received 09/18/21

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034098	A. BUILDING: ______ B. WING ______	R 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(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 with a complaint investigation on August 18, 2021 through August 20, 2021 and exited via telephone on August 23, 2021.	D 000		9/20/21
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic menu for 2 of 7 sampled residents with a physician's order for a no added salt (NAS)/no concentrated sweets (NCS) diet (#1), and a NCS/mechanical soft (MS) diet (#8). The findings are: 1. Review of Resident #1's current FL2 dated 11/04/20 revealed: -Diagnoses included anemia, vitamin B-12 deficiency, anxiety disorder, breast cancer, depression, diabetes, high cholesterol, hypertension, lung cancer, chronic obstructive pulmonary disease, and stroke. -There was a diet order for a NAS/NCS diet. Review of Resident #1's diet order sheet dated 07/08/21 revealed an order for a NAS/NCS diet.	D 296	**D926 NUTRITION AND FOOD SERVICE** Dietary manager spoke with Dietician About getting new menus with combination Diets and spreadsheets matching the Therapeutic diets. New menus should be in Facility no later than 9/25/2021 Dietary manager will ensure that All menus are being used properly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Phillips	ADMINISTRATOR	9/18/2021

reviewed and acknowledged 9/20/21 Jo Scarlett

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Review of the therapeutic diet list posted in the kitchen dated 07/29/21 revealed Resident #1 was to be served a NAS/NCS diet.

Observation of the kitchen on 07/09/21 at 12:09pm revealed:
-There was a seven-day week-at-a-glance menu posted in the kitchen for Spring/Summer 2019.
-There were no therapeutic diet menus posted in the kitchen.
-The dietary manager pulled therapeutic menus from a notebook in the kitchen office.

Review of the facility's therapeutic menus for 08/18/21 (Day 11) revealed there was no menu for a NAS/NCS diet.

Review of the facility's regular menu for 08/18/21 (Day 11) revealed:
-The regular lunch meal scheduled for Day 11 consisted of chef's choice of meat, chef's choice of starchy vegetable, chef's choice of vegetable, fruit of choice, dinner roll, and margarine.
-The regular dinner meal scheduled for Day 11 consisted of salmon patty, rice pilaf, French style green beans, fruit cobbler, white or wheat roll, margarine, and milk.
-The facility swapped the lunch meal for the dinner meal on 08/18/21.
-The facility substituted the salmon patty with crab cake.

Observation of Resident #1's lunch meal service on 08/18/21 at 12:41pm revealed:
-Resident #1 was served crab cake, green beans, rice, roll, pears, sweet tea, and milk.
-Resident #1 ate her lunch meal in her room and it could not be determined how much of the meal she consumed.

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Based on observations, record reviews and interviews, it could not be determined if Resident #2 was served the appropriate diet due to there was no NAS/NCS menu available for staff guidance.

Interview with Resident #1 on 08/18/21 at 9:13am revealed:
-She was diabetic and was supposed to be on a "diabetic" diet.
-She did not think the facility served a "diabetic" diet.

Refer to interview with a cook on 08/19/21 at 12:27pm.

Refer to interview with the Dietary Manager (DM) on 08/20/21 at 3:33pm.

Refer to telephone interview with the registered dietician on 08/23/21 at 9:27am.

Refer to interview with the Administrator on 08/23/21 at 10:18am.

2. Review of Resident #8's current FL2 dated 01/21/21 revealed:
-Diagnoses included diabetes mellitus 2, hypertension, and hyperlipidemia.
-There was a diet order for a NAS/NCS/MS

Review of Resident #8's diet order sheet dated 07/08/21 revealed an order for a NCS/MS diet.

Review of the therapeutic diet list posted in the kitchen dated 07/29/21 revealed Resident #8 was to be served a NAS/NCS/MS diet.

Observation of the kitchen on 07/09/21 at

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D 296	Continued From page 3 12:09pm revealed: -There was a seven-day week-at-a-glance menu posted in the kitchen for Spring/Summer 2019. -There were no therapeutic diet menus posted in the kitchen. -The dietary manager pulled therapeutic menus from a notebook in the kitchen office. Review of Resident #8's signed physician's orders dated 07/08/21 revealed a diet order for a NAS/NCS/MS diet. Review of the facility's therapeutic menus for 08/18/21 (Day 11) revealed there was no menu for a NCS/MS diet or a NAS/NCS/MS diet. Review of the facility's regular menu for 08/18/21 (Day 11) revealed: -The regular lunch meal scheduled for Day 11 consisted of chef's choice of meat, chef's choice of starchy vegetable, chef's choice of vegetable, fruit of choice, dinner roll, and margarine. -The regular dinner meal scheduled for Day 11 consisted of salmon patty, rice pilaf, French style green beans, fruit cobbler, white or wheat roll, margarine, and milk. -The facility swapped the lunch meal for the dinner meal on 08/18/21. -The facility substituted the salmon patty with crab cake. Observation of Resident #8's lunch meal service on 08/18/21 at 12:38pm revealed: -Resident #8 was served crab cake, green beans, rice, roll, pears. -Resident #8 had his own diet soda. -Resident #8 ate his lunch meal in his room and it could not be determined how much of the meal he consumed.	D 296		

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Based on observations, record reviews and interviews, it could not be determined if Resident #2 was served the appropriate diet due to there was no NAS/NCS/MS menu or NCS/MS menu available for staff guidance.

Interview with Resident #8 on 08/19/21 at 12:38pm revealed:
-He had diabetes, but he did not know if he was on a special diet for his diabetes.
-He did not add salt to his food and did not know if the staff cooked with salt.
-His meats were usually ground up because he did not have any teeth.

Refer to interview with a cook on 08/19/21 at 12:27pm.

Refer to interview with the Dietary Manager (DM) on 08/20/21 at 3:33pm.

Refer to telephone interview with the registered dietician on 08/23/21 at 9:27am.

Refer to telephone interview with the Administrator on 08/23/21 at 10:18am.

Interview with a cook on 08/19/21 at 12:27pm revealed:
-The facility did not have menus for combination diet orders such as NAS/NCS, NAS/MS, NCS/MS, or MS/NAS/NCS.
-There were residents in the facility who had combination diet orders.
-If a resident's diet order was NAS/NCS, she served the resident according to the NCS menu.
-If a resident's diet order was NAS/MS or NCS/MS, she served the resident according to the MS menu.
-She had not been given any guidance on how to

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serve residents with combination diet orders.

Interview with the Dietary Manager (DM) on 08/20/21 at 3:33pm revealed:
-There were no therapeutic menus for residents who were on combination diets such as NAS/NCS, NAS/MS, NCS/MS, or NAS/NCS/MS.
-There was no other guidance for how to serve residents who had combination diets.
-If a resident had diet orders for a MS diet along with a NAS or NCS, she served the resident the MS diet.
-If a resident had diet orders for a NCS along with NAS, she served the resident a NCS diet because the residents could not have sweets and the only difference with a NAS was the residents could not add salt at the table.
-She did not know who was responsible for making sure the facility had a matching therapeutic menu for residents with combination diets.

Telephone interview with the registered dietician on 08/23/21 at 9:27am revealed:
-Generally, the company she worked for did not create menus for combination diets.
-The menus would be changing in about 4 months to include combination diets.
-It was the responsibility of the facility to contact her if there was a diet needed that was not on the menu.
-If the facility had contacted her about the need for combination diet menus, she would have adjusted the menus.

Interview with the Administrator on 08/23/21 at 10:18am revealed:
-She knew residents who had combination diets should have a matching therapeutic menu.
-She did not know the facility did not have menus

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D 296	Continued From page 6 for combination diets including NAS/NCS, NAS/MS, NCS/MS, and NAS/NCS/MS. -She did not know what the dietary staff used as a guide when serving residents who had combination therapeutic diets. -The DM was responsible for contacting the registered dietician regarding menus for therapeutic diets.	D 296		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 8 ounces of milk was served twice daily to residents on the Special Care Unit (SCU). The findings are: Observation of the walk-in refrigerator in facility kitchen on 08/18/21 at 12:12pm revealed: -There were 5 gallons of whole milk and 2.5 boxes of 2% and whole milk in 8-ounce cartons. -Each full box contained 48 milk cartons.	D 299	**D299 NUTRITION AND FOOD SERVICE** The dietary manager will order extra milk Beverages to ensure that the floor staff has Enough to provide each resident at each meal Daily. Management will make sure that floor Staff Serves milk at each meal daily.	8/25/21

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Review of the facility's week-at-a-glance menu for 08/15/21 through 08/21/21 (Day 8 through Day 14) revealed:
-Milk was to be served at the breakfast and dinner meals.
-There was no beverage listed for the lunch meal.

Observation of the lunch meal service in the Special Care Unit (SCU) on 08/18/21 between 12:00pm and 12:30pm revealed:
-There were 19 residents in the family room for the breakfast meal service.
-There were 8-ounce cartons of milk in ice on the beverage cart, but milk was not served to all 19 residents present in the family room.

Observation of the breakfast meal service in the SCU on 08/19/21 between 8:12am and 8:30pm revealed:
-There were 16 residents in the family room at 8:12am for the breakfast meal service and only 1 resident had milk.
-There were 8 eight-ounce milk cartons in a bowl of ice on the beverage tray outside of the family room.
-One resident was served milk at 8:28am.
-Another resident was served milk at 8:32am.
-No other residents in the family room were offered or served milk.

Interview with 2 SCU residents on 08/19/20 between 8:35am and 8:45am revealed:
-They were served milk with their cereal, but not in a cup to drink.
-One resident had to ask for milk if she wanted it.
-They liked milk and would drink it with each meal if it was served to them.

Telephone interview with a personal care aide

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D 299	Continued From page 8 (PCA) on 08/23/21 at 10:45am revealed: -Residents were served milk with all meals only if they wanted it. -There was enough milk on the beverage cart for all residents in the SCU. -When they took the beverage cart around, they asked the residents which beverage they wanted. Telephone interview with another PCA on 08/23/21 at 10:51am revealed: -Her duties included serving meals and beverages to residents on the SCU during her shift. -Juice, water, milk, and coffee were on the beverage cart for residents during the breakfast meal. -Tea, water, and milk were on the beverage cart for residents during lunch and dinner. -Staff asked residents if they wanted milk with their meal. -Not every resident wanted milk, so it was served to those who requested it. Telephone interview with the SCU Coordinator on 08/23/21 at 10:59am revealed: -Milk was served with breakfast and lunch in the SCU. -Milk was not automatically placed on the table for residents, but staff asked the residents if they wanted milk. -There was a census of 43 residents in the SCU and about 25 residents drank milk regularly. Interview with the Administrator on 08/19/21 at 12:17am revealed: -Staff offered milk to all residents in the SCU with all meals, but not all residents drank milk. -Enough milk was pulled from the refrigerator for those residents who staff knew would drink milk so that it would not be wasted.	D 299		

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D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure water was served, in addition to other beverages, to each resident in the Special Care Unit (SCU). The findings are: Review of the facility's menus for regular diets revealed water was not listed on the menu. Observation of the lunch meal service in the SCU on 08/18/21 between 12:00pm and 12:30pm revealed: -There were 19 residents present in the family room for the lunch meal service. -Two residents had been served water. Observation of the breakfast meal service in the SCU on 08/19/21 between 8:12pm and 8:32pm revealed: -There were 16 residents present in the family room for the breakfast meal service. -No residents had been served water. Interview with 2 residents on 08/19/21 between 8:35am and 8:45am revealed:	D 306	**D306 NUTRITION AND FOOD SERVICE** Dietary staff will make sure that each beverage Cart that goes to each hall has multiple pitchers Of water, and enough cups to ensure that each Resident is given water at every meal daily. Floor staff will serve the water To each resident at each meal Daily. The coordinator will audit This process on a weekly basis.	8/23/21

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D 306	Continued From page 10 -They were sometimes served water, but not with each meal. -Staff usually served them tea, juice, or coffee. -They liked water and would drink it with each meal if served to them. Telephone interview with a personal care aide (PCA) on 08/23/21 at 10:45am revealed: -She worked in the SCU and served meals and beverages to residents in the SCU. -Staff asked residents at each meal if they wanted water. -Water was not served unless requested. -Water was available to residents throughout the day. Telephone interview with another PCA on 08/23/21 at 10:51am revealed: -Water was available for residents on the SCU for breakfast, lunch, and dinner. -Staff asked residents at meals if they wanted water with their meals. -Most residents wanted water with their meals, but some residents did not want water. Telephone interview with the SCU Coordinator on 08/23/21 at 10:59am revealed: -All SCU residents should be served water with each meal. -She did not know all residents were not served water during the lunch meal service on 08/18/21 and the breakfast meal service on 08/19/21. Telephone interview with the Administrator on 08/23/21 at 10:18am revealed water should be offered to each resident with each meal.	D 306		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	D 310		

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D 310	Continued From page 11 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: Based on observations, record reviews and interviews, the facility failed to serve therapeutic diets as ordered by the physician for 1 of 7 sampled residents with a diet order for no concentrated sweets (NCS) with double protein/meat at all meals, a half meat sandwich at bedtime, and limit dietary intake of sodium, potassium, and phosphorus. The findings are: Review of Resident #7's current FL2 dated 04/21/21 revealed: -Diagnoses included type 2 diabetes, hypertension, colostomy, and neurogenic bladder. -There was a diet order for a no concentrated sweets (NCS) diet with double proteins. -There was an order to limit dietary intake of sodium, potassium, and phosphorus. Review of Resident #7's diet order dated 04/21/21 revealed: -Resident #7 was to be served a NCS diet with double protein/meat at all meals. -Resident #7 was to be served a half meat sandwich at bedtime. -Resident #7 was to be served a limited dietary	D 310	**D310 NUTRITION AND FOOD SERVICE** Dietary manager will ensure that resident Gets extra protein at all meals. And half of Meat sandwich nightly. Dietary staff will Limit sodium, potassium, and phosphorus At all meals. Dietary manager will order low Sodium soups and other low sodium foods as Required by residents diet, and as needed. Dietary manager and RCD will Audit this process on a weekly Basis.	8/23/21

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intake of sodium, potassium, and phosphorus.

Review of documentation from the registered dietician (RD) at Resident #7's dialysis center dated 07/14/21 revealed:
-The RD recommended Resident #7 limit dietary intake of sodium, potassium, phosphorus.
-The RD recommended Resident #7 be served one half a meat sandwich at bedtime.
-The RD recommended double protein/meat at all meals.

Review of the facility's therapeutic diet menus revealed:
-There was a menu for a liberal renal diet.
-There was no guidance specifically for limiting dietary intake of sodium, potassium, and phosphorus for any of the breakfast, lunch, or supper meals.

Review of a "Sack Lunch Ideas for Dialysis" document provided by Resident #7's dialysis center revealed:
-The sack lunch ideas consisted of a diet high in protein, low in sodium, low in phosphorus, and low in potassium.
-There was a list of good choices for snacks to send with Resident #7 when she attended the dialysis center.
-There was a list of snacks to avoid sending with Resident #7 when she attended the dialysis center.
-There was no guidance for serving Resident #7 breakfast, lunch, or dinner.

Observation of Resident #7's dinner meal on 08/20/21 at 5:25pm revealed Resident #7 was served lasagna, carrots, pears, and a bread stick.

Interview with Resident #7 on 08/20/21 at 4:36pm

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SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

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D 310	Continued From page 13 revealed: -She attended her dialysis center 3 days per week. -She was on a "diabetic" diet, received double meat with her meals, and a half sandwich in the evenings. -She knew there were certain foods she was not able to eat due to her being on dialysis treatments. -She knew she could not have dairy, tomatoes, peanut butter, potatoes, baked beans, and pintos. -Her phosphorus had been high at one time, but her binder medications were adjusted, and her phosphorus levels were no longer high. -She sometimes ate tomatoes, cheese, and other food items she knew she was not supposed to have. Interview with a cook on 08/20/21 at 12:27pm revealed: -The facility offered regular, NCS, and NAS diets. -When she cooked, she prepared Resident #7 a NCS diet with double meat. -Resident #7 was also served a half sandwich at night. -She did not use any other menu or guidance when she prepared Resident #7's meals. -There was a sheet that Resident #7's dialysis center sent to the facility that listed food Resident #7 could not have for snacks, but she only used the information on the sheet as guidance to prepare snacks to send with Resident #7 when she went to the dialysis center. Interview with the RD at Resident #7's dialysis center revealed: -It was recommended for Resident #7 to limit her dietary intake of sodium, potassium, and phosphorus. -She had talked to facility staff about Resident	D 310		

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#7's diet in the past.
-Resident #7's phosphorus levels had been high, but her labs this month were within range.

Interview with the dietary manager (DM) on 08/20/21 at 3:33pm revealed:
-When she prepared meals for Resident #7, she used the NCS menu.
-Resident #7 also received double meat portions and a half sandwich at bedtime.
-There was no guidance for serving Resident #7 limited sodium, limited potassium, and limited phosphorus.
-The facility did not offer a liberal renal diet.
-She knew there were certain food items Resident #7 could not have because of the list Resident #7's dialysis center's RD sent to the facility for preparing her snacks on dialysis days.
-The list was kept pinned to the wall at the back of a stack of papers.
-The only food items she could think of that Resident #7 could not have were bananas and certain potatoes.

Interview with Resident #7's PCP on 08/23/21 at 2:46pm revealed:
-She has been filling in for Resident #7's regular PCP for about 1 month.
-She did not remember if she has seen Resident #7 or not.
-She would expect for the facility to follow the dietary recommendations of Resident #7's dialysis center and of resident #7's regular PCP.

Interview with Administrator on 08/23/21 at 10:18am revealed:
-She did not know what the kitchen staff used for guidance for limiting Resident #7's dietary intake of sodium, potassium, and phosphorus.
-Limiting Resident #7's dietary intake of sodium,

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D 310	Continued From page 15 potassium, and phosphorous was just a recommendation of the RD at Resident #7's dialysis center. -Facility staff tried to talk to Resident #7 about eating certain foods, but she ordered take out foods every day. -Resident #7's family and friends also provided food items for her.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 7 sampled residents (#1, #2, and #3) including a medication used to treat chest pain, a topical medication used to decrease pain, and a medication used to treat constipation (Resident #2), a medication used to prevent yeast infections (Resident #3), and an oral medication used to treat pain (Resident #1). The findings are: 1. Review of Resident #2's current FL2 dated 04/22/21 revealed diagnoses included Alzheimer's dementia, hypertension, coronary	D 358	**D 358 Medication Administration** Resident Care Management and Staff was educated by the Administrator on Physician Orders & Medication Administration. All Med Aides will complete all necessary steps when passing our medications. They will compare the MAR to the medication in the cart related to strength, dosage, instructions including timing for administering the medication. Staff was instructed to call the residnets personal physician if they are unsure of an order to get clarification. Documentation on the process will be completed prior to the end of the shift. Documentation to include medication in question, name of physician and name of physicians representative if applicable If medication is missed during this time period, Med Aide will follow procedure for Physician Notification of Missed or Refused Medication Physician will be notified immediately if there is a change in the Resident's status or if the medication is unavailable to the resident. Coordinator and RCD will audit And make sure this process is Being followed.	8/25/21

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artery disease, hyperlipidemia, diabetes mellitus type II, and a history of a coronary artery bypass graft.

a. Review of Resident #2's current FL2 dated 04/22/21 revealed there was an order for nitroglycerin (used to treat chest pain) 0.4 mg as needed for chest pain, dissolve 1 tablet under the tongue, may repeat up to two times for a total of 3 doses.

Observation of Resident #2's medication on hand on 08/19/21 at 4:03pm revealed she had a bottle of nitroglycerin 0.4mg on hand and in date.

Review of Resident #2's electronic medication administration record (eMAR) for June 2021 revealed:
-There was an entry for nitroglycerin 0.4 mg dissolve 1 tablet under the tongue every 5 minutes as needed for chest pain up to 3 doses.
-There was no documentation that nitroglycerin 0.4mg had been administered when the resident complained of chest pain.

Review of Resident #2's incident report dated 06/22/21 revealed the resident complained of chest pain and was sent to the local emergency room (ER) at 12:00pm.

Review of Resident #2's after visit summary from the local ER dated 06/22/21 revealed:
-The reason for the resident's visit was chest pain.
-The resident had a diagnosis of chest wall pain, atypical chest pain, and hypertension.

Interview with Resident #2 on 08/20/21 at 12:45 revealed:
She sometimes had chest pain.

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D 358	Continued From page 17 She did not recall going to the hospital for chest pains. -She did not know if she was administered any medication to help chest pain. Interview with a medication aide (MA) on 08/20/21 at 3:37pm revealed: -She had administered nitroglycerin to Resident #2 in the past when she complained of chest pains. -She worked with Resident #2 on 06/22/21 when the resident had chest pains. -She knew Resident #2 had an order for nitroglycerin as needed for chest pain. -She did not administer Resident #2's nitroglycerin on 06/22/21 because the resident was talking to her granddaughter on the phone and the granddaughter had already called 911. -She just did not think about giving the nitroglycerin. Telephone interview with the primary care provider (PCP) on 08/23/21 at 2:50pm revealed: -She had only been at the facility a month, so she really did not know Resident #2 that well. -Nitroglycerin was used to treat chest pain. -The nitroglycerin should have been administered as ordered. -Resident #2 could have increased chest pain if the nitroglycerin was not administered as ordered. -She expected staff to administer nitroglycerin as ordered before calling 911 to help decrease hospitalizations. Telephone interview with a nurse practitioner from Resident #2's Cardiologist on 08/23/21 revealed: -Resident #2 was on nitroglycerin as needed because she had open heart surgery many years ago.	D 358		

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-There was no way to know if nitroglycerin would have helped Resident #2 and prevent her from going to the ER, if it had been administered.
-She expected for nitroglycerin to be administered as ordered when Resident #2 had chest pain.

Interview with the Memory Care Unit Coordinator (MCUC) on 08/20/21 at 12:50pm revealed:
-Around lunch time on 06/22/21 Resident #2 was speaking to her granddaughter and rubbing her chest.
-Resident #2 told the MA she was having chest pain.
-She did not know Resident #2 was not administered her nitroglycerin for chest pain.
-All staff knew she had an order for nitroglycerin as needed for chest pain because she had been there a long time.
-She did not recall if she had instructed her step by step on administering Resident #2's nitroglycerin but she always reiterated to review the eMARs and check for orders.
-The facility policy was to administer nitroglycerin per the order.

Interview with the Administrator on 08/20/21 at 5:00pm revealed:
-On 06/22/21, Resident #2 had borrowed another residents cell phone to call her granddaughter because she was having chest pains.
-Resident #2's granddaughter called 911 for the resident.
-She did not know the MA did not administer her nitroglycerin.
-She expected Resident #2 to be administered her nitroglycerin even if 911 had been called.

Attempted telephone interview with Resident #2's family member on 08/20/21 at 12:55 was unsuccessful.

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b. Review of Resident #2's current FL2 dated 04/22/21 revealed there was an order for diclofenac sodium (used to treat pain) 1% apply 4 grams topically three times per day.

Review of Resident #2's eMAR for June 2021 revealed:
-There was an entry for diclofenac sodium 1% apply 4 grams topically three times a day scheduled for 9:00am, 3:00pm, and 9:00pm.
-There was documentation all doses had been administered for 9:00am, 3:00pm, and 9:00pm from 06/01/21 to 06/30/21 except 2 doses while she was at the ER on 06/22/21.

Review of Resident #2's MAR for July 2021 revealed:
-There was an entry for diclofenac sodium 1% apply 4 grams topically three times a day scheduled for 9:00am, 3:00pm, and 9:00pm.
-There was documentation the resident had refused all 3 doses of diclofenac sodium on 07/18/21 and a 9:00pm dose on 07/30/21.
-All other doses had been documented as administered.

Review of Resident #2's eMAR for August 2021 revealed:
-There was an entry for diclofenac sodium 1% apply 4 grams topically three times a day scheduled for 9:00am, 3:00pm, and 9:00pm.
-There was documentation all doses had been administered for 9:00am, 3:00pm, and 9:00pm from 08/01/21 to 08/17/21.

Observation of Resident #2's medication on hand on 08/19/21 at 4:03pm revealed:
-There were 2 tubes of diclofenac sodium 1% on the cart.

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D 358	Continued From page 20 -One was dispensed on 11/12/20 and remained new in the box. -The second one had a dispense date of 02/08/21 and had only been used one time. Interview with Resident #2 on 08/20/21 at 12:45 revealed: -She sometimes had leg pain. -She did not know if she was administered any medication to help her leg pain. Telephone interview with a representative from the facility's contracted pharmacy on 08/20/21 at 1:24pm revealed: -Resident #2 had an order for diclofenac sodium 4g to be administered topically 3 times a day. -Resident #2 used the diclofenac sodium for pain. -Diclofenac sodium 200g was dispensed on 02/08/21 and should have lasted for 28 days if applied as ordered. -Diclofenac sodium 200g was dispensed on 05/21/21 and should have lasted for 28 days if applied as ordered. -Diclofenac sodium 100g was dispensed on 08/19/21 and should have last for 2 weeks if applied as ordered. -There would not have been enough diclofenac sodium dispensed for Resident #2 to have been administered 4g three times a day. -The facility was responsible for requesting refills. Interview with a MA on 08/20/21 at 4:10pm revealed: -She had administered Resident #2's medications including diclofenac sodium. -She tried to keep an even bead as she used the measuring tool. -She believed she administered it correctly. Interview with the MCUC on 08/20/21 at 3:47pm	D 358		

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revealed:
-She believed the issue with the diclofenac sodium was that MAs thought they were only supposed to apply a thin line and not a regular strip, thereby making the dose inconsistent.
-She had only observed one MA preparing the diclofenac sodium to administer.
-The line that the MA had applied to the measuring device was inconsistent from thick to thin.
-She demonstrated to the MAs how to squeeze out the diclofenac sodium onto the measuring device using a full bead strip to equal 4g.
-She expected all medication to be administered as ordered.

Interview with the Administrator on 08/20/21 at 5:00pm revealed:
-She did not know medication was not being administered as ordered.
-She thought the MAs would have contacted her or asked someone else if they did not understand how to squeeze out the diclofenac sodium on the measuring device.
-She expected medications to be administered as ordered.

Telephone interview with a second medication aide (MA) on 08/23/21 at 10:21am revealed:
-She had administered Resident #2's medications, including diclofenac sodium.
-Resident #2 used the diclofenac sodium on her thighs for pain.
-The diclofenac sodium had a measuring device in the box.
-She squeezed a thin line onto the measuring stick for 4g.
-She then scraped it off into a medication cup.
-She wore gloves when she administered the diclofenac sodium on Resident #2's thighs.

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D 358	Continued From page 22 Telephone interview with the primary care provider (PCP) on 08/23/21 at 2:50pm revealed: -She had only been at the facility a month, so she really did not know Resident #2 that well. -Diclofenac sodium is a topical gel used to treat pain. -The diclofenac sodium should have been administered as ordered. -Resident #2 could have increased pain if the diclofenac sodium was not administered as ordered. -She expected staff to administer diclofenac sodium as ordered. Attempted telephone interview with Resident #2's family member on 08/20/21 at 12:55 was unsuccessful. c. Review of Resident #2's current FL2 dated 04/22/21 revealed there was an order for polyethylene glycol (used to treat constipation) 17g in 8 ounces of water or juice daily. Review of Resident #2's eMAR for June 2021 revealed: -There was an entry for polyethylene glycol 17g in 8 ounces of water or juice daily scheduled for 9:00am. -There was documentation all doses had been administered for 9:00am from 06/01/21 through 06/30/21. Review of Resident #2's MAR for July 2021 revealed: -There was an entry for polyethylene glycol 17g in 8 ounces of water or juice daily scheduled for 9:00am. -There was documentation all doses had been administered for 9:00am from 07/01/21 through	D 358		

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07/30/21 except on 07/18/21 when the resident refused.

Review of Resident #2's eMAR for August 2021 revealed:
-There was an entry for polyethylene glycol 17g in 8 ounces of water or juice daily scheduled for 9:00am.
-There was documentation all doses had been administered for 9:00am from 08/01/21 through 08/17/21.

Observation of Resident #2's medication on hand on 08/19/21 at 4:03pm revealed there was no polyethylene glycol on hand to administer to Resident #2.

Interview with Resident #2 on 08/20/21 at 12:45 revealed she did not know if she took any medication for constipation.

Telephone interview with a representative from the facility's contracted pharmacy on 08/20/21 at 1:24pm revealed:
-Resident #2 had an order for polyethylene glycol 17g in 8 ounces of water or juice daily to be administered daily.
-Resident #2 used the polyethylene glycol for constipation.
-Polyethylene glycol 510g was dispensed on 02/08/21 and should have lasted for 30 days if administered as ordered.
-Polyethylene glycol 510g was dispensed on 05/21/21 and should have lasted for 30 days if administered as ordered.
-Polyethylene glycol 255g was dispensed on 08/19/21 and should last for 2 weeks if administered as ordered.
-There would not have been enough polyethylene glycol dispensed for Resident #2 to have been

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administered 17g daily.
-The facility was responsible for requesting refills.

Interview with a MA on 08/20/21 at 4:10pm revealed:
-She had administered Resident #2's medications including polyethylene glycol.
-She was not sure how much 17g of polyethylene glycol was.
-She was not sure if she administered it correctly.
-She had not asked anyone for help with measuring 17g of polyethylene glycol.

Interview with the MCUC on 08/20/21 at 3:47pm revealed:
-She believed the issue with the polyethylene glycol was that MAs were not pouring a full cap full to equal 17g.
-She had only observed one MA preparing the polyethylene glycol to administer and she poured it correctly.
-If MAs did not understand how much to administer, they should have asked.
-She expected all medication to be administered as ordered.

Interview with the Administrator on 08/20/21 at 5:00pm revealed:
-She did not know medication was not being administered as ordered.
-She thought the MAs would have contacted her or asked someone else if they did not understand how to pour polyethylene glycol in a cap.
-She expected medications to be administered as ordered.

Interview with a second medication aide (MA) on 08/23/21 at 10:21am revealed:
-She had administered Resident #2's medications, including polyethylene glycol.

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-She poured about a half capful and then transferred it to a cup.
-She administered "about 10 cc in a cup" (approximately half a dose) and mixed it with water or juice.
-She had never been instructed on how to measure 17g of polyethylene glycol.
-The pharmacy representative or the MCUC should in-service the MAs on how to measure polyethylene glycol.

Telephone interview with the primary care provider (PCP) on 08/23/21 at 2:50pm revealed:
-She had only been at the facility a month, so she really did not know Resident #2 that well.
-Polyethylene glycol was used to treat constipation.
-The polyethylene glycol should have been administered as ordered.
-Resident #2 could have increased constipation if the polyethylene glycol was not administered as ordered.
-She expected staff to administer polyethylene glycol as ordered.

Attempted telephone interview with Resident #2's family member on 08/20/21 at 12:55 was unsuccessful.

2. Review of Resident #3's current FL2 dated 10/28/20 revealed diagnoses included Alzheimer's, hypertension, cardiovascular disease, depression, neuropathy, gastroesophageal reflux disorder, and seizures.
-There was an order for acetic acid 0.25% apply 120 ml weekly.

Review of Resident #3's eMAR for June 2021 revealed:
-There was an entry for acetic acid 0.25%

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D 358	Continued From page 26 irrigation solution apply 120 ml weekly for perineum care, scheduled for 8:00am. -There was documentation all doses had been administered at 8:00am from 06/01/21 through 06/30/21. Review of Resident #3's MAR for July 2021 revealed: -There was an entry for acetic acid 0.25% irrigation solution apply 120 ml weekly for perineum care, scheduled for 8:00am. -There was documentation all doses had been administered at 8:00am from 07/01/21 through 07/31/21. Review of Resident #3's eMAR for August 2021 revealed: -There was an entry for acetic acid 0.25% irrigation solution apply 120 ml weekly for perineum care, scheduled for 8:00am. -There was documentation all doses had been administered at 8:00am from 08/01/21 through 08/12/21. Observation of Resident #3's medication on hand on 08/20/21 at 9:55am revealed: -There was one full unopened bottle of acetic acid 0.25% 250 ml. -The acetic acid had a dispense date of 11/18/20. Interview with Resident #3 on 08/20/21 at 1:05 revealed she did not know what medications she took. Telephone interview with a representative from the facility's contracted pharmacy on 08/20/21 at 1:24pm revealed: -Resident #3 had an order for acetic acid 0.25% irrigation solution apply 120 ml weekly for perineum care.	D 358		

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D 358	Continued From page 27 -Resident #3 used the acetic acid 0.25% irrigation solution apply 120 ml weekly for perineum care to help prevent yeast infections. -Acetic acid 0.25% irrigation solution 250 ml was dispensed on 11/18/20 and should have lasted for 2 doses with 10ml left over, if administered as ordered. -Acetic acid 0.25% irrigation solution 250 ml was dispensed on 02/14/21 and should have lasted for 2 doses with 10ml left over, if administered as ordered. -Acetic acid 0.25% irrigation solution 250 ml was dispensed on 03/19/21 and should have lasted for 2 doses with 10ml left over, if administered as ordered. -Acetic acid 0.25% irrigation solution 250 ml was dispensed on 05/16/21 and should have lasted for 2 doses with 10ml left over, if administered as ordered. -Acetic acid 0.25% irrigation solution 250 ml was dispensed on 08/19/21 and should have lasted for 2 doses with 10ml left over, if administered as ordered. -There would not have been enough acetic acid dispensed for Resident #3 to have been administered 120 ml weekly. -The facility was responsible for requesting refills. Interview with the MCUC on 08/20/21 at 3:47pm revealed: -She believed the issue with the acetic acid was that MAs were not pouring 120 ml. -If MAs did not understand how much to administer, they should have asked. -She expected all medication to be administered as ordered. Interview with the Administrator on 08/20/21 at 5:00pm revealed: -She did not know medication was not being	D 358		

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administered as ordered.
-She thought the MAs would have contacted her or asked someone else if they did not understand how much acetic acid wash to administer.
-She expected medications to be administered as ordered.

Interview with a medication aide (MA) on 08/23/21 at 10:21am revealed:
-She had administered Resident #3's medications but not her acetic acid wash.
-She used the acetic acid as a vaginal wash to decrease itching and to help prevent a yeast infection.
-Resident #3 usually used her acetic acid when she got her bath of the afternoon or evening.

Telephone interview with the primary care provider (PCP) on 08/23/21 at 2:50pm revealed:
-She had only been at the facility a month, so she really did not know Resident #3 that well.
-She did not know why Resident #3 used acetic acid.
-She expected staff to administer acetic acid as ordered.

Attempted telephone interview with Resident #3's family member on 08/23/21 at 9:24am was unsuccessful.

3. Review of Resident #1's current FL2 dated 11/04/20 revealed:
-Diagnoses included anemia, breast cancer, lung cancer, chronic obstructive pulmonary disease, stroke, and muscle joint and bone problems.
-There was an order for oxycodone 5 mg 1 tablet four times daily.

Review of Resident #1's signed physician's orders dated 05/05/21 revealed an order for

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oxycodone 5 mg 1 tablet four times daily.

Review of Resident #1's electronic medication administration record (eMAR) for June 2021 revealed:
-There was an entry for oxycodone 5mg 1 tablet 4 times daily scheduled for administration at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was no documentation oxycodone was for 8 of 120 opportunities between 06/01/21 and 06/30/21.
-There was documentation oxycodone was not administered due to "waiting on hard script" and "waiting on pharmacy."
-There was documentation that 7 doses of oxycodone were administered between 06/11/21 and 07/14/21 which were on the same days there was documentation "waiting on hard script."

Review of Resident #1's eMAR for August 2021 revealed:
-There was an entry for oxycodone 5 mg 1 tablet 4 times daily.
-There was no documentation oxycodone was administered for 4 of 70 opportunities between 08/01/21 and 08/18/21.
-There was documentation oxycodone was not administered due to "waiting on hard script" and "waiting on meds from the pharmacy."

Observation of Resident #1's medications available for administration on 08/19/21 at 9:27am revealed:
-There was a bubble pack of oxycodone 5mg 1 tablet 4 times daily.
-The pharmacy label indicated 180 tablets were dispensed on 08/18/21.
-There was a quantity of 116 tablets remaining.

Interview with a representative from the facility

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D 358	Continued From page 30 contracted pharmacy on 08/18/21 at 4:53pm revealed: -Resident #1 had an active order for oxycodone 5mg 1 tablet 4 times daily. -Each time the pharmacy filled oxycodone for Resident #1, they also faxed the facility a notification for a refill request. -The pharmacy could only dispense oxycodone every 30 days unless there was a request for an emergency 3-day supply. -The 3-day supply of oxycodone would have to be approved by the prescriber of the medication. -If the facility sent over the request to fill oxycodone prior to the end of the 30 days, the pharmacy would hold the completed request to fill the oxycodone until it was time for it to be dispensed. -Oxycodone was dispensed on 05/11/21 with a quantity of 120 tablets for a 30-day supply. -On 06/10/21, a pharmacy representative faxed the facility a notification to obtain a hard script, but the hard script was not received at the pharmacy until 06/15/21. -Oxycodone was dispensed on 06/15/21 with a quantity of 120 tablets for a 30-day supply. -Oxycodone was dispensed on 07/09/21 with a quantity of 120 tablets for a 30-day supply. -The facility faxed a request to the pharmacy for a 3-day supply of oxycodone on 08/14/21. -Oxycodone was dispensed on 08/14/21 with a quantity of 12 tablets for a 3-day supply. -Oxycodone was dispensed on 08/18/21 with a quantity of 120 tablets for a 30-day supply. Interview with Resident #1 on 08/20/21 at 3:21pm revealed: -She was prescribed oxycodone for pain in her spine. -There were times when she needed oxycodone and the facility did not have the medication to	D 358		

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administer.
-When the facility was out of oxycodone, they gave her acetaminophen instead, but the acetaminophen did not help with the pain in her spine.

Interview with a medication aide (MA) on 08/20/21 at 3:00pm revealed:
-The MAs were responsible to reorder medications for the residents before the residents ran out of medication.
-The pharmacy had a shaded blue reorder point on residents' medication bubble cards that indicated to reorder when the medication card had 10 tablets remaining.
-MAs were supposed to look at residents' medications on the medication carts and ensure residents had an adequate supply to administer medications as ordered even on weekends.
-If a resident had medication ordered for 4 times a day, the medication should be ordered when 4 or 5-day supply was left not necessarily when 10 tablets were left.
-She knew Resident #1 ran out of her oxycodone 5mg in May 2021 and June 2021 and had to wait a few days before the pharmacy sent the medication.
-She had informed the lead MA that the resident was out of medication when the resident ran out.

Interview with a lead Supervisor/medication aide (S/MA) on 08/20/21 at 4:00pm revealed:
-The medication aides were responsible to reorder residents' medications.
-Residents' medications were routinely packaged in a bubble card which had a suggested reorder point on the bubble card.
-The reorder point was shaded with a blue background and was routinely when 10 tablets of the medication remained.

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D 358	Continued From page 32 -Residents receiving one tablet daily would have a 10-day supply before the medication ran out. -Residents receiving medication 4 times a day would only have 2.5 days of medication remaining if the medication was reordered according to the shaded area of the card. -Resident #1's oxycodone 5mg was ordered 4 times a day, and it needed a new "hard copy" (physician's signed order) from the provider each time it was filled by the pharmacy. -Medications requiring a 'hard copy" were reordered by the facility; the pharmacy would send a response stating a "hard copy" order was required and a document (request) for the facility to fax to the provider in the next order delivery; the facility was responsible to send the fax to the provider who in return completed the order and faxed back to the pharmacy for the medication to be filled and sent to the facility. -If the medication reorder was on Friday, the provider did not routinely respond until Monday, sending the order to the pharmacy on Monday, with the facility receiving the medication late on Monday or Tuesday. A resident would have been out of medication for 1 to 2 days by then. -Resident #1's primary care provider (PCP) was out on medical leave in May 2021. -The PCP's agency had a lag time of around 2 weeks for arranging a fill-in provider. -In the meantime, obtaining medications requiring "hard copy" orders were a problem. -Resident #1 was affected by the transition in May 2021. -The S/MA had been involved in requesting oxycodone 5mg refills for Resident #1 in May 2021 and June 2021, but the delay in the provider's response caused the resident to run out of pain medication. -The MAs could request a refill starting earlier than the 10 tablets if the MA recognized the	D 358		

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D 358	Continued From page 33 medication was more than once a day or if it was close to a weekend. Interview with the Resident Care Coordinator (RCC) on 08/20/21 at 4:03pm revealed: -The MA on duty when the medication bubble pack got down to the blue area was responsible for reordering the medication. -The facility was only able to receive a 30-day supply of oxycodone for Resident #1. -When the MAs contacted the PCPs office to get a new prescription for the oxycodone, a representative at Resident #1's PCP's office told them they would send the prescription to the pharmacy and they often did not send the prescription the same day. -The MAs should call the pharmacy to confirm the prescription was received. -Sometimes Resident #1's PCP did not write the new prescription for oxycodone until she came to the facility on Wednesdays. Telephone interview with the manager of the contracted pharmacy on 08/20/21 at 4:37pm revealed: -The facility was responsible to request medications requiring a "hard copy" earlier than 2 days prior to the medication running out in order to allow the process of notifying the prescriber of the need for a new "hard copy" order and receive and process the order. -The facility could request one-time per 60 days, an emergency 3-day supply of a "hard Copy" needed medication if there was a time when a resident was out of the medication and waiting on a new order. -The pharmacy received a request to refill oxycodone 5mg for Resident #1 on the day before the medication ran out on 05/08/21; the facility did not provide the pharmacy with a "hard	D 358		

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copy" for oxycodone with the request to refill it.
-The pharmacy dispensed oxycodone for Resident #1 on 05/11/21 after receiving a "hard copy" medication order from the provider.
-The pharmacy received a request to refill oxycodone 5mg for Resident #1 on the day before the medication ran out on 06/11/21; the facility did not provide the pharmacy with a "hard copy" for oxycodone with the request to refill it.
-The pharmacy dispensed oxycodone for Resident #1 on 06/15/21 after receiving a "hard copy" medication order from the provider.
-There was a problem contacting the resident's PCP in May 2021.
-The fill-in primary care provider took longer than usual to provide an order for Resident #1's oxycodone 5mg to the pharmacy in June 2021.

Interview with Resident #1's PCP on 08/19/21 at 10:14am revealed:
-She started working with Resident #1 about 1 month ago.
-She signed orders when she came in the facility on Wednesdays.
-She did not recall the facility telling her Resident #1 was out of oxycodone.
-The facility should have requested a "hard script" at least 3 to 4 days prior to running out of a medication.

Interview with the Administrator on 08/23/21 at 10:18am revealed:
-MAs were responsible for reordering medication when the bubble pack was down the blue line which was usually about a week before the medication ran out.
-The MAs sent a request to refill over to the pharmacy, and the pharmacy would reject the request indicating that a new prescription was needed.

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D 358	Continued From page 35 -The facility physician had been out on leave and there had been a delay in getting new prescription orders from the nurse practitioner who was filling in for the facility physician. -She knew Resident #1 was not administered medication in May 2021 due to the facility staff waiting on a new prescription from the PCP, but she did not know Resident #1 missed doses of medication in June 2021 and August 2021. -She expected medication to be administered as ordered.	D 358		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure all residents were treated with respect, consideration, and dignity related to meal service when residents were not provided tables for in-room dining or for use in the Special Care Unit (SCU) when dining in the family room, and serving residents' meals in foam containers and cups with plastic utensils. Observation of the lunch meal service on the Assisted Living (AL) side of the facility on 08/18/21 between 12:20pm and 12:45pm revealed: -All residents were served their meals in foam hinged containers and cups with plastic utensils. -Crab cakes, rice, green beans, a roll, and a beverage were served to residents.	D911	**D911. Declaration of Resident Rights** Resident Care Management and Resident Care Staff were instructed on Resident Rights. by the Administrator The State Ombudsman has been asked to come to do a formal in-service on Resident Rights.	9/1/21

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D911	Continued From page 36 -Residents were eating their lunch meal in their rooms with their food containers on their laps or on their beds. -Some residents sat in a chair and bent over their food container which had been placed on their bed to eat while others had their food containers placed beside them on their beds and leaned over the containers from their sides to eat. -Observation of a resident eating in her room at 12:29pm revealed the resident was seated on her bed and her food container was placed on her bed beside her on top of a disposable incontinence bed pad which appeared to have been previously used for meals. Interview with the resident on 08/18/21 at 12:30pm revealed: -Residents had been eating in their rooms for at least a year. -She preferred to eat at a table, but since she did not have a table in her room, she ate her meals on her bed and placed her meals on top of a disposable incontinence bed pad to keep from soiling her bedding. -She initially used the disposable incontinence bed pad for her meals and had reused it for subsequent meals. -She did not mind eating out of disposable foam containers because at least her meals were hot when delivered. Interview with 2 residents on the AL side of the facility on 08/19/21 at 8:50am revealed: -They wanted to eat in the dining room. -The dining room had been closed since the pandemic started, over a year ago. -Residents had been told the dining room had been under construction for over a year. -One resident was getting tired of spilling food on his bed.	D911		

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-The residents laid disposable incontinence bed pads on their beds during meals to put their foam food containers on.
-One Resident would rather sit at a table.
-No tables had been provided for residents since residents had been eating in their rooms.

Observation of the breakfast meal service in the family room in the SCU on 08/19/21 between 8:12am and 8:32am revealed:
-There were 16 residents present in the family room.
-Grits, eggs, bacon, biscuit, and a beverage were served to residents in foam hinged lid containers and foam cups.
-There were 7 residents sitting in a chair without a table to hold their meals.
-The residents sitting in chairs without tables held their meal on their lap or put the disposable food container on an open chair beside them.
-Two residents had their cups sitting on the floor and 1 resident had their cup on the arm of a chair.

Observations of the meal delivery in the SCU on 08/19/21 at 12:00pm, and 08/19/21 at 4:45pm revealed:
-The food was delivered to the SCU in foam hinged lid containers on a rolling cart.
-The foam hinged lid containers were labeled with a resident's name.
-The personal care aide (PCA) staff entered the SCU with the rolling cart loaded with foam hinged lid containers.
-The PCAs stopped the cart when passing the rooms and served some of the residents the foam hinged lid containers with the residents' name in the rooms.
-The PCAs rolled the cart to the family room and served 18 residents their food containers.

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Observation of the dinner meal service in the family room in the special care unit (SCU) on 08/19/21 at 4:45pm revealed:
-There were 18 residents in the family room waiting to be served the dinner meal.
-There were 9 residents seated at spaces with access to a table.
-The PCAs served each resident one small foam cupful of either sweet or unsweetened tea.
-The residents without table access were observed holding the small foam cup in their hands.
-When the residents received their foam hinged lid containers, the residents not seated at tables placed the foam cups on the arm of their chair, balanced on the opened lid of the foam hinged lid containers which were resting in their laps, on window seals if they were close to a window.
-One resident sat the foam beverage cup on the floor of the family room and picked it up and down repeatedly as beverage was consumed with the meal.

Interview with 2 roommates residing in the special care unit (SCU) on 08/20/21 at 5:15pm revealed:
-They had been dining in their room since the COVID-19 began over a year ago.
-They have not had a dining tray or bedside table on which to place their food container while eating.
-They routinely placed their foam hinged lid containers directly on top of the bed linens.
-They sat on the bed adjacent to the food container.
-They had to lean over to reach the food container.
-If they had soup for the meal, it was very hard to lean toward their side and spoon the soup to their mouths without spilling some soup on the bed.

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	HAL034098	A. BUILDING: ______ B. WING ______	R 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(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
D911	Continued From page 39	D911		

-They would rather be going to the dining room to eat meals on regular plates with non-plastic forks and spoons.
-"It would feel more like home if we ate in the dining room" said one of the roommates.

Interview with the Dietary Manager (DM) on 08/20/21 at 3:33pm revealed:
-The dining rooms had been closed for about a year, but she did not remember why.
-Residents had been served in their rooms since the dining rooms were closed.
-The facility had used a non-disposable place setting occasionally over the last year.
-One of the reasons why foam containers, cups, and bowls were being used now was because the facility had not been able to get dish washing detergent for the dishwasher for the last 6 weeks.

Telephone interview with the SCU Coordinator on 08/23/21 at 10:59am revealed:
-Some residents were served meals in the family room, but did not have a table to sit their meal containers on.
-She did not see residents sit their cups on the floor.
-Some residents came out of their room with their meal and brought it to the family room because they were used to dining room setting.
-Residents have asked her when they would be going back to the dining room.
-The SCU dining room was currently under construction and had been closed since the beginning of the pandemic.

Telephone interview with the Administrator on 08/23/21 at 10:18am revealed:
-The dining halls had been closed due to needed repairs and she hoped they would be opened back up soon.

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D911	Continued From page 40 -The facility did not have enough bedside tables for all residents. -The facility was working on coming up with a plan to get wheels on tables for resident to eat on until the dining rooms opened back up. -She did not know residents were sitting their cups on the floor during meals. -Residents have been served their meals in foam containers, beverages in foam cups, and ate with plastic utensils for about a year. -Residents in the SCU hoarded silverware and cups when they were served with a non-disposable place setting while eating in their rooms. -Residents in the SCU used knives to try to take the alarms off the windows. -On the AL side of the facility, many of the residents preferred plastic utensils and disposable containers. -On the AL side about half of the residents preferred to eat in their rooms and the other half of the residents want to return to the dining room for their meals.	D911		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the	D935	**D935. MEDICATION AIDES TRAINING AND COMPETENCY** Resident Care Management staff will ensure that all staff has Had proper and complete training before working on the Carts unsupervised. Management was under the impression Of the medication aide exam to be taken within 90 days and Not 30. Now that all staff is aware of the 30 day time period No staff member will conduct the medication aide job duties Outside of the state permitted time line. Administrator will ensure that all Proper documents are acquired In employees file.	8/23/21

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D935	Continued From page 41 Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled staff (Staff D) who administered medications had passed the written medication aide exam within 60 days of completing the medication clinical skills competency validation checklist. The findings are:	D935	**D935. MEDICATION AIDES TRAINING AND COMPETENCY** Resident Care Management staff will ensure that all staff has Had proper and complete training before working on the Carts unsupervised. Management was under the impression Of the medication aide exam to be taken within 90 days and Not 30. Now that all staff is aware of the 30 day time period No staff member will conduct the medication aide job duties Outside of the state permitted time line.	8/23/21

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D935	Continued From page 42 Review of Staff D's, medication aide (MA)/personal care aide (PCA) personnel record revealed: -Staff D was hired on 07/29/19. -There was a certificate of completion dated 04/14/21 for the 15-hour state approved medication aide training for Staff D. -There was documentation of a medication clinical skills competency validation checklist completed for Staff D dated 04/14/21. -There was no documentation Staff D had successfully passed the written medication aide exam. Review of residents' medication administration records for June, July, and August 2021 revealed: -Staff D documented administration of medications for 14 of 30 days in June 2021. -Staff D documented administration of medications for 15 of 31 days in July 2021. -Staff D documented administration of medications for 11 of 18 days from 08/01/21 through 08/18/21. Interview with the Administrator on 08/20/21 at 4:35pm revealed: -Staff D had begun medication cart duties in April 2021. -Staff D was removed from medication cart duties during the week of 08/17/21 through 08/20/21. -Staff D had taken the written MA exam on 07/15/21 and had not passed the written MA exam. -The Administrator was responsible to ensure MA written testing was scheduled and completed by staff. Attempted telephone interview with Staff D on 08/20/21 at 4:44pm was unsuccessful.	D935		

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D935	Continued From page 43 Interview with the Business Office Manager on 08/20/21 at 5:33pm revealed: -She was responsible to ensure that new hire paperwork had been completed. -She had made copies of documentation from new staff to ensure there was a record in the employee files.	D935		