STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043024	A. BUILDING: _____ B. WING _____	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTER'S REST HOME	40 RAWLS CLUB ROAD FUQUAY VARINA, NC 27526

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and a complaint investigation on August 11 - 12, 2021.	D 000	Responses to the cited deficencies does not constitute an admisssion or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.	
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: Based on observations, record reviews and interview, the facility failed to ensure therapeutic diets were served as ordered for 1 of 2 sampled residents who had an order for a pureed diet with nectar thickened liquids (#5). The findings are: Review of Resident #5's current FL2 dated 10/14/20 revealed: -Diagnoses included Alzheimer's Disease, generalized weakness and a cardioembolic stroke. -The diet order section was blank. Review of Physician's Order form dated 08/04/21 revealed an order for a pureed diet with nectar thickened liquids. Review of the week at a glance menu posted in	D 310		

Reviewed and acknowledged on 9/27/21 by Jennifer Fender RN jf

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D 310	Continued From page 1 the kitchen revealed the lunch meal service for 08/11/21 was beef pot roast, rice orzo pilaf, garlic green beans, buttery carrots, fresh biscuit, beverage of choice and strawberry ice cream. Review of the facility's recipe book revealed: -Instructions on how to modify regular texture foods to the correct modified diet consistency. -There were no instructions on how to modify the consistency of ice cream. Review of the diet order report in the kitchen revealed Resident #5 was to be served a pureed diet with nectar thick liquids. Observation of the lunch meal service on 08/11/21 at 12:00pm revealed: -Resident #5 was served pureed pot roast, mashed potatoes, pureed green beans and pureed cauliflower. -A single serving of container of commercially made chocolate ice cream was placed next to his plate of food. -He had three beverages in front of him which included: thin water with ice, thin iced tea and a pre-thickened nutritional supplement. -A personal care aide (PCA) was preparing to assit feed Resident #5 with his meal. Observation of the lunch meal service on 08/11/21 from 12:10pm- 12:45pm revealed: -Resident #5 had eaten all of the pureed foods on his plate. -He was offered sips of the pre-thickened nutritional supplement. -He was not offered any of the thin liquid beverages that were in front of him. -The PCA took the lid off of the container of chocolate ice cream and brought a spoonful of ice cream to Resident #5's lips.	D 310		

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D 310	Continued From page 2 Interview with the PCA on 08/11/21 at 12:45pm revealed: -She knew Resident #5 was on a pureed diet with nectar thick liquids. -She thought ice cream was considered a nectar thick liquid. -She did not remember if she received training related to identifying thickened liquids. -A medication aide (MA) and the Dietary Manager (DM) told her ice cream was considered a thickened liquid. Interview with the dietary aide (DA) on 08/11/21 at 12:45pm revealed: -She was responsible for pouring the beverages and bringing residents' food out to their table. -She knew that Resident #5 required thickened liquids but forgot to thicken his water and iced tea. -The facility did not have any pre-thickened beverages on hand. -She thought ice cream was allowed when residents required thickened liquids. -She learned about thickened liquids when she was hired. Interview with the DM on 08/11/21 at 12:50pm revealed: -She had been working in the kitchen for the last year and was promoted to DM three months ago. -She was trained by a DM that worked at an alternate location. -She thought ice cream was a thick liquid. Telephone interview with the Hospice Registered Nurse (RN) on 08/12/21 at 11:02am revealed: -The facility notified her that Resident #5 was choking on meals so his diet was changed to puree with nectar thick liquid on 08/04/21	D 310	All personal care staff and dietary staff had an inservice training by ED to educate them on thickened liquids and therapeutic diet requirements. Dietary manager (DM) will meet weekly with ED before food order placed to ensure that adequate thickened fluids are on hand to meet the needs of all residents with physician orders for thickened liquids. DM and ED will observe meals each week to ensure that residents are served the correct diet according to physician orders. ED and DM will also ensure that staff present are aware and understand what residents should receive therapeutic diets.	9/10/21 9/26/21 9/26/21

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D 310	Continued From page 3 -She discussed the risk of aspiration pneumonia due to difficulty swallowing with the Resident Care Coordinator (RCC) during her visit on 08/04/21. -Hospice expected the facility or family to provide nectar thick liquids to Resident #5. -If Resident #5 consumed consistencies that were not nectar thick then he could aspirate and develop aspiration pneumonia which would need to be treated with antibiotics. Interview with the Regional Executive Director on 08/11/21 at 1:00pm revealed ice cream should not be given to a resident who required thickened liquids and staff should have looked up an appropriate dessert substitution in the substitution book. Based on record review it was determined that Resident #5 was not interviewable.	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 ensure 1 of 2 residents observed during the medication pass received their medications as ordered by the primary care physician (PCP) including a	D 358		

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D 358	Continued From page 4 medication used to treat high blood pressure (#6). The findings are: The medication error rate was 4% as evidenced by the observation of 1 error out of 25 opportunities during the 7:00am medication pass on 08/12/21. Review of Resident #6's current FL2 dated 03/10/21 revealed: -Diagnoses included Alzheimer's disease, altered mental status, convulsions, kidney failure, hypertension, type 2 diabetes and intellectual disabilities. -There was an order for Hydralazine (a medication used to treat high blood pressure) 100mg three times a day. -There was no order to check blood pressures. Observation of the morning medication pass on 08/12/21 at 7:10am revealed: -The medication aide (MA) prepared 10 oral medications for Resident #6. -The Hydralazine in the multidose pack did not match the electronic Medication Administration Record (eMAR) for the Hydralazine. Interview with the MA on 08/12/21 at 7:15am revealed: -She did not know the multidose pack contained Hydralazine 50mg instead of the Hydralazine 100mg as indicated on the eMAR. -She administered Hydralazine 50mg seven times during August 2021. -Resident #6 received Hydralazine 50mg three or four times a day since March 2021 because the order changed several times. -The light in the hallway was dim and the writing on the multidose pack was very small and difficult	D 358		

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D 358	Continued From page 5 to read. -She notified the Resident Care Director (RCC) for clarification of the order. Observation of medications on hand for administration for Resident #6 on 08/12/21 revealed: -There was a multidose pack to start on 08/06/21 to 08/12/21 containing Hydralazine 50mg three times a day. -There were 3 of 21 doses of Hydralazine 50mg remaining. Review of Resident #6's hospital records dated 07/14/21 revealed: -He presented to the hospital with vomiting for 2 days. -There was an admission diagnoses included acute kidney injury and dehydration. -The vital signs at admission were as follows; blood pressure 142/81 and heart rate of 91. -His blood pressure fluctuated throughout admission from 142/81 to 147/106 down to 127/81. Review of Resident #6's hospital discharge instructions dated 07/16/21 revealed there was an order for Hydralazine 100mg three times a day. Review of Resident #6's July 2021 eMAR revealed there was an entry for Hydralazine 100mg documented as administered three times a day, 07/01/21 to 07/31/21 at 8:00am, 2:00pm and 8:00pm. Review of Resident #6's August 2021 eMAR revealed there was an entry for Hydralazine 100mg documented as administered three times a day, 08/01/21 to 08/11/21 at 8:00am, 2:00pm	D 358	Med techs were reinserviced by the Special Care Coordinator during a staff meeting on the importance of completing their mandatory cart audits, notifying pharmacy when new medications have not arrived, following the 6 rights of medication administration, and preventing medication errors. Weekly cart audits are to be completed by med techs on each resident to ensure that all ordered medications are on hand. Once completed, cart audits will be submitted to the SCC for verification of completion. Lead supervisor in charge (LSIC) will complete comprehensive cart audit weekly to verify results of med tech cart audit to ensure residents have accurate medications on hand. SCC will review eMar compliance report daily with ED to ensure residents have received medications according to physician orders. SCC will notify physician when resident does not receive medications according to physician orders.	9/10/21 9/26/21 9/26/21 9/26/21 9/26/21

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D 358	Continued From page 6 and 8:00pm. Review of the facility clarification of orders 07/16/21 for Resident #6 revealed: -The clarification was needed because Resident #6 returned from the hospital with new orders and needed reviewed. -There was an order transcribed as Hydralazine 100mg three times a day. -Resident #6's physician continued the Hydralazine 100mg three times a day as transcribed. -The physician signed the clarification orders on 07/21/21. Review of the facility medication cart audit schedule revealed Resident #6 was to have his medications on hand and eMAR checked for accuracy on first shift every Friday. Review of Resident #6's July 2021 medication cart audits revealed there was 1 out of 5 audits completed. Review of Resident #6's August 2021 medication car audits revealed there was 0 out of 1 audit completed. Review of Resident #6 medication cart audit dated 07/09/21 revealed a MA completed the audit and the medications ordered by the physician were on the medication cart. Review of Resident #6's FL2, hospital discharge orders, medication car audits, medications on hand, eMARs for July 2021 and August 2021, Resident #6 did not receive Hydralazine 100mg three times a day as ordered for 127 out of 127 doses.	D 358		

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D 358	Continued From page 7 Telephone interview with Resident #6's contracted pharmacy on 08/12/21 at 9:50am revealed: -There was a signed physician's order for Hydralazine 50mg three times a day dated 06/02/21. -The was no order in their records for Hydralazine 100mg three times a day dated 07/16/21. -The facility staff could enter a medication on the eMAR and we would print what was in the system but only send the medications according to the orders on hand. -Hydralazine 50mg three times a day was dispensed to the facility, with a quantity of 21 doses on, 06/04/21, 06/11/21, 06/18/21, 06/25/21, 07/02/21, 07/09/21, 07/16/21, 07/23/21, 07/31/21, and 08/06/21. -The facility was responsible for faxing over the hospital discharge orders dated 07/16/21 and or the physician's clarification orders dated 07/21/21. A second interview with the MA on 08/12/21 at 10:26am revealed: -On 07/16/21, when Resident #6 arrived at the facility after discharge from the hospital, the MA on duty was to fax all orders to the pharmacy and notify the RCC. -The pharmacy would enter the medications in the eMAR and the RCC would approve the medications prior to the MAs administering the medications to the residents. -Medication cart audit was to be completed each shift, every day by the MA, for the residents per the medication cart audit schedule located in the nurse's station. -During the audits, the MAs were responsible for checking the medications on hand with the eMARs and physician orders for accuracy. -If there were any concerns, the MAs were to	D 358		

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D 358	Continued From page 8 report them to the RCC. -She could not remember the last time she performed a medication cart audit but she did not complete them as scheduled because she was busy with other duties. Interview with the RCC on 08/12/21 at 10:41am revealed: -The MAs were responsible for completion of the medication cart audits on each resident on a weekly basis per the audit schedule. -The MAs were responsible for comparing the medications on hand with the eMAR and physician's orders and report any concerns to her. -She did not receive notification there was a problem with Resident #6's Hydralazine. -She was responsible for ensuring the medication cart audits were completed on a monthly basis. -She did not complete the medication cart audits on a monthly basis because she was only in the facility 2 days a week and those days she was with the physician and completing orders from the physician. -She did not know Resident #6 was not getting his Hydralazine as ordered. -She expected the MAs to complete the medication cart audits as scheduled. Interview with the Administrator on 08/12/21 at 12:06pm revealed: -It was their policy for the MAs to fax the hospital discharge orders to the pharmacy and inform the RCC of the new orders. -She did not know Resident #6's Hydralazine order was not administered as ordered. -The MAs were responsible for medication cart audits but not sure how often. -The medication cart audits were to check the medications on hand against the eMAR and	D 358		

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D 358	Continued From page 9 physician's orders for accuracy and let the RCC know if there were any issues. -She did not know the medication cart audits were not completed as scheduled. -She expected the medications be administered as ordered. Based on record review it was determined that Resident #6 was not interviewable. Attempted telephone interview with Resident #6's primary care physician on 08/12/21 at 12:20pm, 2:10pm and 3:40pm was unsuccessful.	D 358		