RECEIVED NOV 17 2021 ADULT CARE LICENSURE SECTION RALEIGH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033005	A. BUILDING ______ B. WING ______	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE OF ROCKY MOUNT	1650 COKEY ROAD ROCKY MOUNT, NC 27801

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D 000	Initial Comments	D 000		

The Adult Care Licensure Section conducted a annual survey and complaint investigation on 10/06/21-10/07/21.

D 273 10A NCAC 13F .0902(b) Health Care — D 273

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.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to assure health care referral and follow up for 4 of 5 residents sampled (#1, #3, #4, #5) included a resident who was ordered a cardiology referral (#1), a resident who had elevated blood sugar levels (#3), a resident who refused a medication to treat constipation and asthma (#5), and a resident that refused a diabetic medication to lower blood sugar (#4).

The findings are:

1. Review of Resident #1's current FL-2 dated 08/04/21 revealed diagnoses included hypertension (HTN), congestive heart failure (CHF), diabetes myelitis (DM), and coronary artery disease (CAD).

Review of Resident #1's physician orders dated 08/04/21 revealed there was a cardiology referral for HTN and heart disease.

Review of Resident #1's physician's visit notes, orders, and progress notes revealed the resident had not been evaluated by a cardiologist.

Review of Resident #1's facility record revealed

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Williams — TITLE: Administrator — (X6) DATE: 11/08/2021

Reviewed and acknowledged NM 11/29/21

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there was no documentation the resident had a cardiology appointment.

Review of Resident #1's facility progress notes dated 09/29/21 revealed Resident #1 was transferred to the hospital for right hand swelling and shortness of breath.

Review of Resident #1's local hospital after visit summary revealed:
-He was admitted from 09/29/21 - 10/01/21 with diagnoses of chronic obstructive pulmonary disease (COPD) exacerbation, a blood clot, HTN, and ischemic heart disease.
-He was prescribed Eliquis (an anticoagulant used to treat and prevent blood clots and strokes).
-He was to follow up with his primary care provider (PCP) in 1 - 2 weeks and discharged on a heart healthy diet.

Observation of Resident #1 on 10/07/21 at 10:35am revealed:
-He walked from the hallway into his room.
-His abdomen was round and prominent, right hand was swollen, respirations were short, and speech was broken.

Interview with Resident #1 on 10/07/21 at 10:40am revealed:
-He was admitted to the hospital the end of September 2021 because of left arm and hand swelling where he was diagnosed with a stroke.
-He was short of breath.
-He had not seen a cardiologist.

Interview with the office assistant on 10/07/21 at 10:00am revealed:
-She was responsible for reviewing and processing PCP orders.

Provider's plan of correction (handwritten):

Cardiology appointment for resident #1 was immediately made when made aware — 10/26/2021

Resident #1 was also seen by his primary doctor as ordered on his discharge orders from physician — 10/30/2021

Division of Health Service Regulation

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D 273	Continued From page 2 -She reviewed orders, compared the visit notes to the order, then faxed the order with the resident's visit notes to the referral provider for an appointment. -She called the provider in about 4 - 5 days if she had not been contacted with an appointment. -She would not always document pending appointments when appointment referrals were faxed to the provider. -Resident #1's PCP emailed the resident's 08/04/21 cardiology referral order to the facility and she printed the order. -She did not remember if she made Resident #1's cardiology referral per the 08/04/21 order. A second interview with the office assistant on 10/07/21 at 11:30am revealed she did not make an appointment with the cardiologist for Resident #1 because she overlooked the order. Interview with the Administrator on 10/07/21 at 4:36pm revealed: -The office assistant was responsible for reviewing physician orders and making referrals. -She did not expect referrals to be faxed to a provider because a fax could not be confirmed as received by the provider. -The office assistant had never faxed a provider to request a resident appointment. -She expected the office assistant to have called the cardiologist office to make Resident #1's appointment by the next business day after receiving the referral order. -The office assistant was expected to fax the referral order along with visit notes to the cardiologist after the call was made to make the appointment. -She expected the office assistant to call the cardiologist the next day to confirm the appointment.	D 273	To date the office assistant is responsible to read doctor's notes and contact any referrals to be made after receiving. Also, she will document contacts made concerning referrals and discuss with administrator done. Administrator will monitor	10/28/2021 10/28/2021

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-She did not know Resident #1's 08/04/21 cardiology referral had not been made until today, 10/07/21.
-There was no process in place to be certain orders were not missed.

Telephone interview with Resident #1's PCP on 10/07/21 at 11:26am revealed:
-The resident was examined on 08/04/21 as a follow up for hypoxia.
-The resident had a history of HTN, heart failure, and CAD.
-He ordered a referral on 08/04/21 to cardiology for management of HTN and heart failure for the resident.
-He last examined the resident on 08/06/21 via telemedicine as a routine hospital follow up visit.
-He had not been informed by the facility that the resident was had not been seen by cardiology as ordered.
-He expected the facility to make the residents cardiology appointment within one week of the referral order.
2. Review of Resident #3's current FL-2 dated 03/02/21 revealed:
-Diagnoses included diabetes mellitus, left foot stage III diabetic foot ulcer, and treated osteomyelitis.
-There was a physician's order for Levemir 100 units (used to lower high blood sugar) inject 25 units subcutaneously at bedtime for diabetes mellitus.

Review of physician's order for Resident #3 dated 03/12/21 revealed:
-A physician's order for FSBS checks three times a day before meals; notify Primary Care Provider (PCP) for FSBS less than 60 or greater than 400.
-A physician's order for Humalog sliding scale (Humalog is a rapid acting insulin used to lower

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high blood sugar) three times daily before meals for blood sugar 151-200 give 3 units, 201-250 give 5 units, 251-300 give 7 units, 301-350 give 9 units, 351-400 give 11 units, and greater than 401 recheck to verify accuracy. If accurate, give 13 units and recheck in 30 minutes. Notify physician.

Review of the Resident #3's treatment administration records (TARs) for August 2021 FSBS revealed:
-Fingerstick blood sugar (FSBS) readings were documented for 7:00am, 11:00am, and 4:00pm daily.
-On 08/08/21 at 7:00am, the medication aide (MA) documented Resident #3's FSBS was 433.
-On 08/27/21 at 7:00am, the MA documented Resident #3's FSBS was 413.
-There was no documentation for PCP notification of the August 2021 FSBS's greater than 400.

Review of the Resident #3's TARs for September 2021 FSBS revealed:
-FSBS readings were documented for 7:00am, 11:00am, and 4:00pm daily.
-On 09/10/21 at 4:00pm, the MA documented Resident #3's FSBS was 451.
-On 09/12/21 at 7:00am, the MA documented Resident #3's FSBS was 402.
-On 09/14/21 at 11:00am, the MA documented Resident #3's FSBS was 406.
-On 09/15/21 at 7:00am, the MA documented Resident #3's FSBS was 429.
-On 09/15/21 at 4:00pm, the MA documented Resident #3's FSBS was 423 and a rechecked FSBS was 196.
-There was no documentation for PCP notification of the September 2021 FSBS's greater than 400.

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Review of the Resident #3's TARs for October 2021 FSBS revealed:
-FSBS readings were documented for 7:00am, 11:00am, and 4:00pm daily.
-On 10/06/21 at 7:00am, the MA documented Resident #3's FSBS was 464.
-There was no documentation for PCP notification for the 10/06/21 FSBS greater than 400.

Review of documented progress notes for Resident #3 from 08/01/21 through 10/06/21 revealed:
-On 09/15/21 at 8:17am, the MA documented Resident #3's FSBS was 429, sliding scale insulin was administered, and FSBS was 237 upon rechecking.
-On 10/06/21 at 9:00am, the MA documented Resident #3's FSBS was 464, sliding scale insulin was administered, and FSBS was 381 upon rechecking.
-There was no documentation of PCP notification for the August 2021, September 2021, and October 2021 FSBS's greater than 400.

Interview with Resident #3 on 10/06/21 at 9:05am revealed:
-Staff checked his FSBS four times a day.
-He was administered insulin this morning (10/06/21).
-His FSBS was high sometimes.
-His FSBS was 468 this morning (10/06/21).
-His FSBS was rechecked and it was "200 and something".
-He ate two peanut butter and jelly sandwiches the night of 10/05/21 that "probably" ran his blood sugar up.
-He had not been to the hospital when his FSBS was high.
-He was seen by the PCP who came to the facility.

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Interview with the MA on 10/06/21 at 9:35am revealed:
-Resident #3's FSBS was checked three times a day.
-Resident #3's FSBS was 464 this morning (10/06/21).
If Resident #3's FSBS was over 400, she administered 13 units of insulin, rechecked the FSBS, and if still over 400, she called the PCP.
-She had not had to notify the PCP about the resident's FSBS because it would be lower than 400 once the insulin was administered.

Second interview with the MA 10/07/21 at 4:35pm revealed:
-She interpreted Resident #3's Humalog sliding scale order to mean staff were to call the PCP if the resident's rechecked FSBS was still greater than 400 after the Humalog insulin 13 units had been administered.
-She had not called the PCP for FSBS's greater than 400 documented for Resident #3 in August 2021, September 2021, or October 2021.
-The PCP reviewed the FSBS documentation for Resident #3 when she made visits to the facility

Interview with a second MA on 10/07/21 at 3:20pm revealed:
-Documentation for FSBS rechecks would be in the resident progress notes or documented in the computerized resident notes.
-He had never had to call the PCP for FSBS readings greater than 400 for Resident #3.
-The FSBS reading he had obtained for Resident #3 had been in the 300's and had never reached 400.

Telephone interview with Resident #3's PCP on 10/07/21 at 4:20pm revealed:

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-She expected to be called or a fax sent to her office when Resident #3's FSBS was greater than 400.
-She had not received any notification from the facility for Resident #3's September 2021 FSBS readings that were greater than 400.
-She was aware of one elevated FSBS greater than 400 for Resident #3 obtained in August 2021 because she saw the FSBS reading documentation when she last visited the resident at the facility on 08/31/21.
-If Resident #3's FSBS was consistently greater than 400, there would be concern for "danger" to the resident. The PCP did not provide any specific danger she would be concerned for.
-Consistent meant if Resident #3's FSBS was elevated more than 2 - 3 times per month.
-An elevated FSBS more than a few times needed intervention.
-She reviewed the resident's vital report record (a record of FSBS readings) when she saw the resident at the facility.

Interview with the Administrator on 10/07/21 at 3:00pm revealed:
-She had not contacted the PCP regarding any elevated FSBS's greater than 400 for Resident #3.
-She expected the MAs to contact the PCP as ordered, and to follow any instructions given by the PCP.
-She did not know where documentation of PCP contact regarding the resident's FSBS readings greater than 400 would be if the documentation for PCP contact was not in the resident progress notes.

3. Review of Resident #4's FL-2 dated 10/05/21 revealed diagnoses included dementia,

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hypertension, diabetes mellitus, anemia, and a cognitive disorder.

a.Review of Resident #4's FL-2 dated 10/05/21 revealed there was an order for Metformin (medication to control high blood sugar) 500 milligrams (mg) once by mouth daily.

Review of Resident #4's September electronic medication administration record eMAR revealed:
-There was an entry for Metformin HCL 500mg 1 tablet by mouth daily with breakfast for diabetes.
-Metformin 500mg was documented as refused on the eMAR 10 out of 30 opportunities from 09/01/21 to 09/30/21.
-There was no documentation in the eMAR notes that the primary care physician (PCP) was contacted about the Metformin refusals.

Review of Resident #4's progress notes, eMAR notes, and PCP communication notes revealed there was no documentation that the PCP was contacted about Resident #4's refusals of Metformin.

Review of the facility's medication policy revealed:
-The attending physician shall be notified after a resident refused 3 doses of medication.
-The refusals shall be documented by external notes or in the nursing notes section of the resident's chart.

Interview with Resident #4's PCP on 10/07/21 at 4:30pm revealed:
-She last saw the resident in July 2021.
-She saw the resident every 3 months.
-She was not notified that Resident #4 refused Metformin 10 times in September.
-She should have been notified immediately after the third medication refusal.

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-She ordered Resident #4 Metformin 500mg to help control her blood sugar.
-If Resident #4 did not take her Metformin as ordered it could cause her blood sugar levels to rise.

Interview with the Administrator on 09/29/21 at 2:44pm revealed:
-When a resident refused 3 doses of a medication the MAs were supposed to notify the residents' PCP about medication refusals the same day as the third refusal.
-The MAs were responsible for contacting the medical providers about medications refusals.
-She was not aware that Resident #4 refused her Metformin 500mg 10 out of 30 opportunities from 09/01/21 to 09/30/21.

b. Review of Resident #4's FL-2 dated 10/05/21 revealed there was an order for Trazadone (a medication prescribed to treat depression and insomnia) 150mg one tablet at bedtime.

Review of Resident #4's September electronic medication administration record eMAR revealed:
-There was an entry for Trazadone 150 milligram (mg) tablet take 1 tablet by mouth at bedtime for mood.
-Trazadone 150mg was documented as refused on the eMAR 7 out of 30 opportunities from 09/01/21 to 09/30/21.
-There was no documentation in the eMAR notes that the PCP was contacted about the Trazadone refusal.

Review of Resident #4's progress notes, eMAR notes, and PCP communication notes revealed there was no documentation that the PCP was contacted about Resident #4's refusals of Trazadone.

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Interview with Resident #4's PCP on 10/07/21 at 4:30pm revealed:
-She was not notified that Resident #4 refused her Trazadone 7 times in September.
-She should have been notified immediately after the third medication refusal.
-She ordered Resident #4 Trazadone 150mg to help control her sleep.
-If Resident #4 did not take her Trazadone as ordered she would not sleep well during the night.
-If she was notified of the refusals, she would have discontinued the medication if Resident #4 was sleeping well.

Interview with the Administrator on 09/29/21 at 2:44pm revealed:
-The MAs were responsible for contacting the PCP about medications refusals.
-She was not aware that Resident #4 refused her Trazadone 150mg 7 out of 30 opportunities from 09/01/21 to 09/30/21.

c. Review of Resident #4's FL-2 dated 10/05/21 revealed there was an order for Vitamin B-12 1000 micrograms (mcg) once daily.
Review of Resident #4's September electronic medication administration record eMAR revealed:
-There was an entry for Vitamin B-12 1000mcg once daily.
-Trazadone 150mg was documented as refused on the eMAR 10 out of 30 opportunities from 09/01/21 to 09/30/21.
-There was no documentation in the eMAR notes that the PCP was contacted about the Trazadone refusal.

Review of Resident #4's progress notes, eMAR notes, and PCP communication notes revealed there was no documentation that the PCP was

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contacted about Resident #4's refusals of Vitamin B-12.

Interview with Resident #4's primary care physician (PCP) on 10/07/21 at 4:30pm revealed:
-She was not notified that Resident #4 refused her Vitamin B-12 10 times in September.
-She should have been notified immediately after the third medication refusal.
-She prescribed Resident #4 Vitamin B-12 to help give her more energy and possibly control psychiatric behaviors.
-If Resident #4 did not take her Vitamin B-12 as prescribed it could cause her to potentially have abnrmal behaviors and low energy.
-If she was notified of the resident refusing medications, she would have ordered labs to check her Vitamin B-12 levels.

Interview with the Administrator on 09/29/21 at 2:44pm revealed she was not aware that Resident #4 refused her Vitamin B-12 10 out of 30 opportunities from 09/01/21 to 09/30/21.

d. Review of Resident #4's FL-2 dated 10/05/21 revealed there was an order for Vitamin D3 1000 units once daily.

Review of Resident #4's September electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin D3 1000 units once daily.
-Vitamin D3 was documented as refused on the eMAR 10 out of 30 opportunities from 09/01/21 to 09/30/21.
-There was no documentation in the eMAR notes that the PCP was contacted about the Vitamin D3 refusal.

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Review of Resident #4's progress notes, eMAR notes, and PCP communication notes revealed there was no documentation that the PCP was contacted about Resident #4's refusals of Vitamin D3.

Interview with Resident #4 on 10/07/21 at 10:30am revealed:
-She did not like to take her medicine.
-She did not feel like her medicine helped her so she often refused to take it.

Interview with Resident #4's PCP on 10/07/21 at 4:30pm revealed:
-She was not notified that Resident #4 refused her Vitamin D3 10 times in September.
-She should have been notified immediately after the third medication refusal.
-She prescribed Resident #4 Vitamin D3 to help increase her calcium levels.
-If Resident #4 did not take her Vitamin D3 as prescribed it would cause her to have low calcium levels.
-If she was notified, she would have ordered labs to check her Vitamin D3 levels.

Interview with the Administrator on 09/29/21 at 2:44pm revealed she was not aware that Resident #4 refused her Vitamin D3 10 out of 30 opportunities from 09/01/21 to 09/30/21.

4. Review of Resident #5's current FL-2 dated 08/04/21 revealed diagnoses included history of hepatis C, history of neurocognitive disorder, history of polysubstance abuse, hypothyroidism, and paranoid schizophrenia.

a. Review of Resident #5's current FL-2 dated 08/04/21 revealed there was an order for Milk of Magnesia 30 milliliters (ml) daily (a liquid laxative

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used to treat constipation).

Review of Resident #5's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Milk of Magnesia Suspension 30ml daily for constipation scheduled at 7:00am.
-There was documentation the resident refused Milk of Magnesia from 08/02/21 - 08/05/21, 08/07/21 - 08/08/21, 08/17/21 - 08/18/21, 08/20/21 - 08/21/21, 08/23/21 - 08/28/21, and 08/31/21 at 7:00am.
-Resident #5 refused Milk of Magnesia 17 of 31 in August 2021.
-There was no documentation Resident #5's Primary Care Provider (PCP) was notified.

Review of Resident #5's September 2021 eMAR revealed:
-There was an entry for Milk of Magnesia Suspension 30ml daily for constipation scheduled at 7:00am.
-There was documentation the resident refused Milk of Magnesia from 09/03/21 - 09/04/21, 09/05/21, 09/13/21, 09/16/21 - 09/19/21, 09/22/21, 09/24/21, 09/27/21 - 09/29/21 at 7:00am.
-Resident #5 refused Milk of Magnesia 15 of 30 days in September 2021
-There was no documentation Resident #5's PCP was notified.

Review of Resident #5's October 2021 eMAR revealed:
-There was an entry for Milk of Magnesia Suspension 30ml daily for constipation scheduled at 7:00am.
-There was documentation the resident refused Milk of Magnesia Suspension 30ml on 10/01/21,

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10/04/21, and 10/06/21 at 7:00am.
-Resident #5 refused Milk of Magnesia 3 of 6 days in October 2021
-There was no documentation Resident #5's PCP was notified.

Review of Resident #5's progress notes and PCP visit notes revealed there was no documentation the resident's PCP was notified of the resident's refusal of Milk of Magnesia.

Interview with a medication aide (MA) on 10/07/21 at 12:30pm revealed:
-The MA was responsible to document the resident's refusal of Milk of Magnesia on the resident's eMAR.
-The MA was responsible to report when a resident refused a medication three times to the Administrative Assistant (AA).
-She did not recall reporting Resident #5's refusal of Milk of Magnesia to the AA.
-The AA was responsible for notifying the resident s PCP of medication refusals.

Interview with the AA on 10/07/21 at 12:40pm revealed:
-The MA was responsible to document the resident's refusal of Milk of Magnesia on the resident's eMAR.
-The MA was responsible to report when a resident refused a medication three times to the AA.
-She did not recall reporting Resident #5's refusal of Milk of Magnesia to the resident's PCP.
-The AA was responsible for notifying the resident's PCP of medication refusals.

Telephone interview with Resident #5's family member on 10/07/21 at 4:46pm revealed:
-The resident needed encouragement to take his

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10/04/21, and 10/06/21 at 7:00am.
-Resident #5 refused Milk of Magnesia 3 of 6 days in October 2021
-There was no documentation Resident #5's PCP was notified.

Review of Resident #5's progress notes and PCP visit notes revealed there was no documentation the resident's PCP was notified of the resident's refusal of Milk of Magnesia.

Interview with a medication aide (MA) on 10/07/21 at 12:30pm revealed:
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-The MA was responsible to report when a resident refused a medication three times to the Administrative Assistant (AA).
-She did not recall reporting Resident #5's refusal of Milk of Magnesia to the AA.
-The AA was responsible for notifying the resident s PCP of medication refusals.

Interview with the AA on 10/07/21 at 12:40pm revealed:
-The MA was responsible to document the resident's refusal of Milk of Magnesia on the resident's eMAR.
-The MA was responsible to report when a resident refused a medication three times to the AA.
-She did not recall reporting Resident #5's refusal of Milk of Magnesia to the resident's PCP.
-The AA was responsible for notifying the resident's PCP of medication refusals.

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-The resident needed encouragement to take his

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medications at times because of his diagnosis of schizophrenia and he did not trust others.
-The facility had not notified her of the resident refusing medications.
-The resident's PCP had not notified her of the refusal of medications.
-She was satisfied with the facility's care of the resident over all, but she was planning to relocate him to a facility closer to her hometown as soon as possible.

Attempted telephone interview with Resident #5's PCP on 10/07/21 at 5:00pm was unsuccessful.

b. Review of Resident #5's current FL-2 dated 08/04/21 revealed there was an order for Symbicort 80-4.5mcg inhaler twice daily (used for the treatment of asthma and maintenance treatment for chronic obstructive pulmonary disease).

Review of Resident #5's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Symbicort 80-4.5mcg inhaler twice daily scheduled at 7:00am and 7:00pm.
-There was documentation the resident refused Symbicort inhaler on 08/01/21, 08/03/21, 08/07/21, 08/09/21, 08/13/21 - 08/15/21, and 08/19/21 -08/20/21 at 7:00am
-There was documentation the resident refused Symbicort 80-4.5mcg inhaler on 08/07/21 - 08/08/21, 08/11/21, 08/18/21 - 08/19/21, and 08/23/21 at 7:00pm.
-Resident #5 refused Symbicort inhaler 15 of 62 times in August 2021
-There was no documentation Resident #5's Primary Care Provider (PCP) was notified.

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D 273	Continued From page 16 Review of Resident #5's September 2021 eMAR revealed: -There was an entry for Symbicort 80-4.5mcg inhaler twice daily scheduled at 7:00am and 7:00pm. -There was documentation the resident refused Symbicort inhaler on 09/28/21 at 7:00am -Resident #5 refused Symbicort inhaler 1 of 60 times in September 2021. -There was no documentation Resident #5's PCP was notified. Review of Resident #5's progress notes and PCP visit notes revealed there was no documentation the resident's PCP was notified of the resident's refusal of Symbicort inhaler. Interview with a medication aide (MA) on 10/07/21 at 12:30pm revealed: -The MA was responsible to document the resident's refusal of Symbicort inhaler on the resident's eMAR. -The MA was responsible to report when a resident refused a medication three times to the Administration Assistant (AA). -She did not recall reporting Resident #5's refusal of Symbicort inhaler to the AA. -The AA was responsible for notifying the resident's PCP of medication refusals. Interview with the AA on 10/07/21 at 12:40pm revealed: -The MA was responsible to document the resident's refusal of Symbicort inhaler on the resident's eMAR. -The MA was responsible to report when a resident refused a medication three times to the AA. -She did not recall reporting Resident #5's refusal of Symbicort inhaler to the resident's PCP.	D 273	Concernsaited were addressed with physicians and/or psychiatrist	10/30/2021

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D 273	Continued From page 17 -The AA was responsible for notifying the resident's PCP of medication refusals. Telephone interview with Resident #5's family member on 10/07/21 at 4:46pm revealed: -The resident needed encouragement to take his medications at times because of his diagnosis of schizophrenia and he did not trust others. -The facility had not notified her of the resident refusing medications. -The resident's PCP had not notified her of the refusal of medications. -She was satisfied with the facility's care of the resident over all, but she was planning to relocate him to a facility closer to her hometown as soon as possible. Attempted telephone interview with Resident #5's PCP on 10/07/21 at 5:00pm was unsuccessful.	D 273	Meeting was held with staff by administrator to clarify who was responsible to contact physician when resident refuses medication also reminding that when refuse medication (any) three times that a physician is to be notified and document on MAR. Attachment #1 - those who attended and what was discussed.	10/21/2021
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure foods were free from contamination related to flies swarming on resident food, a blender blade and lid stored in a kitchen sink, and dietary staff touching resident	D 283	Another meeting is scheduled with RN, S.R., to discuss refusuals to medication and high/low of blood sugars (to go over policies and procedures) Attached #2 - those that attended and summary of what discussed. above will be monitored by assisant and administrator	11/8/2021 10/28/2021

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D 283	Continued From page 18 food with contaminated gloves during meal service. The findings are: Observation of the dinner meal preparation on 10/06/21 at 4:25pm revealed: -The facility cook pureed rice in a blender on top of the sink countertop, placed the blender lid rim down in the sink basin, and the blade in the sink drain. -The cook retrieved additional rice and placed it in the blender, picked up the blade from the sink drain, rinsed it under running water, and put the blade in the blender. -The cook picked up the blender lid from the sink basin and placed it on the blender. -The cook pureed the rice, scooped it in a bowl, and sat the bowl of rice under the steam bar. -The cook did not wash the blade or blender lid after placing them in the sink and drain or before using them to puree the second portion of rice. A second observation of the dinner meal preparation on 10/06/21 from 4:33pm - 4:40pm revealed: -The facility cook washed the blender blade and lid. -The cook put on gloves, touched a lid from the hot bar, touched a serving spoon to obtain Salisbury steak, placed the steak in the blender, touched and turned on the blender, removed and placed the blender lid rim down in the sink basin, and the blade in the sink drain. -The cook picked up the blended Salisbury steak and crumbled it wearing the same gloves. -The cook poured the Salisbury steak into a bowl and placed it under the steam bar. -The cook placed more Salisbury steak in the blender, picked up the blade from the sink drain,	D 283	Meeting was held by administrator with kitchen staff and discussed the issues at hand Attachment #3 - those that attended A meeting to be held with dietitian to discuss issues at hand. Administrator will monitor along with assistant to see that staff follow policy and procedures	10/29/2021 11/10/2021 immediate 10/29/2021

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rinsed the blade under running water, and put the blade in the blender with the Salisbury steak while wearing the same gloves.
-The cook picked up the blender lid from the sink basin, placed it on the blender, and blended the Salisbury steak.
-The cook removed the lid and scooped the food from the blender into a bowl wearing the same gloves worn while she touched the hot bar lid, serving spoon, and blender blade and lid.
-The cook placed the blended steak under the steam bar.
-The cook removed 4 pieces of Salisbury steak with a serving spoon from the steam bar wearing the same gloves.
-The cook picked up the steak with her left hand and placed it in a metal pan, held the steak with her left hand and cut the steak with a knife in her right hand wearing the same gloves on both hands.
-The cook scraped the cut steak from the metal pan into a bowl with her hand wearing the same gloves and placed the bowl on the steam bar.
-The cook did not wash her hands or put on clean gloves before preparing the chopped steak.

Observation of the dinner meal preparation on 10/06/21 between 4:45pm - 5:00pm revealed:
-The dietary aid placed 7 resident trays with plates, water, tea, and utensils on top of the steam bar.
-The cook prepared each resident plate with food from the steam bar.
-The cook prepared a resident plate with pureed Salisbury steak and pureed rice then placed it on top of the steam bar.
-Two flies landed on the pureed Salisbury steak twice and was shooed away by the cook.
-The plate was served to a resident by a personal care aide (PCA).

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-The cook prepared a resident plate with the chopped Salisbury steak. The plate was served to a second resident.
-There were plate lids on the counter behind the hot steam bar.
-The plates were not covered while waiting to be served to the residents.

Review of the facility cook's staff folder on 10/07/21 revealed:
-She completed training in food preparation and sanitation on 05/14/19.
-She completed training in food safety on 05/28/20.
-She competed training in food service orientation on 03/21/17.

Interview with the facility cook on 10/07/21 at 12:25pm revealed:
-She always placed the blender blade in the sink drain when prepping food to keep from getting cut on the blade.
-She would rinse the blade under running water before placing back in the blender.
-She always placed the blender lid in the sink basin when prepping food to keep from getting food on the sink countertop.
-She would wash the blender blade and lid in another sink with detergent and water before preparing a different food.
-The sink basin was used to thaw meat. She did not remember the last time meat was thawed in the sink basin.
-It was okay to touch resident food with her hands if she was wearing gloves.
-She would reach in the blender with her gloved hands to remove food the spoon could not reach.
-She did not need to change gloves after touching other items in the kitchen before touching the resident's food.

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-She could not control the flies in the kitchen during meal service.
-She did not think the flies would contaminate the resident's food because she shooed them away.
-She had not reported to the Administrator there were flies in the kitchen because she would kill them with a fly swatter or spray when meals were not being served to the residents.
-Plate covers were only used for resident's who chose to eat in their rooms.

Interview with the Administrator on 10/07/21 at 4:36pm revealed:
-The sink basin that the cook placed the blender blade and lid in was used to thaw meat.
-She expected the blender blade and lid to be washed with detergent and water before used to process foods after removing from the sink.
-Not washing the blender blade and lid could contaminate resident food because of germs in the sink drain and sink basin.
-She did not expect the cook to handle food with gloved hands because it was a risk of possible food contamination.
-She expected the cook to wash her hands and apply new gloves with each food preparation because of touching contaminated surfaces in the kitchen.
-She did not know there were flies in the kitchen.
-She expected the cook to report to her that flies were in the kitchen as soon as they were discovered so the flies could be exterminated.
-She did not expect residents to be served food that had been contaminated with flies because the flies carried germ which placed the residents at risk for sickness.
-She expected the cook to throw away the contaminated food and prepared another plate.
-The facility had never used plate covers but thought it would be beneficial to protect residents'

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D 283	Continued From page 22 food. -The cook had dietary training when she was hired in 2017.	D 283		