

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041078	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/27/2020
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NAME OF PROVIDER OR SUPPLIER THE ARBORETUM AT HERITAGE GREENS	STREET ADDRESS, CITY, STATE, ZIP CODE 709 MEADOWOOD STREET GREENSBORO, NC 27409
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D 000	<p>Initial Comments</p> <p>The Adult Care Licensure Section conducted an annual survey on 02/26/20 through 02/27/20.</p>	D 000	<p><i>See included documentation pages 13-14</i></p>	
D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (Resident #4), related to significant weight loss of 12 pounds within a month.</p> <p>The findings are:</p> <p>Review of Resident #4's current FL2 date 12/20/19 revealed: -Diagnoses included cognitive communication deficit, chronic kidney disease stage III, acute kidney failure, paroxysmal atrial fibrillation, acute posthemorrhagic anemia, hypothyroidism, and chronic diastolic heart failure. -Resident #4's recommended level of care was memory care.</p> <p>Review of Resident #4's Monthly Weight and Vitals Record revealed:</p>	D 273		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

M. A. AED TITLE

(X6) DATE
3/20/20

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D 273	<p>Continued From page 1</p> <ul style="list-style-type: none"> -Resident #4's weight was 134.4 pounds on 01/01/20. -Resident #4's weight was 122.4 pounds on 02/01/20. -Resident #4 had a 12 pound and 9% weight loss in 30 days. -Resident #4's weight was 119 pounds on 02/27/20. -There was a column to enter a weight change of 5 pounds, weight loss of 5% in one month, verification of documentation of significant weight loss in progress notes, and a signature column verifying weights were reviewed, the physician was notified, and there was documentation in the progress notes. -There was no information documented in any of the columns regarding weight except for the documented weights for 01/01/20 and 02/01/20. <p>Review of Resident #4's progress notes revealed there was no documentation regarding weight loss or physician notification of weight loss.</p> <p>Interview with Resident #4's primary care physician on 02/27/20 at 3:47pm revealed:</p> <ul style="list-style-type: none"> -A nurse practitioner (NP) was Resident #4's primary care provider (PCP). -He did not know Resident #4 had a 12-pound weight loss in a month and he did not know if Resident #4's NP knew. -He did not see any documentation regarding any issues with weight loss. -Resident #4 was last seen by the NP on 02/24/20. -He would like to know why Resident #4 was having weight loss. -He expected the facility staff to contact Resident #4's NP to inform of her weight loss. <p>Interview with the Administrator on 02/27/20 at</p>	D 273		

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D 273	<p>Continued From page 2</p> <p>4:08pm revealed: -Medication aides (MAs) were responsible for weighing residents monthly on first shift. -Weights and any significant changes in weight should have been documented monthly on the Monthly Weight and Vitals Record. -MAs should report any significant changes in weight to the Resident Care Coordinator (RCC) or the Administrator. -A Notification of Weight Form should have been completed and faxed to Resident #4's PCP by the RCC or the Administrator to inform the PCP of Resident #4's weight loss. -The MA or the RCC should have followed up with the physician after about 3 days.</p> <p>Interview with Resident #4's NP on 02/27/20 at 4:20pm revealed: -She knew Resident #4 had "gone down hill" and could tell by looking at her, she had some weight loss. -She had not been contacted by the facility staff and did not know Resident #4 had significant weight loss of 12 pounds between 01/01/20 and 02/01/20. -She had not seen documentation of Resident #4's monthly weights at the facility. -Facility staff had not contacted her regarding Resident #4's weight loss.</p> <p>Interview with Resident #4's Responsible Party on 02/27/20 at 4:31pm revealed: -Staff did not tell him Resident #4 had weight loss of 12 pounds between 01/01/20 and 02/01/20. -He noticed Resident #4 lost weight and asked staff what her current weight was in February 2020. -He was told by staff, after asking, Resident #4 weighed "120 something" where she had weighed "130 something."</p>	D 273		

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D 273	<p>Continued From page 3</p> <p>-He was concerned with Resident #4's weight loss because she should not be losing weight so quickly.</p> <p>Interview with the RCC on 02/27/20 at 4:57pm revealed:</p> <p>-She had worked at the facility for about two weeks and did not know about Resident #4's weight loss.</p> <p>-If staff found a resident had significant weight loss, she would have staff to re-weigh the resident to make sure the numbers were correct.</p> <p>-Staff were expected to notify the RCC of weight loss of more than 3 pounds so she could notify the resident's physician and family.</p> <p>Interview with the Special Care Unit (SCU) Manager on 02/27/20 at 5:10pm revealed:</p> <p>-Personal care aides (PCA) were responsible for weighing residents between the first and fifth of every month and document the weights on the Monthly Weight and Vitals Record.</p> <p>-If there was a weight loss of 3 pounds or more, the PCAs were to notify the MAs who were to notify the resident's physician.</p> <p>-She did not know about Resident #4's weight loss.</p> <p>-The Monthly Weight and Vitals Records were given to the NP when she visited weekly.</p> <p>-The PCP did not look at any other residents' weight unless prompted by staff to do so.</p> <p>-She did not know if staff notified Resident #4's PCP of a 12 pound weight loss between 01/01/20 and 02/02/20.</p> <p>Review of the facility's policy and procedure manual related to a resident's change in condition on 02/27/20 revealed:</p> <p>-The PCAs were to notify the RCC or the manager on duty of changes in the condition of a</p>	D 273		

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D 273	<p>Continued From page 4</p> <p>resident.</p> <ul style="list-style-type: none"> -The resident's PCP was to be notified of a change in condition. -Weight loss was an example of a change in condition. -There was not a specific number or a range defining a change in weight that would prompt staff to report a resident's weight loss to management or the PCP. <p>Interview with a PCA on 02/27/20 at 4:10pm revealed:</p> <ul style="list-style-type: none"> -The PCA on first shift weighed the residents on the first of each month. -The PCA gave a list of the weights to the medication aide (MA) to enter in the weight log. <p>Interview with a MA on 02/27/20 at 4:12pm revealed:</p> <ul style="list-style-type: none"> -The residents were weighed on first shift. -The PCA weighed the residents and the MA entered the weights in the weight log. -There was no policy regarding a specific change in weight that needed to be reported to management or the PCP. -She thought a minimum 10-pound weight gain or loss in a month would be a significant change and she would call the PCP. -She would contact the PCP and inform the RCC if a resident had a significant change in weight. -She would fax the PCP if a resident was not eating or if a family member noticed a resident was losing weight and requested, she contacted the PCP. -Resident #4 was admitted on 12/24/19. -Resident #4's family member said she was not a "big eater." -The pharmacy representative told the MA the pharmacy did not carry the size of the nutritional supplement that was ordered. 	D 273		

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D 273	<p>Continued From page 5</p> <ul style="list-style-type: none"> -Resident #4 had not received the nutritional supplement since being admitted to the facility. -She talked with Resident #4's family member and was told the family member did not want Resident #4 to continue receiving the nutritional supplement. -She thought the nutritional supplement had been discontinued. -She did not contact Resident #4's PCP about Resident #4's weight loss or the nutritional supplement. <p>Interview with a second MA on 02/27/20 at 4:30pm revealed:</p> <ul style="list-style-type: none"> -The PCA on first shift weighed all the residents between the 1st and 5th of each month. -The PCA or MA entered the weight in the weight log. -She would notify a Manager if a resident's weight changed. -She did not know if there was a policy about how much of a weight change would require a call to the PCP. -She thought a 5-7-pound change in one week was a significant change. -She thought a 10-pound weight change in one month was a significant change. -She did not know the amount of weight a PCA would consider a significant change. -The PCP reviewed the weight log and changed diet orders if necessary. -She was not aware of Resident #4's weight loss. <p>Telephone interview with a second PCA on 02/27/20 at 5:00pm revealed:</p> <ul style="list-style-type: none"> -The residents were weighed on the first of the month or according to the PCP's order. -The PCA on first shift normally weighed the residents. -She gave the list of weights to the MA to record 	D 273		

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D 273	Continued From page 6 in the weight log. -She never entered weights in the weight log. -The MA always wrote the weight in the weight log. -She would not be able to remember a resident's weight from the previous month. -The MA would see the weight change in the weight log. -If there was a specific order for weight other than monthly, the MA was responsible for weighing the resident. -The MA would have the PCA weigh the resident if the MA was unable to weigh the residents. -She was not aware of Resident #4's weight loss.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 2 sampled residents (Resident #4) with physician's orders for a nutritional supplement. The findings are: Review of Resident #4's current FL2 date	D 310		

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D 310	<p>Continued From page 7</p> <p>12/20/19 revealed: -Diagnoses included cognitive communication deficit, chronic kidney disease stage III, acute kidney failure, paroxysmal atrial fibrillation, acute posthemorrhagic anemia, hypothyroidism, and chronic diastolic heart failure. -Resident #4's recommended level of care was memory care. -There was an order for a nutritional supplement give 237 ounces in the afternoon.</p> <p>Review of physician's orders for Resident #4 between December 2019 and February 2020 there was no order to discontinue nutritional supplements.</p> <p>Review of Resident #4's Monthly Weight and Vitals Record revealed: -Resident #4 weight was 134.4 pounds on 01/01/20. -Resident #4's weight was 122.4 pounds on 02/01/20. -Resident #4 had a 12 pound and 9% weight loss in 30 days. -Resident #4's weight was 119 pounds on 02/27/20.</p> <p>Review of Resident #4's progress notes revealed there was no documentation regarding nutritional supplements or weight loss.</p> <p>Review of Resident #4's electronic Medication Administration Record (eMAR) for December 2019, January and February 2020 revealed there was no entry for a nutritional supplement and no documentation of administration.</p> <p>Interview with a medication aide (MA) on 02/27/20 at 1:41pm revealed: -Nutritional supplements were kept in the</p>	D 310		

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D 310	<p>Continued From page 8</p> <p>refrigerator in Community A (the area of the facility where Resident #4 resided). -MAs were responsible for serving and documenting nutritional supplements on the eMARs. -Resident #4 did not have nutritional supplements in the refrigerator and she had never served nutritional supplements to Resident #4. -Nutritional supplements were not on Resident #4's eMAR.</p> <p>Interview with the facility's contracted pharmacy on 02/27/20 at 3:29pm revealed: -The pharmacy began servicing Resident #4 on 12/26/19. -There was no documentation the pharmacy had received an order for a nutritional supplement.</p> <p>Interview with a second MA on 02/27/20 at 4:12pm revealed: -The pharmacy representative told the MA the pharmacy did not carry the size of the nutritional supplement that was ordered. -Resident #4 had not received the nutritional supplement since being admitted to the facility. -She talked with Resident #4's family member and was told the family member did not want Resident #4 to continue receiving the nutritional supplement. -She thought the nutritional supplement had been discontinued. -She had not contacted Resident #4's PCP about Resident #4's weight loss or the nutritional supplement.</p> <p>Interview with Resident #4's responsible party on 02/27/20 at 4:31pm revealed: -Resident #4 was provided a nutritional supplement at her former facility, but she had not had a nutritional supplement since she had been</p>	D 310		

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D 310	<p>Continued From page 9</p> <p>at the current facility.</p> <ul style="list-style-type: none"> -He did not know why Resident #4 was not being served a nutritional supplement and had not asked staff about the nutritional supplement. -He noticed Resident #4 had lost weight and asked staff what her current weight was in February 2020. <p>Interview with the Special Care Unit (SCU) Manager on 02/27/20 at 5:10pm revealed:</p> <ul style="list-style-type: none"> -MAs were responsible for sending orders to the pharmacy and following up with the pharmacy with any questions. -The order for the nutritional supplement for Resident #4 was sent to the pharmacy and there were questions regarding the order for nutritional supplement 237 ounces in the afternoon. -She did not know if the MA followed up with the pharmacy or Resident #4's PCP regarding the nutritional supplement. <p>Interview with the Administrator on 02/27/20 at 4:08pm revealed:</p> <ul style="list-style-type: none"> -MAs were responsible for ensuring medication orders were faxed to the pharmacy. -There had been a question about how much of the nutritional supplement to serve to Resident #4 and a MA reached out to the facility contracted pharmacy. -The facility contracted pharmacy never got back with the MA regarding the nutritional supplement. -The MA was responsible for following up with the pharmacy regarding the nutritional supplement. -She did not know if there had been any further follow-up with the pharmacy or Resident #4's PCP regarding the nutritional supplement for Resident #4. <p>Interview with Resident #4's primary care physician on 02/27/20 at 3:47pm revealed:</p>	D 310		

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D 310	<p>Continued From page 10</p> <ul style="list-style-type: none"> -A nurse practitioner (NP) was Resident #4's primary care provider (PCP). -The order for the nutritional supplement came with Resident #4 when she was admitted to the facility. -He did not see an order to discontinue the nutritional supplements for Resident #4. -He did not see any documentation regarding a nutritional supplement or issues with weight loss. -The nutritional supplement would have assisted with preventing weight loss if the weight loss was age related. <p>Interview with Resident #4's NP on 01/27/20 at 4:20pm revealed:</p> <ul style="list-style-type: none"> -Resident #4 was admitted to the facility with an FL2 completed by another facility. -She had not written the order for nutritional supplements and had not written an order to discontinue the nutritional supplement for Resident #4. -She did not know Resident #4 was not being served a nutritional supplement and had a 12 pound weight loss in a month. -The facility had not notified her regarding the nutritional supplement or weight loss for Resident #4. -Not being served a nutritional supplement could have contributed to significant weight loss for Resident #4. -She would have expected the facility staff to contact her if there were questions regarding the order for a nutritional supplement for Resident #4. <p>The facility failed to serve Resident #4 a nutritional supplement daily as ordered contributing to a 12 lb weight loss within 1 month placing the resident at risk for increased significant weight loss. This failure was detrimental to the health, safety and welfare of</p>	D 310		

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D 310	Continued From page 11 the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/27/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 12, 2020.	D 310		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights 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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure every resident had the right to receive care and services which are adequate, appropriate and in compliance with relevant state laws and rules related to Nutrition and Food. The findings are: 1. Based on observations, record reviews and interviews, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 2 sampled residents (Resident #4) with physician's orders for a nutritional supplement. [Refer to Tag D0310 10A NCAC 13F .09049(e)(4) Nutrition and Food (Type B Violation)].	D912		

Policy

The community monitors weight and provides modified diets as ordered by the Physician/Prescribing Practitioner.

Procedure

- 1) The Assisted Living Director assigns the task of measuring resident weights to Resident Care Assistants (after appropriate training and verification of competency).
- 2) Weights are measured more often if ordered by the physician/prescribing practitioner.
- 3) Weight measurements are recorded in the resident's record on the Monthly Weight & Vital Signs Record (CS_301) which records the scale the resident is weighed upon.
- 4) If there is a weight change greater or less than 5 pounds since the resident's last weight, re-weigh the resident.
- 5) A weight change of 5% of body weight in a 30-day period, 7.5% in 90 days and 10% in six months notes a significant change and is reported to the physician/prescribing practitioner. Physician Notification of Weight Change (CS_302).
- 6) Nutritional supplements will be arranged for the resident as ordered by the physician/prescribing practitioner.
- 7) Modified diets will be provided as ordered by the physician/prescribing practitioner.
- 8) Residents with complex nutritional needs/diets will be reviewed for appropriateness of placement if they cannot self-manage their dietary needs. Consulting dietitians should be used to determine approaches to consider.
- 9) Assisted Living Director/Residential Care Coordinator will sign off review of all weights and subsequent documentation monthly.

March 20, 2020

RE: Plan of Correction for The Arboretum at Heritage Greens HAL041078

D 273

The Arboretum at Heritage Greens has in-serviced all MAs on our Nutrition and Weight policy 4-3.02 along with proper weight log completion and weight notification documents for overseeing physician.

Vitals have been added to MAR for weights to be entered electronically and monitored monthly by Memory Care Director and/or Assisted Living Director.

Please see included Policy 4-3.02 Nutrition and Weight

D 310

The Arboretum at Heritage Greens has in-serviced MAs on diet reconciliation and next steps when faxed with issues along with our Nutrition and Weight policy 4-3.02.

Diets will be maintained as ordered per prescribing physician.

Memory Care Director and/or Assisted Living Director will review and approve all orders weekly to verify accuracy.

Please see included Policy 4-3.02 Nutrition and Weight

D 912

In compliance with our policy on Nutrition and Weight (4-3.02), all residents will receive the proper nutritional supplements as ordered per prescribing physician. This will be monitored weekly by the Memory Care Director and/or the Assisted Living Director.

Please see included Policy 4-3.02 Nutrition and Weight