STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL070006	A. BUILDING: _____ B. WING _____	R 06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE OF ELIZABETH CITY	100 TIMMERMAN DRIVE ELIZABETH CITY, NC 27909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation on June 14, 2023 through June 15, 2023. The complaint investigation was initiated by the Pasquotank Department of Social Services on May 18, 2023.	D 000		
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 observations, records reviews, and interviews, the facility failed to ensure the routine needs of 1 of 5 sampled residents (#3) as evidenced by not referring a resident to a mental health provider per physician order, who was diagnosed with depression and had inappropriate behaviors. The findings are: Review of Resident #3's current FL-2, dated 10/05/22, revealed: -Diagnoses included muscle wasting and atrophy, hypertension, insomnia, hypothyroidism, hyperlipidemia, depression, and dementia onset. -The resident was intermittently disoriented. Review of Resident #3's Resident Register revealed an admission date of 10/16/22. Review of Resident #3's court authorized letter dated 11/22/22 revealed:	D 273	In future facility HSD and Administrator will encourage all guardians to assure all referrals for followup services are given to facility staff immediately. Guardians will be encouraged to allow facility staff to attend all physician appointments to assure facility has knowledge of all orders and referrals. All medical entities that provide service to residents will be encouraged to provide facility, rather than guardians with referrals. When resident refuses proscribed care the facility and guardian will explain to resident the necessity of following Dr's. recommendations . If no action is taken on order by the guardian and If the facility is aware of order, a follow up contact will be made to the PC by facility to obtain orders. This will be monitored by HSD every time a resident is taking to a medical appointment by DSS / Guardian.	6/16/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Jonne Mills TITLE Administrator (X6) DATE 7-6-23
Reviewed and Acknowledged SCM 8/23/23

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D 273	Continued From page 1 -There was a court authorized letter of appointment for guardian for Resident #3. -A local county department of social services (DSS) was appointed guardian for Resident #3. Review of Resident #3's signed primary care provider's (PCP) progress note, dated 05/03/23, revealed: -The patient had been referred two times for psychiatric care and it had "stalled." -She did not know why the guardian, or the facility had not implemented the referral request. -The resident needed psychiatric care but there had been no follow through after orders were given. -There was an order for the facility and the guardian to collaborate to get Resident #3 psychiatric care. Review of a Licensed Health Professional Support (LHPS) quarterly review, dated 05/03/23, revealed: -There was a recommendation to follow up with Resident #3's PCP due to complaints of worsening depression. -The resident was currently on Cymbalta 60mg daily. (Cymbalta, also called Fluoxetine, was used to treat generalized anxiety disorder and depression). Review of Resident #3's pharmacy review report dated 05/03/23 revealed: -There was a recommendation to follow-up with the resident's PCP due to complaints of worsening depression. -She was currently on Cymbalta 60 mg daily. -The facility's response was that the resident refused psychiatric consultation per the resident's PCP.	D 273		

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D 273	Continued From page 2 Review of Resident #3's facility progress notes dated 06/10/23 revealed the resident was very aggressive, abusive, and used foul language toward staff. Interview with Resident #3 on 06/14/23 at 9:30am revealed: -Her main concern was that she wanted and needed to see a "shrink". -She had a history of receiving mental health services since she was a child. -She had suffered from depression all her life. -She recently lost two close family members and, as a result, experienced frequent episodes of deep depression. -Sometimes, she had behaviors that she later regretted or was "ashamed" of. -She could not remember if she had told anyone at the facility that she wanted mental health services. -She could not remember the last time she saw her PCP but was told today (06/14/23) by a staff person she had an appointment with the PCP on 06/20/23. -She did not know what the appointment was for. Interview with Resident #3's Social Worker (guardian) on 06/15/23 at 9:15am revealed: -She had been Resident #3's social worker for about two weeks. -She had visited the resident once on 06/08/23. -The resident told her that she wanted mental health services. -A review of Resident #3's record showed there had been a referral made on 05/03/23 but no record that it had been done. A second interview with Resident #3's Social Worker and Supervisor (guardian) on 06/15/23 at 1:15pm revealed:	D 273		

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D 273	Continued From page 3 -The guardian had received an order, dated 05/03/23, from Resident #3's PCP for mental health services. -She contacted a local mental health service provider, but the provider did not accept patients living in long term care facilities. -She was not aware the facility had a contracted mental health provider that came on-site to the facility to provide mental health services to residents on an on-going basis. -She was not aware Resident #3's diagnoses included dementia onset. -She had not sent or communicated the PCP's referral order to the facility. -She planned to contact the facility to request mental health services for Resident #3 with the facility's contracted mental health provider. Interview with the facility's Health Services Director (HSD) on 06/15/23 at 10:45am revealed: -Her responsibilities included ensuring orders were implemented per physician order. -She was aware of Resident #3's PCP progress note dated 05/03/23. -She called the PCP's office and spoke to a staff person regarding the progress note who told her Resident #3 had refused mental health services. -She did not take any further action regarding the referral on the progress note. -She was aware Resident #3 had inappropriate behaviors and depression. -She had not thought about requesting a referral for mental health service for Resident #3 from the resident's PCP due to inappropriate behaviors and depression. -The facility re-directed Resident #3 when inappropriate behaviors were exhibited. -Resident #3's behaviors included anxiety, using profanity toward staff, slamming doors, and stomping feet.	D 273		

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D 273	Continued From page 4 -The resident had not mentioned to her that she wanted mental health services until 06/10/23 when she was having behaviors. -The facilty's contracted mental health provider was at the facility today (06/15/23) for a routine visit. -She mentioned to the mental health provider if they could see Resident #3 as a client. -The mental health provider agreed to enroll Resident #3 as a client to receive mental health services once a referral had been received and the required paperwork submitted and approved. -Resident #3 agreed to see the facility's contracted mental health provider. -She sent a communication to Resident #3's social worker and PCP today (06/15/23) to see if the PCP would like to send a referral to the facility for the resident to see their contracted mental health provider. Interview with the Administrator on 06/15/23 at 4:00pm revealed: -She did not consider the instructions on Resident #3's progress note, dated 05/03/23, an order. -Resident #3's guardian was responsible for arranging mental health services for the resident since they received the referral. -There had been multiple changes in Resident #3's social worker that caused a lack of continuity of care and communication. -The HSD sent a communication to Resident #3's PCP and guardian today (06/15/23) regarding the referral for mental health services. Interview with Resident #3's PCP on 06/15/23 at 8:30am revealed: -She made a referral for Resident #3 to receive mental services to the resident's guardian. -She thought the guardian would follow-up on the referral.	D 273		

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D 273	Continued From page 5 -She wrote an order on 05/03/23 for the guardian and the facility to collaborate to get Resident #3 mental health services. -There had been no follow-up to the referral to her knowledge. -The resident had recently suffered the loss of a family member who oversaw her health care needs and was now under the care of a guardian (the local DSS). -There was a history of the resident receiving mental health services and medications prior to being admitted to the facility, such as Seroquel (Seroquel is a medication used to treat schizophrenia, bipolar disorder, and depression). -The only mental health medication she was currently on was Cymbalta. -Resident #3 needed mental health services due to her frequent inappropriate behaviors and depression. -She would write another order for the referral today if necessary. The facility failed to ensure the referral and follow-up of 1 of 5 sampled resident (#3) for mental health services as ordered for a resident who suffered from inappropriate behaviors and worsening depression and who requested mental health services due to deep depression. This failure was detrimental to the health and safety of the resident and constitutes a Type B violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/15/23 for this violation. CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED JULY 30, 2023.	D 273		

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D 276	Continued From page 6	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 5 sampled residents with an order for laboratory testing (#5). The findings are: Review of Resident #5's current FL2 dated 08/12/22 revealed -Diagnoses included chronic obstructive pulmonary disease (COPD), hypertension and hepatic stenosis. -There was an order for alendronate sodium (Fosamax) 70mg to be administered weekly on Monday. Review of Resident #5's resident record revealed: -There was a note to Resident #5's attending provider from a pharmacy consultant dated 01/06/23 stating Resident #5 was on Fosamax without calcium supplement and requested clarification if a calcium supplement should be added. -There was documentation the pharmacist's note to provider was faxed on 01/06/23. -There was documentation of a physicians response stating "will check vitamin D level" that	D 276	All Physician's orders will be implemented within specified time frame. This will be monitored by HSD on a daily basis as physician appointments occur.	06/16/2023

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D 276	Continued From page 7 was signed and dated 01/10/23. -There was documentation of a clarification from the provider requesting to send order for a vitamin D level on 01/16/23. -There was no documentation a vitamin D level had been obtained for Resident #5. Review of Resident #5's pharmacy review dated 02/13/23 revealed recommendations included vitamin D level results. Review of Resident #5's progress note dated 06/14/23 revealed: -Resident #5's primary care provider was notified of an order dated 01/16/23 for a vitamin D level had not been completed. -A new order for vitamin D level was obtained and would be completed on 06/15/23. Telephone interview with the Licensed Practical Nurse (LPN) for Resident #5's primary care provider (PCP) on 06/15/23 at 8:29am revealed: -Resident #5 was on Fosamax for osteoporosis. -Calcium was usually prescribed with Fosamax because it could cause decreased calcium in the blood that could effect muscles in the body. -Resident #5's PCP wanted to check the vitamin D level before adding calcium supplements because vitamin D levels help with the absorption of calcium. Interview with a medication aide (MA) on 05/15/23 revealed: -Lab orders were placed in a lab book for processing when they were received. -The Health Services Director (HSD) was responsible for requesting new lab orders in the laboratory system. Interview with the HSD on 06/15/23 at 9:22am	D 276		

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D 276	Continued From page 8 revealed: -Laboratory services came to the facility weekly on Fridays. -She was responsible for requesting laboratory testing when it was ordered. -The lab order did not have a code that indicated why the lab was ordered. -She did not contact the provider to request the code. -She expected a lab request slip to be provided and she should have followed up with the provider. Interview with the Administrator on 06/15/23 at 4:03pm revealed: -The HSD was responsible for ensuring laboratory testing was completed as ordered. -She was not aware of the process for ensuring orders were completed.	D 276		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure the medication cart was locked when left unattended. The findings are:	D 378	Medicine carts will remained locked at all times when not under direct supervision of medication staff. Staff training was held by administrator to assure all medication aides are aware of this policy. To be monitored on a daily basis by Administrator, HSD and medication aides. This deficiency was corrected immediately upon discovery and did not reoccur during survey	06/16/2023

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D 378	Continued From page 9 Review of the facility's undated medication storage policy revealed: -Each resident has an individual tray for the storage of medications and the trays are stored in a locked space. -Medication cabinets and carts are kept locked. Observation of the front hall of the facility on 06/14/23 at from 9:12am to 9:18am to revealed: -There was an unattended medication cart on A Hall. -The drawers on left side of the medication cart opened when pulled and closed freely without locking. -The medication cart was unattended, and the medication aide (MA) was not seen on A Hall or B Hall. -At 9:15am the MA came up to the medication cart and quickly walked away. -The MA observed the drawers on the left side of the cart open and did not lock the cart. -The MA walked down the A Hall toward the nursing station. -At 9:16am the MA returned to the medication cart. -The top drawer on the left side of the medication cart had 20 multidose packages of medication. -The second drawer on the left side of the medication cart contained two prescription bottles of two different medications. -The third drawer on the left side of the medication cart had six multidose packages of medication, one tube of medication and one prescription bottle of medication. -The fourth drawer on the left side of the medication cart had 15 multidose packages of medication, three inhalers and one tube of medication. -The fifth drawer on the left side of the medication cart had 11 multidose packages of medication,	D 378		

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D 378	Continued From page 10 one prescription bottle of medication, and one tube of medication. Interview with a MA on 06/14/23 at 9:30am revealed: -She thought the five drawers on the left side of the medication cart were locked. -She was responsible to ensure that all medication cart drawers were locked and to keep the key to the medication cart in her pocket. -She should have locked the medication cart to ensure that residents were unable to open the medication cart drawers and take medications. -She had observed one resident who used a wheelchair and liked to touch the medication cart drawers in the past when he passed the medication cart in the hallway. -There was a second resident that was always first in line to get medications and she was concerned that this resident could have taken medications out of the medication cart; the resident had never taken any medications from the cart to her knowledge. -The facility had a new medication cart that had an automatic lock system after the cart had not been touched for two to three minutes; the medication cart was supposed to automatically lock but did not at 9:12am on 06/14/23. Interview with the Health Services Director (HSD) on 06/15/23 at 3:50pm revealed: -The medication carts should be locked and secured when a MA was not at the medication cart. -The MAs were responsible to ensure medication carts were locked to prevent residents from obtaining medications that they were not prescribed. -If a resident took medications from the medication cart that they were not prescribed it	D 378		

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D 378	Continued From page 11 put their safety at risk and it could be fatal. Interview with the Administrator on 06/15/23 at 4:03pm revealed medication carts should be locked when a MA was not at the medication cart to ensure resident safety.	D 378		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on observations, record reviews, and	D 454	The facility shall assure the notification of a resident's responsible party in the event of accident or incident. A training was held by administrator with all supervisory staff to assure compliance with this policy. To be monitored by HSD and administrator as accidents or incidents occur. This deficiency was corrected immediately upon discovery and did not reoccur during survey	6/16/2023

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D 454	Continued From page 12 interviews, the facility failed to ensure the notification of the guardian of 1 of 1 sampled resident (#3) within 24 hours of being sent to the emergency room for chest pain that required treatment. The findings are: Review of Resident #3's current FL-2 dated 10/05/22 revealed: -Diagnoses included muscle wasting and atrophy, hypertension, insomnia, hypothyroidism, hyperlipidemia, depression, and dementia onset. -The resident was intermittently disoriented. Review of Resident #3's records dated 11/22/22 revealed: -There was a court authorized letter of appointment for guardian for Resident #3. -A local county department of social services was appointed guardian for Resident #3. Review of a hospital visit report, dated 06/10/23, revealed Resident #3 was seen and treated in the local hospital for chest pain on 06/10/23. Interview with Resident #3's Social Worker (guardian) on 06/15/23 at 1:15pm revealed: -They were Resident #3's guardian. -They were not notified that the resident was sent to the emergency room on 06/10/23 for chest pain. -They expected to be notified when the resident went to the emergency room. Interview with the medication aide (MA) on 06/15/23 at 3:30pm revealed: -She was working at the facility when Resident #3 informed her she was experiencing chest pain on 06/10/23.	D 454		

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HERITAGE CARE OF ELIZABETH CITY	100 TIMMERMAN DRIVE ELIZABETH CITY, NC 27909

(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 454	Continued From page 13 -The emergency medical service (EMS) was called, and the resident was sent to the emergency room on 06/10/23. -The process was to notify the resident's guardian within 24 hours of being sent to the emergency room (ER). -She was aware of the process. -She thought she had called Resident #3's guardian, but she had not. Interview with the Health Services Director (HSD) on 06/15/23 at 10:45am revealed: -The process was to notify the responsible person or guardian when a resident was sent to the ER. -She thought the MA had notified the guardian. -The MA or whoever sends the resident to the ER were responsible for notifying the responsible person or guardian. Interview with the Administrator on 06/15/23 at 4:00pm revealed: -The protocol was to notify the guardian when Resident #3 was sent to the ER. -The MA who sent the resident to the ER was responsible for notifying the guardian. -The guardian should have been notified.	D 454		