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 10/25/2023

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 conducted a follow-up survey and complaint investigation from 10/24/23 to 10/25/23 with the Irdell County Depratrment of Social Services. The complaint investigations were initiated by the Iredell County Department of Social Services.	D 000		
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 interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents who had orders for a medication to treat a bacterial infection and a medication to treat a fungal infection (Resident #5). The findings are: Review of Resident #5's current FL2 dated 05/24/23 revealed diagnoses included Alzheimer's disease, acute respiratory failure (difficulty breathing) and pyelonephritis (kidney infection). a. Review of Resident #5's Primary Care Provider's (PCP) order dated 09/14/23 revealed an order for fluconazole 150mg (a medication used to treat fungal infections), one tablet once.	D 276		

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D 276	Continued From page 1 Review of Resident #5's September 2023 electronic Medication Administration Record (eMAR) revealed there was no entry for fluconazole 150mg, one tablet once. Telephone interview with a representative with the facility's contracted pharmacy on 10/25/23 at 11:37am revealed: -They did not receive an order for Resident #5 for fluconazole 150mg, one tablet once. -Fluconazole was used to treat yeast infections and if the resident did not receive the medication the yeast infection could cause a urinary tract infection. Telephone interview with Resident #5's PCP on 10/25/23 at 1:27pm revealed: -He expected facility staff to implement orders when they were received. -He was not aware the facility did not implement the order for Resident #5's fluconazole. -He expected the facility to notify him if an order was not implemented. Refer to the interview with the Special Care Unit Coordinator (SCC) on 10/25/23 at 12:21pm. Refer to the interview with the Administrator on 10/25/23 at 2:10pm. b. Review of Resident #5's PCP's order dated 10/08/23 revealed: -There was an order for Macrobid 100mg (a medication used to treat bacterial infections), one tablet twice daily for five days. -The Macrobid was to be started after a urine specimen was collected. Review of Resident #5's urinalysis results	D 276		

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D 276	Continued From page 2	D 276		

revealed a urine sample was collected on 10/09/23.

Review of Resident #5's October 2023 eMAR revealed there was no entry for Macrobid 100mg, one tablet twice daily for five days.

Telephone interview with a representative with the facility's contracted pharmacy on 10/25/23 at 11:37am revealed:
-They did not receive an order for Resident #5 for Macrobid 100mg, one tablet twice daily for five days.
-Possible outcomes of not receiving Macrobid included fever, pain, and the infection could worsen.

Telephone interview with Resident #5's PCP on 10/25/23 at 1:27pm revealed:
-He expected facility staff to implement orders when they were received.
-He thought he reviewed Resident #5's record, noticed the Macrobid was not implemented, and brought it to the facility's attention.
-He expected the facility to notify him if an order was not implemented.

Refer to the interview with the SCC on 10/25/23 at 12:21pm.

Refer to the interview with the Administrator on 10/25/23 at 2:10pm.

Based on interviews and record review it was determined that Resident #5 was not interviewable.

_____

Interview with the Special Care Unit Coordinator (SCC) on 10/25/23 at 12:21pm revealed:
-In September 2023, either the previous SCC or

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D 276	Continued From page 3 the pharmacy put orders on the eMAR. -If she received a new order while working as a MA, she faxed the order to the pharmacy unless the PCP stated he had sent it to the pharmacy. -After she transitioned to SCC, she was responsible for placing medication orders on the eMAR and faxing the order to the pharmacy. -It was her responsibility to ensure the medication arrived from the pharmacy, the order was on the resident's eMAR, and it was administered as ordered. Interview with the Administrator on 10/25/23 at 2:10pm revealed: -The SCC was responsible for ensuring all orders were implemented. -The SCC was responsible for faxing all medication orders to the pharmacy, ensuring the order was on the eMAR, the medication was received from the pharmacy, and administered as ordered. -She tried to audit PCP orders weekly to ensure the orders were implemented and medications were administered as ordered but she sometimes got behind. -She was not aware the fluconazole and Macrobid orders for Resident #5 were not implemented.	D 276		