 at 3:47pm revealed there was a new blister pack of Resident #8's lisinopril 10mg in the bottom drawer of the medication cart. Interview with the RCC on 02/02/23 at 10:56am revealed: -If a resident had more than one blister pack of a medication, it was to be either turned backwards in the resident's dedicated location or placed in a back-up location in the bottom drawer of the medication cart. -Resident medications sometimes were misplaced in another resident's group of medications. -If a resident's medication was not available in the dedicated location, she expected the MA to search the cart in other locations. -She was unsure why the MA had not searched in other locations of the medication cart for Resident #8's lisinopril 10mg. Refer to the telephone interview with the Administrator on 02/02/23 at 1:45pm. Telephone interview with the Administrator on 02/02/23 at 1:45pm revealed: -The MAs were responsible to notify the RCC of all medication errors. -The RCC or the MA was responsible to notify the resident's PCP and the Administrator when a medication error occurred. -The nurse was responsible to provide follow-up training after any medication error. -She expected the MAs to check in all medication back-up locations before documenting a medication was not available to administer.	D 358		

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D 367	Continued From page 12	D 367		
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; (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 electronic Medication Administrator Records (eMAR) were accurate for 2 of 5 sampled residents (#4 and #5) related to the documentation of finger stick blood sugars (FSBS) (#4 and #5), documentation of administration of a medication to lower cholesterol , two medications to lower blood sugar levels, a medication to increase blood pressure, and an iron supplement (#4). 1. Review of Resident #5's current FL2 dated 01/25/2022 revealed diagnoses included	D 367		

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unspecified dementia, diabetes mellitus, hypertension and congestive heart failure.

Review of Resident #5's current signed physician orders dated 12/13/2022 revealed Humalog Kwikpen 100 units, check finger stick blood sugar (FSBS) before each meal and at bedtime and inject per sliding scale: FSBS: 0-199 = 0 units, 200-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, 401-450 = 10 units, greater than 450 give 12 units repeat in one half hour and if still above 400, call the medical doctor.

Review of Resident #5's December 2022 electronic Medication Administration Record (eMAR) revealed there was no documentation a FSBS was completed on 12/27/22 before breakfast.

Review of Resident #5's January 2023 eMAR revealed:
-There was no documentation on the eMAR a FSBS was completed on 01/17/23 before breakfast.
-There was no documentation on the eMAR a FSBS was completed on 01/20/23 before breakfast.
-There was no documentation on the eMAR a FSBS was completed on 01/23/23 before breakfast.
-There was no documentation on the eMAR a FSBS was completed on 01/23/23 before dinner.

Review with the medication aids (MA) on 02/02/23 at 1:19pm revealed:
-She was not sure how a MA had forgotten to do a FSBS on Resident #5.
-Sometimes Resident #5 would refuse but there was a space on the eMAR to document his

RCC will assure all MT's are re-trained with RN from Southern Pharmacy on Diabetes and will weekly shadow a MT for medication and documentation compliance and for teaching opportunities. Signed training sheets will be placed in Employee file and reviewed monthly by Administrator.

5/26/23

D367 Addendum per email with Ms. Jayme Shatley on 5/23/23.

Jennifer Fender, RN / jbf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049036	A. BUILDING: _____ B. WING _____	R-C 02/02/2023

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 14 refusal. -She felt staff were careless at times and forgot to document. Attempted interview with Resident #5's primary care physician on 02/02/23 at 1:00pm was unsuccessful. Refer to the interview with the Resident Care Coordinator (RCC) on 02/02/23 at 1:34pm. Refer to the interview with the Administrator on 02/03/23 at 1:45pm. 2. Review of Resident #4's current FL2 dated 11/28/22 revealed: -Diagnoses included E. Coli septicemia (a blood infection) and type II diabetes. -There was an order to check Resident #4's FSBS before meals and at bedtime. -There was an order for atorvastatin 20mg (a medication to lower cholesterol levels) one tablet in the evening. -There was an order for metformin 500mg (a medication to decrease blood sugar levels) two tablets twice daily. -There was an order for novolin insulin (used to decrease blood sugar levels) 5 units three times daily before meals. -There was an order for midodrine (a medication to increase blood pressure) 5mg one tablet every 8 hours. -There was an order for ferrous sulfate (an iron supplement) 325mg, one tablet before supper. Review of Resident #4's signed physician orders dated 12/13/22 revealed: -There was an order to check Resident #4's FSBS before meals and at bedtime. -There was an order for atorvastatin 20mg one tablet in the evening.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049036	A. BUILDING: _____ B. WING _____	R-C 02/02/2023

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HERITAGE PLACE	1372 EUFOLA ROAD STATESVILLE, NC 28677

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D 367	Continued From page 15	D 367		

-There was an order for metformin 500mg two tablets twice daily.
-There was an order for novolin insulin 5 units before each meal.
-There was an order for midodrine 5mg one tablet every 8 hours.
-There was an order for ferrous sulfate 325mg, one tablet before supper.

Review of Resident #4's December 2022 electronic Medication Administration Record (eMAR) revealed:
-There was no documentation metformin 500mg two tablets was administered on 12/27/22 at 7:30am.
-There was documentation Resident #4's FSBS was checked on 12/27/22 at 6:00am with a result of 168.
-There was no documentation novolin insulin 5 units was administered to the resident on 12/27/22 at 7:30am.

Review of Resident #4's January 2023 eMAR revealed:
-There was no documentation atorvastatin 20mg was administered on 01/23/23.
-There was no documentation ferrous sulfate 325mg was administered on 01/23/23 at 5:00pm.
-There was no documentation metformin 500mg, two tablets was administer on 01/17/23 at 7:30am and on 01/23/23 at 4:30pm.
-There was no documentation midodrine 5mg was administered on 01/16/23 at 2:00pm
-There was documentation Resident #4's FSBS was checked on 01/17/23 at 6:00am with a result of 206.
-There was no documentation novolin insulin 5 units was administered to the resident on 01/17/23 at 7:30am.
-There was documentation Resident #4's FSBS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049036	A. BUILDING: _____ B. WING _____	R-C 02/02/2023

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

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D 367	Continued From page 16	D 367		

was checked on 01/20/23 at 6:00am with a result of 220.
-There was no documentation novolin insulin 5 units was administered on 01/20/23 at 7:30am.
-There was documentation Resident #4's FSBS was checked on 01/23/23 at 6:00am with a result of 241.
-There was no documentation novolin insulin 5 units was administered on 01/23/23 at 7:30am.
-There was no documentation Resident #4's FSBS was checked on 01/23/23 at 4:30pm.
-There was no documentation novolin insulin 5 units was administered on 01/23/23 at 4:30pm.

Refer to the Interview with the Resident Care Coordinator (RCC) on 02/02/23 at 1:34pm.

Refer to the telephone interview with the Administrator on 02/02/23 at 1:45pm.

Interview with the RCC on 02/02/23 at 1:34pm revealed:
-She thought the blank boxes on the residents' eMARs were due to human error.
-She thought the MA failed to scan a medication or check it off manually.
-She was unsure if a medication was given when there was a blank box for a medication administration time.
-It was her responsibility to audit the eMARs for any medications not administered or other discrepancies.
-Her goal was to audit the eMARs daily but she did not always have the time.

Telephone interview with the Administrator on 02/02/23 at 1:45pm revealed:
-She was unsure why a medication administration time would appear blank on a resident's eMAR.
-It was possible the MA did not click on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049036	A. BUILDING: _____ B. WING _____	R-C 02/02/2023

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 17 medication when administering it. -The RCC was responsible to audit residents' eMARs for discrepancies on Mondays, Wednesdays, and Fridays.	D 367		

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

Electronic Mail

February 20, 2023

Syed Husain, Director
Heritage Place Business LLC, Licensee
Heritage Place
1372 Eufola Road
Statesville, NC 28677

email address: khizer0@gmail.com

Re: Follow-up Survey and Complaint Investigation completed February 2, 2023 (ASPEN Event ID 7DB211 / Complaint Intake Reference NC0019676?)

Facility:	**Heritage Place**
Licensure Number:	**HAL-049-036**
County:	**Iredell**

Dear Mr. Husain:

Thank you for the cooperation and courtesy extended during the survey completed February 2, 2023, by staff with the Adult Care Licensure Section and Iredell County DSS.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

The Type B Violations in the rule areas of **10A NCAC 13F .0902(b) Health Care, 10A NCAC 13F .1004(a) Medication Administration, and 10A NCAC 13F .1205 Health Care Personnel Registry** were abated as of the correction date, December 25, 2022. Therefore, penalties will not be recommended.

Based on survey findings, the complaint allegations were not substantiated.

Enclosed you will find all 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 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 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.

Enclosures: Statement of Deficiencies
Revisit Report

cc: Blondzella Harris, Administrator w/Enclosures
JimmiAnne Johnson, Supervisor/Designee, Iredell County DSS
Kim Ruppel, Branch Manager, Western Region, Adult Care Licensure Section
Mary Agena, Team Supervisor, West 2 Region, Adult Care Licensure Section
Victor Orija, State LTC Ombudsman, Division of Aging and Adult Services
Star Rating, Adult Care Licensure Section
Quality and Compliance Unit, Adult Care Licensure Section
Facility File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION		DATE OF REVISIT
HAL049036 Y1	A. Building B. Wing	Y2	2/2/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PLACE	1372 EUFOLA ROAD STATESVILLE, NC 28677

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0234	Correction	ID Prefix D0235	Correction	ID Prefix D0273	Correction
Reg. # 10A NCAC 13F .0703(a)	Completed	Reg. # 10A NCAC 13F .0703 (b)	Completed	Reg. # 10A NCAC 13F .0902(b)	Completed
LSC	02/02/2023	LSC	02/02/2023	LSC	12/25/2022
ID Prefix D0278	Correction	ID Prefix D0287	Correction	ID Prefix D0296	Correction
Reg. # 10A NCAC 13F .0903(a)	Completed	Reg. # 10A NCAC 13F .0904(b) (2)	Completed	Reg. # 10A NCAC 13F .0904(c) (7)	Completed
LSC	02/02/2023	LSC	02/02/2023	LSC	02/02/2023
ID Prefix D0310	Correction	ID Prefix D0338	Correction	ID Prefix D0392	Correction
Reg. # 10A NCAC 13F .0904(a) (4)	Completed	Reg. # 10A NCAC 13F .0909	Completed	Reg. # 10A NCAC 13F .1008 (a)	Completed
LSC	02/02/2023	LSC	02/02/2023	LSC	02/02/2023
ID Prefix D0433	Correction	ID Prefix D0438	Correction	ID Prefix D0451	Correction
Reg. # 10A NCAC 13F .1201(a)	Completed	Reg. # 10A NCAC 13F .1205	Completed	Reg. # 10A NCAC 13F .1212(a)	Completed
LSC	02/02/2023	LSC	12/25/2022	LSC	02/02/2023
ID Prefix D0464	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 10A NCAC 13F.1307	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/02/2023	LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Jennifer B. Fender	DATE 02/20/2023
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES	WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/10/2022		☐ YES ☐ NO

EVENT ID: FJM112

STATE FORM: REVISIT REPORT (11/06)