

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL077011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/26/2016
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NAME OF PROVIDER OR SUPPLIER HERMITAGE RET CNT OF ROCKINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 139 MALLARD LANE ROCKINGHAM, NC 28379
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{D 000}	<p>Initial Comments</p> <p>The Adult Care Licensure Section conducted a follow-up survey on February 24, 25 and 26, 2016.</p> <p>D 270 10A NCAC 13F .0901(b) Personal Care and Supervision</p> <p>10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, record review and interview, the facility failed to provide supervision for 1 of 6 sampled residents (Resident #6), who eloped from the facility.</p> <p>The findings are:</p> <p>Review of Resident #6 current FL-2 dated 08/05/15 revealed: -Diagnoses of falls and schizoaffective disorder. -Medications included clozaril (antipsychotic medication) 400 mg at bedtime and divalproex sodium (used to treat manic episodes) 300 mg at bedtime. -Documented level of care was Assisted Living (AL).</p> <p>Review of Resident #6's Resident Register revealed: -An admission date of 05/31/13. -Resident had a Power of Attorney (POA).</p>	{D 000}		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 270	<p>Continued From page 1</p> <p>-Resident #6 was assessed as needing extensive assistance with toileting, bathing, dressing, and grooming/personal hygiene.</p> <p>-Resident #6 was assessed needing limited assistance with ambulation/locomotion and transferring.</p> <p>Observation of the Special Care Unit (SCU) on 02/24/16 at 11:00 am, during the initial tour of facility, revealed Resident #6 lying on a couch in the activity room with eyes closed.</p> <p>Review of Resident #6's Care Plan dated 05/13/15 revealed:</p> <p>-Resident #6 was assessed as independent for eating.</p> <p>-No documented assessment of wandering or elopement.</p> <p>Interview on 02/24/16 at 5:15 pm with a personal care aide (PCA) revealed:</p> <p>-Resident #6 had left the facility after supper on 02/22/16 without signing out or notifying staff that she was leaving the facility.</p> <p>-Resident #6 was not in the facility at routine checks after supper.</p> <p>-Resident #6 was found walking on the road, approximately 2 miles from the facility, later that evening.</p> <p>Review of the facility's confidential Occurrence Report dated 02/22/16 revealed:</p> <p>-Resident #6 "left facility and walked to Hwy 74" at 8:00 pm.</p> <p>-The type of occurrence was marked "elopement/wandering left facility".</p> <p>-Resident #6's family had been notified.</p> <p>Interview on 02/25/16 at 9:50 am with a Medication Aide/Supervisor revealed:</p>	D 270		

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D 270	<p>Continued From page 2</p> <ul style="list-style-type: none"> -She was the supervisor on duty when Resident #6 walked away from the facility on 02/22/16. -Resident #6 had been observed smoking at approximately 3:40 pm, 20 minutes before the the designated, supervised smoking break at 4:00 pm. - As a result of Resident #6 smoking outside the designated, supervised time frame, her smoking privileges were revoked for the smoke break at 4:00 pm. -Resident #6 had grown angry when her smoking privileges were revoked for the 4:00 pm smoke break, and had walked around outside for about 30 minutes before returning to the facility to eat her supper. -Resident #6 left the facility again at around 6:10 pm and a search was conducted of the facility and the grounds. -Resident #6 was not located on the facility grounds. -She then notified the POA, the Administrator, the physician, the mental health provider, the police and the local Department of Social Services. -Resident #6 was found by a member of the community near the 4-lane Hwy 74 and returned to the facility on 02/22/15 at 9:55 pm. -Resident #6 had not eloped from the facility before. -This was the first time Resident #6 displayed this behavior. -Upon her return to the facility, at 9:55 pm, Resident #6 was placed into the SCU at the recommendation of the physician, for her own safety. -Resident #6 was to remain temporarily in the SCU, until she calmed dawn. -Upon her return to the facility, Resident #6 was still very angry over the revoked smoke break and needed time to settle down. 	D 270		

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D 270	<p>Continued From page 3</p> <p>Interview on 02/25/16 at 10:45 am with the Assistant Special Care Unit Coordinator revealed:</p> <ul style="list-style-type: none"> -Resident #6 walked away from the facility on 02/22/16 after supper. -Resident #6 was upset that her smoking privilege had been revoked for the 4:00 pm smoke break. -Resident #6 had been temporarily placed in the SCU for her own safety, at the physician's recommendation. -Resident #6 would go back to the AL side of the building soon, after she had calmed down enough to resume her normal behavior. <p>Interview on 02/25/16 at 12:10 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -Residents were allowed to smoke at any of the designated supervised smoking times, which started at 6:00 am and were every 2 hours until midnight, for a total of 10 opportunities to smoke daily. -Resident #6 resided in the Assisted Living Unit of the facility, but was temporarily placed in the SCU due to behaviors displayed on 02/22/16. -On 02/22/16 at 3:40 pm, Resident #6 was observed smoking during a time that was not a designated supervised smoking time. -As a result, her smoking privileges were revoked for the next smoke break, which was 4:00 pm. -Resident #6 was not pleased that her smoking privileges were revoked. -Resident #6 was angry and shouted at staff and the Administrator as she walked out of the building. -Resident #6 was outside for approximately 30 minutes and returned to the facility in a calm state. -Resident #6 often got angry and then walked outside for approximately 30 - 45 minutes only to return when she had calmed down. 	D 270		

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D 270	<p>Continued From page 4</p> <ul style="list-style-type: none"> -Dinner was served shortly after her return to the building and Resident #6 ate her meal uneventfully. -After dinner, Resident #6 left the facility on foot without signing out and without notifying staff. -Resident #6's exit from the building was not witnessed by staff. -When Resident #6 did not return in around 30 minutes, staff unsuccessfully searched the premises for her. -Staff notified the Administrator, Resident #6's Power of Attorney (POA), the physician, the mental health provider, the DSS and the police. -Resident #6 was located and returned to the facility by a member of the community on 02/22/16 at 9:55 pm. -Resident #6 had been away from the facility for approximately 3 hours and 45 minutes. She had never walked away from the facility for such an extended period of time. -When Resident #6 returned to the facility, the physician recommended placing her in the SCU for a temporary basis, for her own safety. -The Administrator agreed the temporary placement into the SCU would be the most safe option for Resident #6, considering she had never attempted elopement before and was still very angry about the revoked smoking privilege. -Resident #6's POA agreed that temporary placement in the SCU was the best thing to do at the time, while Resident #6 was so upset. -This was the first and only time a resident had been placed temporarily into the SCU. -Resident #6 often became verbally abusive toward staff and administration when angered, but had never displayed anger at other residents. -Resident #6 was posed no threat to the other residents in the SCU, she had never displayed aggressive behavior toward other residents. -After discussing with the physician, mental 	D 270		

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D 270	<p>Continued From page 5</p> <p>health provider and POA, Resident #6 had been moved back to the AL side of the building prior to lunch service at 12:00 pm on 02/25/16.</p> <ul style="list-style-type: none"> -Resident #6 was placed on 15 minute checks and would remain so for the present time. -The staff had followed the facility policy for a missing resident. <p>Interview on 02/25/16 at 3:20 pm with the mental health care provider revealed:</p> <ul style="list-style-type: none"> -She had been notified on 02/22/16 of Resident #6's elopement from facility. -She was also notified on 02/22/16 of Resident #6's temporary placement into the SCU, until she calmed down. -She agreed the temporary placement into the SCU was a safe alternative to Resident #6 returning to her regular room on the AL unit. -She was aware that Resident #6 was currently back on the AL side of the building. -Resident #6 had an appointment scheduled with her next week, to review medications and discuss her recent behavior. <p>Interview on 02/26/16 at 8:20 am with Resident #6's POA revealed:</p> <ul style="list-style-type: none"> -Resident #6 had lived at the facility for almost 3 years and enjoyed living there. -Resident #6 would get upset if she did not get her way. -Usually, when angered, Resident #6 would go outside and walk around for about 30 minutes, and then return to the facility when she had calmed down. -The facility had notified her on 02/22/16 when Resident #6 was upset about the revoked smoking privilege for the 4:00 pm smoke break and that Resident #6 had walked away from the facility and returned about 30 minutes later. -She was notified that Resident #6 had left the 	D 270		

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D 270	<p>Continued From page 6</p> <p>facility after supper and had not returned.</p> <p>-She was notified when Resident #6 had been located and temporarily placed for her safety into the locked SCU.</p> <p>-She agreed that placement into the SCU was the safest action to take for Resident #6 while she was so upset and angry.</p> <p>-Resident #6 was not a threat to the other residents in the SCU, she did not have a history of aggression toward other residents.</p> <p>-She came to visit Resident #6 on 02/23/16, the day following the elopement, and explained the reason Resident #6 was to stay in the SCU .</p> <p>-The facility did the best thing for her that night by placing Resident #6 into the SCU for her own safety.</p> <p>-Resident #6 had been moved back to the AL side of the facility before 12:00 pm on 02/25/16 and was calm now.</p> <p>-She requested Resident #6 not be interviewed and possibly make her angry again.</p> <p>Interview on 02/26/16 at 9:45 am with the health care provider's office representative revealed:</p> <p>-The physician was made aware of Resident #6's elopement on 02/22/16.</p> <p>-The physician recommended temporary placement into the SCU for immediate safety, until she calmed down.</p> <p>-The health care provider was in the facility to see residents on 02/24/16, but the visit to the facility had to be abbreviated due to inclement weather.</p> <p>-She did not actually get to see Resident #6 on 02/24/16, but she received a verbal report about Resident #6's condition from staff.</p> <p>-She was aware Resident #6 was in the SCU until just before noon on 02/25/16.</p> <p>Interview on 02/26/16 at 9:25 am with the SCU Coordinator revealed:</p>	D 270		

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D 270	<p>Continued From page 7</p> <ul style="list-style-type: none"> -She was aware Resident #6 had walked away from the facility on 02/22/16. -The facility notified her at approximately 6:00 pm and she returned to the facility. -She confirmed the resident was located off facility premises after 9:00 pm. -Resident #6 had never been placed in the SCU for behaviors. -She was aware of the requirements for placing a resident in the SCU. -The Administrator advised her that Resident #6 was being placed in the SCU for her personal safety, until she calmed down. <p>Interview on 02/26/16 at 10:00 am with member of community who located Resident #6 on 02/22/16 revealed the community member was unavailable and did not return the phone call.</p> <p>Interview on 02/26/16 at 3:15 pm with local police revealed:</p> <ul style="list-style-type: none"> -They were notified on 02/22/16 when Resident #6 had walked away from the facility. -They were provided with a physical description of Resident #6 and the clothing she wore. -The patrol officers had looked for her, but she was located by a member of the community who returned her to the facility on 02/22/16 at approximately 10:00 pm. <hr/> <p>A Plan of Protection provided by the facility on 02/25/16 as follows:</p> <ul style="list-style-type: none"> -Staff are currently monitoring Resident #6 every 15 minutes. -All staff are aware of the increased supervision for Resident #6. -The supervisor will monitor the increased supervision of Resident #6. 	D 270		

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D 270	<p>Continued From page 8</p> <p>-The Administrator will ensure the 15 minute checks are being performed and documented.</p> <p>DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 11, 2016.</p> <p>{D 358} 10A NCAC 13F .1004(a) Medication Administration</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 4 sampled residents (Resident #1) with orders for sliding scale insulin.</p> <p>The findings are:</p> <p>Review of Resident #1's current hospital FL-2 dated 02/11/15 revealed: -Diagnoses included diabetes mellitus II, hypertension, and hypothyroidism. -An order for Levemir (a long acting insulin analog) insulin 38 units 2 times a day. -An order for fingerstick blood sugars (FSBSs) 3 times daily before meals. -An order to administer Humalog (a rapid acting</p>	D 270		

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{D 358}	<p>Continued From page 9</p> <p>insulin analog used to treat elevated blood sugar) insulin before meals using sliding scale as follows: 157-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units.</p> <p>Review of Resident #1's record revealed physician's orders dated 11/19/15 ordering: -FSBS 4 times a day before meals and at bedtime, and continue current dosages of insulin. (Levemir insulin 38 units two times a day and Humalog insulin by sliding scale before meals were the current insulin orders.) -If blood glucose less than 70 treat with 8 ounces of orange juice; repeat every 15 minutes till blood sugar of 100.</p> <p>Review a hospital discharge summary dated 02/01/16 revealed: -An order for Levemir insulin 38 units in the morning and evening. -An order for Humalog insulin 3 times daily (before meals) using sliding scale as follows: 157-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units. -Resident #1's Endocrinologist was carbon copied for the discharge summary.</p> <p>Review of Resident #1's record revealed a physician's order to decrease Levemir insulin to 34 units at bedtime dated 02/09/16.</p> <p>Review of the February 2016 MAR revealed: -Check blood sugar before meals and at bedtime was preprinted on the MAR and scheduled for 7:30 am, 11:30 am, 4:30 pm, and 9:00 pm daily. -If blood glucose less than 70 treat with 8 ounces of orange juice; repeat every 15 minutes till blood sugar of 100 was preprinted on the MAR. -FSBS documented at 11:00 am, 4:30 pm, and</p>	{D 358}		

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{D 358}	<p>Continued From page 10</p> <p>9:00 pm ranged from 82 to 390.</p> <ul style="list-style-type: none"> -Humalog insulin with sliding scale before meals was preprinted on the MAR. -In addition, Humalog insulin with sliding scale was handwritten and scheduled for 9:00 pm. -FSBS documented at 7:30 am ranged from 79 to 300. -Levemir insulin was documented for administered as ordered from 02/01/16 to 02/24/16. -Humalog sliding scale was documented as administered 17 times at 9:00 pm from 02/01/16 to 02/24/16. <p>Observation on 02/26/16 at 5:00 pm of Resident #1's medications on hand revealed:</p> <ul style="list-style-type: none"> -A partial vial of Levemir insulin on hand for administration to Resident #1. -A partial 10 milliliter vial of Humalog insulin available for sliding scale administration for Resident #1. <p>Interviews on 02/25/16 at 10:55 am and 12:00 pm with the Director of Resident Services (DRS) revealed:</p> <ul style="list-style-type: none"> -She was responsible for transcribing physician orders to the residents' MARs. -She was responsible for the month to month comparison of the MARs for accuracy. -She made the handwritten entry for sliding scale Humalog at 9:00 pm to Resident #1's MARs for February 2016 because she thought the pharmacy left it off the MAR. -She was aware the Nurse Practitioner (NP) changed Resident #1's FSBS from 3 times a day (before meals) to 4 times a day (before meals and at bedtime) on 11/19/15 and overlooked that sliding scale Humalog insulin remained 3 times a day, before meals. -She overlooked the order for Humalog sliding 	{D 358}		

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{D 358}	<p>Continued From page 11</p> <p>scale insulin 3 times a day, before meals, on the hospital discharge dated 02/01/16.</p> <p>-She thought the NP had changed Resident #1's sliding scale Humalog to 4 times a day when she increased FSBS to 4 times a day.</p> <p>-She did not call the NP to clarify the order for Resident #1's Humalog insulin.</p> <p>-Medication Aide (MA) staff were trained to administer medications and treatments as ordered on the MAR.</p> <p>Telephone interview on 02/25/16 at 12:35 pm with Resident #1's Endocrinologist's office revealed:</p> <p>-The Nurse Practitioner had written the order to change FSBS from 3 times a day, before meals, to 4 times a day, before meals and at bedtime, on 11/19/15.</p> <p>-Resident #1 was to have sliding scale insulin before meals only.</p> <p>-There was no documentation for the facility contacting the endocrinologist's office for clarification of the order.</p> <p>Interview on 02/25/16 at 1:00 pm with a dayshift MA revealed:</p> <p>-Orders were entered on the residents' MARs by the DRS.</p> <p>-MA staff were trained to administer medications and treatments according to the MARs.</p> <p>-She performed FSBS and administered Sliding scale insulin for Resident #1 according to the MAR.</p> <p>-She was not responsible for reviewing physicians' orders for accuracy of transcription to the MAR.</p> <p>Interview on 02/26/16 at 12:25 pm with Resident #1 revealed:</p> <p>-He was aware his physician had changed FSBS checks to 4 times a day in November 2015.</p>	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL077011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/26/2016
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NAME OF PROVIDER OR SUPPLIER HERMITAGE RET CNT OF ROCKINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 139 MALLARD LANE ROCKINGHAM, NC 28379
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(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}	<p>Continued From page 12</p> <p>-He was not aware if he was supposed to be receiving his sliding scale insulin at bedtime, but knew it had been ordered before meals for a long time.</p> <p>-His blood sugar had not been low in the mornings.</p> <p>-The facility could give him orange juice if he had a low blood sugar but he did not remember having a low blood sugar in a few months.</p> <p>Telephone interview on 2/26/16 at 1:40 pm with the contract pharmacy representative revealed the current order for Humalog sliding scale insulin for Resident #1 was dated 02/01/16 for Humalog sliding scale insulin 3 times a day before meals.</p> <p>Interview on 02/26/16 at 3:50 pm with the Administrator revealed the DRS was responsible for assuring medications and treatments were administered as ordered.</p> <p>Interview on 02/26/16 at 4:08 pm with an evening shift MA revealed:</p> <p>-She had been a MA at the facility for approximately 1 month.</p> <p>-She did not transcribe orders to the residents' MARs.</p> <p>-She administered medications and treatments according to the MAR.</p> <p>Based on observation, interview, and record review, Resident #1 was administered sliding scale Humalog insulin at bedtime from 02/01/16 to 02/14/16 without an order on the hospital discharge dated 02/01/16.</p>	{D 358}		
{D912}	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights</p>	{D912}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL077011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/26/2016
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NAME OF PROVIDER OR SUPPLIER HERMITAGE RET CNT OF ROCKINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 139 MALLARD LANE ROCKINGHAM, NC 28379
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(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
{D912}	<p>Continued From page 13</p> <p>Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure all residents received care and services which were adequate, appropriate and in compliance with relevent federal and state laws and rules and regulations related to providing personal and supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.</p> <p>The findings are:</p> <p>Based on observation, record review and interview, the facility failed to provide increased supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 1 of 6 sampled residents (Resident #6), who eloped from the facility [Refer to Tag 0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].</p>	{D912}		