

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL070006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/20/2023
NAME OF PROVIDER OR SUPPLIER HERITAGE CARE OF ELIZABETH CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 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 a follow-up survey and complaint investigation on 09/19/23 through 09/20/23. The complaint investigation was initiated by the Pasquotank Department of Social Services on 09/12/23.	{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: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation is abated. Non-compliance continues. Based on observations, record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (#5) related to failing to ensure scheduling of cardiology, otolaryngology and vascular surgeon appointments. The findings are: Review of Resident #5's current FL-2 dated 06/14/23 revealed: -Diagnoses included cerebral infarction and syncope. -He was non-ambulatory. -He was intermittently disoriented. Observation of Resident #5 on 09/19/23 at 3:00pm revealed he was sleeping in bed and there were resolving bruises noted over both cheeks and around his eyes.	{D 273}		

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

TITLE

(X6) DATE

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{D 273}	Continued From page 1 Review of Resident #5's nursing progress notes dated 08/03/23 at 7:10am and 10:30am revealed: -Staff responded to Resident #5's call bell and found him on the floor. -There appeared to be injuries to his forehead, nose and left arm. -He was sent to the local hospital emergency room (ER) for evaluation and diagnosed with a nasal bone fracture. Review of Resident #5's ER after visit summary dated 08/03/23 revealed: -Initial encounter was related to a fall. -Diagnosis included closed fracture of the nasal bone. Review of Resident #5's nursing progress note dated 08/04/23 at 7:30am and 4:30pm revealed: -Resident #5 was sent to the local hospital ER because he was spitting up blood. -He returned with orders to follow-up with the cardiologist in 2 days, the otolaryngologist in 3 days and with the vascular surgeon in 1 week. Review of Resident #5's ER after visit summary dated 08/04/23 revealed: -Diagnoses included closed fracture of the nasal bone, anemia, aneurysm of ascending aorta with rupture, and aortic valve stenosis. -There was an order to follow-up with the cardiologist in 2 days. -There was an order to follow-up with the otolaryngologist in 3 days. -There was an order to follow-up with the vascular surgeon in 1 week. Review of Resident #5's nursing progress note dated 09/12/23 at 9:20 (am/pm not documented) revealed:	{D 273}		

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{D 273}	Continued From page 2 -The otolaryngologist's office was contacted. -Resident #5's record would need to be reviewed by the provider to determine if Resident #5 needed to be seen and the office would call the facility with an appointment if one was needed. Telephone interview with the medical assistant for Resident #5's otolaryngologist on 09/19/23 at 2:38pm revealed: -She received a call from the facility on 09/13/23 to schedule an appointment for follow-up from an ER visit where he was diagnosed with a nasal bone fracture on 08/03/23. -The office had not been contacted prior to 09/13/23 for an appointment for Resident #5. -Resident #5 should have been seen in 3-7 days of the diagnosis for treatment and to evaluate the need for surgery but too much time had passed for surgery to be an option. Telephone interview with the medical assistant for Resident #5's cardiologist on 09/19/23 at 3:02pm revealed: -Resident #5 had an appointment scheduled for October 2023 that was made on 09/12/23 when she received a call from the facility. -Aortic stenosis decreased blood flow due to narrowing of the aortic valve and could cause symptoms such as shortness of breath, dizziness and heart failure which can increase the risk of falls. -Patients are usually seen within 1-2 weeks of aortic stenosis diagnosis and prior to seeing a vascular surgeon. Telephone interview with the scheduling coordinator for Resident #5's vascular surgeon's office on 09/20/23 at 9:40am revealed Resident #5 was not in the system and there were no pending appointments.	{D 273}		

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{D 273}	Continued From page 3 Interview with the Health Services Director on 09/19/23 at 2:20pm and 3:30pm revealed: -She was responsible for ensuring appointments were made as ordered. -She had a hard time getting Resident #5's appointments scheduled. -She faxed referrals on 09/07/23 after she received them and called the office between 09/07/23 and 09/12/23 to follow-up. -The otolaryngology office told her they would call with the appointment. -She could not remember when she called to schedule Resident #5's appointment with the cardiologist and the cardiologist had to see Resident #5 prior to being seen by the vascular surgeon. -She got busy and did not always document the communications with these providers in progress notes as she should. Interview with the Administrator on 09/19/23 at 4:19pm revealed Resident #5 should be seen as ordered but the facility could not help that the providers did not call back with appointments. Attempted telephone interview with Resident #5's primary care provider on 09/20/23 at 10:27am was unsuccessful. Attempted interview with Resident #5 on 09/19/23 at 3:45 was unsuccessful.	{D 273}			