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
	HAL075010	A. BUILDING: ______ B. WING ______	12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOODS	1062 WEST MILLS STREET COLUMBUS, NC 28722

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D 000 Initial Comments — D 000

The Adult Care Licensure Section and the Polk County Department of Social Services conducted an annual survey and a complaint investigation from 12/07/21 through 12/09/21.

D 219 10A NCAC 13F .0606 Staffing Chart — D 219

10A NCAC 13F .0606 Staffing Chart

10A NCAC 13F .0606 STAFFING CHART The following chart specifies the required aide, supervisory and management staffing for each eight-hour shift in facilities with a capacity or census of 21 or more residents according to Rules .0601, .0603, .0602, .0604 and .0605 of this Subchapter.

Bed Count Position Type First Shift Second Shift Third Shift
21 - 30 Aide 16 16 8
Supervisor Not Required Not Required Not Required
Administrator/SIC In the building, or within 500 feet and immediately available.
31-40 Aide 16 16 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
41-50 Aide 20 20 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
51-60 Aide 24 24 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
61-70 Aide 28 28 24
Supervisor 8* 8* 4 hours within the facility/4 hours within 500 feet and immediately

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available.**
Administrator On call
71-80 Aide 32 32 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
81-90 Aide 36 36 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
91-100 Aide 40 40 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
101-110 Aide 44 44 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
111-120 Aide 48 48 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
121-130 Aide 52 52 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
131-140 Aide 56 56 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call
141-150 Aide 60 60 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
151-160 Aide 64 64 48
Supervisor 16 16 8

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D 219	Continued From page 2 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 161-170 Aide 68 68 48 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 171-180 Aide 72 72 48 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 181-190 Aide 76 76 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 191-200 Aide 80 80 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 201-210 Aide 84 84 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 211-220 Aide 88 88 64 Supervisor 16 16 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 221-230 Aide 92 92 64 Supervisor 16 16 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 231-240 Aide 96 96 64 Supervisor 24 24 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure required staffing hours	D 219		

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were met on first and second shifts based on a census of 22 for 11 of 21 sampled shifts from 12/01/21 to 12/07/21.

The findings are:

Review of the facility census record from 12/01/21 to 12/07/21 revealed there was a census of 22 residents in the assisted living which required 16 staff hours on 1st and 2nd shifts.

Review of the staff time records from 12/01/21 to 12/07/21 revealed:
-On 12/01/21, on 2nd shift there was a total of 12 hours provided with a shortage of 4 hours.
-On 12/02/21, on 2nd shift there was a total of 12 hours provided with a shortage of 4 hours.
-On 12/03/21, on 1st shift there was a total of 8.25 hours provided with a shortage of 7.75 hours.
-On 12/03/21, on 2nd shift there was a total of 9.75 hours provided with a shortage of 6.25 hours.
-On 12/04/21, on 2nd shift there was a total of 14 hours provided with a shortage of 2 hours.
-On 12/05/21, on 1st shift there was a total of 8 hours provided with a shortage of 8 hours.
-On 12/05/21, on 2nd shift there was a total of 9 hours provided with a shortage of 7 hours.
-On 12/06/21, on 1st shift there was a total of 12 hours provided with a shortage of 4 hours.
-On 12/06/21, on 2nd shift there was a total of 8.75 hours provided with a shortage of 7.25 hours.
-On 12/07/21, on 1st shift there was a total of 8 hours provided with a shortage of 8 hours.
-On 12/07/21, on 2nd shift there was a total of 9 hours provided with a shortage of 9 hours.

Interview with two residents during the initial tour

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D 219	Continued From page 4 on 12/07/21 from 9:28am to 9:45am revealed: -There was not enough staff in the facility. -All shifts were low on staff. -Sometimes it took staff a long time to come assist residents to the bathroom. Interview with a medication aide (MA) on 12/08/21 at 8:30am revealed: -Sometimes the facility would be short of staff. -A local staffing agency was providing staff and it had gotten better but the facility was still short of staff occasionally. Interview with the Administrator on 12/09/21 at 11:15am revealed: -She was not aware of the facility being short of staff in the last month. -She was not always aware when staff called out of work for the shift. -Two local staffing agencies were providing staff for the facility. -Two MAs would stay past the end of their shifts if staff called out of work for the shift.	D 219		
D 273	10A NCAC 13F .0902(b) Health Care 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: TYPE B VIOLATION Based on observations, record reviews, and interviews the facility failed to ensure referral and follow up to meet the acute healthcare needs for 4 of 7 sampled residents (Residents #2, #6, #8, #9) related to a physician follow up to evaluate	D 273		

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pain (#2), a speech therapy referral to evaluate swallowing (#6, #8) and no orders for the care of an open tracheostomy (#9).

The findings are:

1. Review of Resident #2's current FL2 dated 06/28/21 revealed diagnoses included epilepsy and hypothyroidism.

Review of Resident #2's physician's orders revealed:
-There was an order for follow up with Rheumatology for low back pain dated 08/25/21
-There was an order for follow up with Rheumatology with computed tomography (CT) results dated 10/27/21.

Review of Resident #2's record revealed there were no Rheumatology physician's progress notes for review.

Interview with a Medication Aide (MA) on 12/08/21 at 10:40am revealed:
-She and another MA were responsible for scheduling physician appointments.
-She had faxed the requested paperwork to the Rheumatology office required before they would schedule an appointment for Resident #2.
-She had not heard back from the Rheumatology office regarding the appointment.
-She had not followed up on scheduling the appointment.

Interview with a second MA on 12/09/21 at 9:45am revealed:
-She had contacted the Rheumatology office to schedule an appointment for Resident #2 in September 2021, but they required paperwork to be faxed before scheduling the appointment.

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-She had contacted the Rheumatology office twice but had not heard back from them to schedule the appointment.
-She made no other attempt to schedule the appointment for Resident #2.

Telephone interview with a nurse at the Rheumatology office on 12/08/21 at 10:30am revealed:
-A referral for Resident #2 was received in September 2021.
-A request was made for the facility to fax Resident #2's laboratory results and x-ray results before an appointment could be scheduled.
-The facility did not send the requested laboratory results and x-rays and an appointment was not scheduled.
-There was no record the facility called to follow up on scheduling an appointment for Resident #2.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 12/08/21 at 11:03am revealed:
-He had ordered the Rheumatology referral due to Resident #2 experiencing joint pain.
-Resident #2 needed to be evaluated by a Rheumatologist as she was at risk of continued and worsening pain and discomfort.
-The facility had not informed him that Resident #2 had not been to see the Rheumatologist.
-He expected the facility to follow the physician orders.

Interview with Resident #2 on 12/08/21 at 11:20am revealed:
-She experienced pain in her hip joints that would increase when the weather was cold and damp.
-Her pain was a 5 on the 0-10 pain scale (a measure of pain intensity) at this time.
-She had not been to see a Rheumatologist but

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she "needed to go".

Refer to Interview with the Resident Care Coordinator (RCC) on 12/08/21 at 11:15am.

Refer to the Interview with the Administrator on 12/08/21 at 11:45am.

2. Review of Resident #6's current FL2 dated 07/13/21 revealed diagnoses hyperthyroidism, pulmonary hypertension and hearing loss.

Review of physician's orders for Resident #6 revealed an order dated 09/22/21 for speech therapy to evaluate and treat.

Review of Resident #6's record revealed there were no speech therapy progress notes available for review.

Interview with a Medication Aide (MA) on 12/09/21 at 9:17am revealed:
-She and another MA were responsible for scheduling referrals.
-The referral was not completed because his insurance would not cover speech therapy.
-She never informed the primary care provider (PCP) that the referral was not completed.

Telephone interview with the therapy scheduler at the contracted home health agency on 12/08/21 at 10:25am revealed:
-A referral for Resident #6 was received in September 2021.
-The referral could not be completed because Resident #6's insurance was out of network.
-She informed the facility of the insurance issue on 10/01/21.

Telephone interview with the facility's contracted

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Nurse Practitioner (NP) on 12/08/21 at 11:03am revealed:
-He had ordered the Speech therapy referral because Resident #6 was having some possible aspiration.
-The facility had not informed him that Resident #6 had not been evaluated by speech therapy.
-He expected the facility to follow the physician orders.

Based on observation, interview and record review it was determined Resident #6 was not interviewable.

Refer to Interview with the Resident Care Coordinator (RCC) on 12/08/21 at 11:15am.

3. Review of Resident #8's current FL2 dated 06/11/21 revealed diagnoses included permanent atrial fibrillation.

Review of Resident #8's physician's orders dated 10/27/21 revealed an order for a speech therapy evaluation due to possible silent aspiration.

Review of Resident #8's record revealed there were no speech evaluation progress notes.

Interview with a Medication Aide (MA) on 12/07/21 at 3:05pm and 12/08/21 at 8:11am revealed:
-She and another MA were responsible for processing referrals.
-She was unaware a speech therapy referral was ordered for Resident #8.
-She was not working on 10/27/21 when the order was written so she did not know who would have processed the order.
-Referrals were normally faxed by the MA who was working or the Resident Care Coordinator

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(RCC) to the agency and the scheduler arranged for the evaluation to be completed.
-The Nurse Practitioner (NP) never requested the results for the speech evaluation so she did not know to look for it when she returned to work.

Interview with a second MA on 12/07/21 at 3:05pm revealed:
-She and another MA were responsible for processing referrals.
-She was unaware a speech therapy referral was ordered for Resident #8.
-She was not working on 10/27/21 when the order was written so she did not know who would have processed the order.

Telephone interview with the therapy scheduler at the contracted home health agency on 12/08/21 at 10:31am revealed:
-Referrals were faxed to the agency.
-A fax was never received for a speech therapy evaluation order dated 10/27/21.

Telephone interview with Resident #8's responsible person on 12/07/21 at 1:27pm revealed:
-When Resident #8 was admitted to the facility in June 2021 he was aspirating.
-He visited Resident #8 daily and was rarely alert and oriented enough to give an accurate answer.

Telephone interview with the facility's contracted NP on 12/09/21 at 10:04am revealed:
-Resident #8's family member questioned why he was coughing.
-He ordered the speech therapy evaluation because Resident #8 was coughing and recent chest x-rays indicated pneumonia so he wanted to be sure he was not aspirating.
-The facility had not informed him that Resident

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#2 had not been evaluated by speech therapy.
-He expected the facility to follow the physician orders.

Based on observation, interview and record review it was determined Resident #8 was not interviewable.

Refer to Interview with the Resident Care Coordinator (RCC) on 12/08/21 at 11:15am.

Refer to Interview with the Administrator on 12/08/21 at 11:45am.

4. Review of Resident #9's current FL2 dated 06/14/21 revealed:
-Diagnoses included dementia, atrial fibrillation, hypothyroidism, and depression.
-There was no documentation Resident #9 had a stoma and there were no orders for the care of the stoma.
-The level of care was for a Special Care Unit (SCU).

Review of Resident #9's care plan revealed there was no documentation regarding a stoma or care of the stoma.

Interview with Resident #9's family member on 12/07/21 at 1:25pm revealed:
-Resident #9 received a stoma in 2009 related to cancer.
-Resident #9 received a shower from staff on 12/06/21 and staff had not used the collar he required to cover the stoma during his shower.
-If the neck collar was not used then water could go directly into his lungs and he could choke.
-The family member spoke with both staff who had given the shower and they were new to the facility and did not know Resident #9 needed to

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use the neck collar during the shower.

Observation of Resident #9 on 12/07/21 at 1:25pm revealed:
-There was a stoma at the skin surface of the anterior neck about the size of a quarter.
-The area was clean, with no observed mucus.
-There was a small red scratch mark on the left side of the stoma about the length of a small eraser.

Interview with a personal care aide (PCA) on 12/08/21 at 10:55am revealed:
-She had worked with Resident #9 for a long time and was familiar with how the family wanted Resident #9 cared for.
-She assisted with all personal care for Resident #9.
-She was dependant on the medication aide (MA) or family to advise her if there were any changes with Resident #9's care needs.
-She had taken a wash cloth and cleaned around the opening of the residents stoma when needed.
-She had learned that if water entered the open stoma Resident #9 would cough or get choked.
-There was nothing written down for her to review for residents personal care needs.

Interview with a MA on 12/08/21 at 11:10am revealed:
-She was working on 12/06/21 when the new staff gave the shower to Resident #9 without his neck collar.
-She was aware both PCAs were new.
-She had not explained the need for or the use of the neck collar for Resident #9 in the shower to the new PCA's.
-She was not aware the PCAs were giving Resident #9 a shower otherwise she would have advised the staff to use the collar located in the

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medication room.
-Staff communicate by word of mouth.
-The MA's told the PCAs of any care need changes related to any new orders staff received but nothing was written down.
-Sometimes staff forgot to tell the other staff about changes in resident care needs as staff got busy and forgot.
-The staff there knew what needed to be done and would let the agency staff know what they needed to do.
-She was not aware of any physician's order related to Resident #9's stoma.
-The facility did not use treatment sheets so there was no place to document the cleaning of the stoma.
-She had not asked for any care orders for Resident #9's stoma.

Interview with Resident #9's Nurse Practioner on 12/08/21 at 12:45pm revealed:
-Resident #9 resided on the SCU.
-Resident #9 frequently put his fingers in his stoma and could be difficult to redirect as he could become combative.
-The stoma for Resident #9 should be covered during a shower as it could cause coughing/choking.
-It was his understanding that even with Resident #9's level of dementia he cleaned his own stoma.
-The stoma should be cleaned with a 4 x 4 gauze pad with saline as it was needed.
-If Resident #9 had any kind of respiratory infection he would need it cleaned more often.
-He could not remember if he had written any orders for the care and cleaning of the stoma for Resident #9.
-He was not aware of any current issues with Resident #9's stoma.

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Interview with another MA on 12/09/21 at 9:10am revealed:
-She was not aware of any orders for the care of Resident #9's stoma.
-She was aware there were other staff members who had taken a Q-tip dipped in Saline and cleaned around the opening of the stoma.
-She had not been trained to clean Resident #9's stoma.
-She felt uncomfortable with cleaning or caring for Resident #9's stoma.
-She was aware the Hospice nurse for Resident #9 had been cleaning and caring for the stoma.
-The Resident Care Coordinator (RCC) was responsible in the past for cleaning the stoma and observing for any signs of infection prior to the Hospice nurse cleaning and caring for the stoma.

Telephone interview with Resident #9's Hospice nurse on 12/09/21 at 9:30am revealed:
-She had been caring for Resident #9 for about 6 weeks.
-She would check the stoma for Resident #9 when she visited three times a week for signs of infection and cleaning.
-It was important to use the neck collar for Resident #9 during his showers to prevent the water from entering the stoma.
-It could possibly cause coughing, choking, aspiration pneumonia if water entered the stoma.
-Resident had recently been on an antibiotic for coughing, yellow mucus and was treated prophylactically to prevent the spread of disease or infection.
-Resident also had a tendency to pick at the stoma which was common but could also cause infection and needed to be monitored.

Telephone interview with a PCA on 12/09/21 at 10:02am revealed:

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-Her first day of employment with the facility was 12/04/21.
-She was familiar with Resident #9 as he received the first shower she had given.
-She had assisted another newly hired PCA with Resident #9's shower on 12/06/21.
-She was not aware Resident #9 had a neck collar to be used during his shower until the residents family member told her.
-She and the other PCA had just given Resident #9 a "regular shower" as they had not been told about Resident #9 having any special needs during the shower.
-A family member for Resident #9 asked her if she had used the collar during his shower to which she replied "no".
-The family member showed the aide where the collar was kept in the medication room and asked her to use it to prevent the resident from choking.
-Resident #9 was not coughing during the shower or after the shower that she was aware of.
-No staff had shared with her Resident #9's need for a neck collar to cover the stoma during showers or how to place the neck collar on Resident #9 as of 12/09/21.
-She had nothing in writing to go by for the care needs for Resident #9 only what other staff chose to share with her.

Interview with the RCC on 12/09/21 at 8:35am revealed:
-She had only been employed with the facility for two full weeks.
-She was aware of Resident #9 and that he had a stoma.
-She was not aware there were no orders for the care and cleaning of the stoma for Resident #9.
-The MA's were responsible for requesting orders for the residents and should have asked for orders for the care of Resident #9's stoma.

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-She felt it was important for his care plan to reflect all his care needs and specific orders needed to be written for the care of the stoma for Resident #9.
-It was important for Resident #9 to be monitored for excessive secretions.
-It was important for the staff who cared for him to be educated on the care needs associated related to his stoma.

Interview with the Administrator on 12/09/21 at 11:34am revealed:
-She had been employed by the facility since November 15, 2021.
-She felt there had been much confusion with who was responsible for what role as there had been several changes in staff in Administrative positions.
-She was not aware Resident #9 had a stoma and there were no orders to address the care needs for this resident.
-She would expected specific orders to be written in order for her staff to be able to provide the care Resident #9 needed .

Based on observations, interviews and record reviews it was determined Resident #9 was not interviewable.

____

Interview with the RCC on 12/08/21 at 11:15am revealed:
-There were two MAs in the facility that were responsible for ensuring all referrals were completed.
-She did not know what the process was to ensure the referrals were completed.

Interview with the Administrator on 12/08/21 at 11:45am revealed:
-Referrals were given to the MA by the Primary

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D 273	Continued From page 16 Care Provider (PCP). -The MA who received the referral was responsible for faxing the referral and following it through until it was completed and then notifying the PCP of the results. -The RCC should review the list of referrals weekly. -Referrals were discussed weekly at the interdisciplinary team meeting. -She was not aware there were referrals that had not been completed. _______________________ The facility failed to ensure an appointment for low back pain with the Rheumatologist for a resident which could result in continued and worsening pain and discomfort (#2); failed to ensure two residents were evaluated by speech therapy for swallowing which could result in the risk of aspiration issues (#6, #8) and failed to inform the PCP of needed orders for the care of a resident's stoma which could result in coughing/choking, aspiration or infection issues for the resident (#9). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _______________________ The facility to provide a plan of protection in accordance with G.S. 131D-34 on 12/08/21 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 23, 2021.	D 273		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home:	D 292		

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(3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to ensure substitutions made to the menu were of of equal nutritional value and documented to indicate what food was actually served to the 43 residents that resided at the facility.

The findings are:

Interview with the Dietary Supervisor on 12/07/21 at 10:20am revealed:
-She did not maintain a substitution list for changes made to the menu.
-She ran out of papers to document substitutions and would need to locate more.

Attempted review of the substitution book on 12/07/21 at 10:20am revealed a book was not available for review.

Review of the lunch menu for 12/07/21 revealed:
-The regular lunch menu consisted of apple-ginger pork chops, seasoned zucchini, oven-roasted potaotes, and peach crisp.

Interview with the dietary supervisor on 12/07/21 at 12:23pm revealed:
-She was not serving the regularly scheduled lunch menu because the residents liked grilled cheese better.
-They made lots of substitutions to the menu

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D 292	Continued From page 18 because residents preferred the items on the "always available" menu and some foods were not coming in on the delivery truck as ordered. -They have an "always available" menu that residents can order from. -Items on the "always available" menu consisted of grilled cheese, hamburger or cheeseburger, ham or turkey sandwich, french fries, soup of the day or chef salad. -She was serving loaded potato soup, broccoli/cauliflower salad and a banana nut muffin with the grilled cheese. Review of the lunch menu for 12/08/21 revealed the lunch menu consisted of bombay chicken, brown rice pilaf, baked eggplant, a wheat dinner roll and a 7-layer cookie. Observation of the lunch service on 12/08/21 revealed the meal offered consisted of a ham and swiss tortilla wrap, broccoli pasta salad, potato chips and chocolate pudding. Interview with the Administrator on 12/08/21 at 11:45am revealed: -The kitchen was short staffed and therefore not following the menus provided by the contracted food service distributor. -She did not know that dietary staff were making as many substitutions as they were; she thought it was only occasionally. -She expected a substitution list to be kept. -She had requested from the dietary staff that the substitutions be nutritionally equivalent.	D 292		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service	D 296		

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(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 record reviews and interviews the facility failed to have a therapeutic diet menu for 1 of 6 sampled residents (Resident #2) with an order for a low glycemic, low carbohydrate, high protein, epilepsy diet.

The findings are:

Review of Resident #2's current FL2 dated 06/28/21 revealed:
-Diagnoses included intractable epilepsy, seizure disorder,, hypothyroidism, vagal nerve stimulator, history of transient ischemic attack.
-A low glycemic, high protein, low carbohydrate epilepsy diet order.

Review of the facility's therapeutic menu spreadsheet revealed:
-The menus were provided by the facility's contracted food service on 11/11/21.
-The menu did not contain any information about a low glycemic, low carbohydrate, high protein, epilepsy diet.

Interview with the dietary supervisor on 12/07/21 at 12:23am revealed:
-Resident #2 changed to a low glycemic, low carbohydrate, high protein, epilepsy diet about a year ago.
-She did not know what an epilepsy diet was.
-She used the internet to search for information

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D 296	Continued From page 20 about the diet but was unsuccessful. Interview with the Administrator on 12/08/21 at 11:45am revealed: -She thought there was a matching therepeutic menu for each ordered diet at the facility. -She was unaware Resident #2 had a low glycemic, high protein, low carbohydrate epilepsy diet order and there was no information in the kitchen about that type of diet. -She would have expected the dietary staff to request information about a diet that she did not a menu for.	D 296		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. The findings are: Observation in the kitchen on 12/07/21 at 10:20am revealed there was not a list of physician-ordered therapeutic diets posted for	D 309		

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D 309	Continued From page 21 guidance of staff. Review of the facility's therapeutic diet list revealed: -The therapeutic diet list was provided to the surveyor at the beginning of the survey on 12/07/21. -Two residents were documented as receiving a puree diet and one resident was documented as receiving nectar thickened liquids. Interview with the dietary supervisor on 12/07/21 at 12:23pm revealed: -Someone from the office brought her a list of the therapeutic diets earlier that morning but she did not have one before that and not had one for a "long time". -She had access to a book that had a copy of everyones diet order. -She usually used the book but it was taken to the Administrators office earlier in the morning. -She did not know two residents were ordered pureed diets and one resident was ordered nectar thickened liquids. Interview with a first shift medication aide (MA) on 12/09/21 at 8:30am revealed: -A copy of all resident diet orders were kept in a book in the kitchen. -She updated the book whenever a resident had a new diet order written. -She verbally communicated diet changes to the dietary staff. Interview with the Administrator on 12/08/21 at 11:45am revealed: -Diet orders were communicated to the kichen staff from the MAs. -There was a book in the kitchen that contained all resident diet orders.	D 309		

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D 309	Continued From page 22 -There should be a current list of therapeutic diets visible and readily available for review. -She had only been the Administrator for one month but she did not think the list had been updated or followed correctly. -She had been concerned about the diet list since she started and last week ordered a dit communication board for the kitchen.	D 309		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews the facility failed to ensure therapeutic diet orders were served as ordered for 3 of 7 residents (#2, 6, 8) who had orders for a low glycemic, low carbohydrate, high protein, epilepsy diet (#2), a puree diet (#6) and a puree diet with nectar thickened liquids (#8). The findings are: 1. Review of Resident #8's current FL2 dated 06/11/21 revealed: -Diagnoses included permanent atrial fibrillation.	D 310		

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D 310	Continued From page 23 -There was an order for a pureed diet with nectar thickened liquids. Interview with the Dietary Supervisor on 12/07/21 at 10:20am revealed no residents at the facility received thickened liquids. Second interview with the Dietary Supervisor on 12/07/21 at 12:23am revealed: -She did not know Resident #8 was ordered a pureed diet with thickened liquids. -When a diet was changed the MA brought a new copy of the diet order and put it in the diet order book that was referenced when they were preparing meals. -She must have overlooked the pureed diet order when she was preparing his meals. -Dietary staff were responsible for providing thickened liquids when there were orders for thickened liquids. -Resident #8 was not receiving thickened liquids. -Thickener was available and it was used when preparing pureed foods. -When she started working at the facility about 3 years ago she did not receive much training on therapeutic diets. Interview with a MA on 12/07/21 at 1:17pm and 3:05pm revealed: -Resident #8 was admitted to the facility in June 2021 with orders for a pureed diet with nectar thickened liquids. -She noticed 2 weeks ago that he was not eating as well. -Resident #8 did not like the pureed diet and thickened liquids. -Resident #8 and his family member asked if the diet could be changed. -She started pursuing a diet change last week but did not obtain a verbal order until today.	D 310		

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-She was not aware Resident #8 was not receiving his pureed diet with thickened liquids.
-Resident #8 took his medication with regular liquids.
-She did not know the thickened liquids would also apply to medications.
-The Resident Care Coordinator (RCC) audited diet orders monthly to confirm they were accurate.

Telephone interview with Resident #8's responsible person revealed:
-Resident #8 was admitted to the facility in early June 2021 with aspiration and was ordered a pureed diet with thickened liquids.
-Resident #8 did not like the diet and by the end of June 2021 he started receiving regular food and liquids.
-He had not talked with a MA about a diet change recently because there was no need; he had been on a regular diet since the end of June 2021.

Telephone interview with Resident #8's Primary Care Provider (PCP) on 12/07/21 at 1:36pm and 3:26pm revealed:
-Resident #8 was on a pureed diet with thickened liquids because of dysphagia (a swallowing disorder).
-He was contacted earlier today about changing Resident #8's diet.
-He did not remember if he was contacted last week about the diet.
-He requested a speech evaluation be done before the diet was changed because he wanted to be sure a regular diet would be safe.
-He was unaware Resident #8 had been receiving a regular diet and regular liquids since the end of June 2021.
-Resident #8 could aspirate food and liquid with a

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regular diet and only a speech therapist could determine that.
-Aspirating food and liquid could lead to aspiration pneumonia.
-He expected the facility to follow diet orders.

Telephone interview with Resident #8's speech therapist on 12/08/21 at 10:38am revealed:
-She provided therapy to Resident #8 from 06/23/21 through 08/19/21 for dysphagia.
-She did not have access to a resident's diet and relied on the staff to tell her what the diet order was.
-Staff told her Resident #8 was ordered a regular diet.

Observation of Resident #8's lunch service on 12/08/21 at 12:16pm revealed:
-He was served a ham and cheese tortilla wrap on a bed of lettuce, broccoli pasta salad, barbeque potato chips, chocolate pudding, unthickened tea and unthickened water.
-Resident #8 consumed half of his meal and liquids and did not cough or choke.

Interview with a MA on 12/09/21 at 9:00am revealed
-Resident #8's medications were administered with unthickened juice.
-She had never seen or heard Resident #8 cough at medication administration.

Observation of Resident #8 on 12/09/21 at 9:05am revealed:
-He was standing in the hall taking his medications from the MA.
-He swallowed his medications with juice.
-He coughed once after swallowing his medication and cleared his throat 3 times.
-He coughed again two times at 9:07am.

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Refer to Interview with the Administrator on 12/08/21 at 11:45am.

2. Review of Resident #6's current FL2 dated 07/13/21 revealed diagnoses included hyperthyroidism, pulmonary hypertension and hearing loss.

Review of Resident #6's record revealed a diet order change from mechanical soft to a pureed diet on 09/22/21.

Observation of the kitchen on 12/07/21 at 12:22pm revealed:
-Dietary staff were plating food for the residents.
-No therapeutic diet list or menu was posted in the kitchen.

Interview with the Dietary Supervisor on 12/07/21 at 12:23am revealed:
-When a diet order was changed, the Medication Aide (MA) brought a new copy of the diet order and put it in the diet order book that was referenced when they were preparing meals.
-She was not using the diet order book because it was in the Administrators office and she knew the Resident's diet orders.
-She did not know Resident #6 was on a pureed diet.
-When she started working at the facility about 3 years ago, she did not receive much training on therapeutic diets.

Interview with a MA on 12/08/21 at 8:51am revealed:
-Dietary staff informed her yesterday that Resident #6 did not want a pureed diet so she contacted the Primary Care Provider (PCP) and obtained a diet order change.

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-She did not know if Resident #6 was receiving regular food or pureed food at his meals.
-The PCP told her Resident #6 could not be changed to regular food until he had a speech evaluation.

Review of Resident #6's progress notes revealed:
-There was a note dated 12/07/21 at 8:00am documenting dietary staff informed the MA that Resident #6 had been refusing the pureed diet and requesting a mechanical soft diet.
-The MA contacted the PCP and received an order to have speech therapy evaluate for diet advancement.

Interview with a dietary staff on 12/08/21 at 12:15pm revealed:
-Resident #6 had already eaten his lunch and gone back to his room.
-Resident #6 did not want the ham and cheese tortilla wrap so he only ate the potato chips, broccoli pasta salad and the pudding.

Interview with the Dietary Supervisor on 12/09/21 at 9:12am revealed:
-Resident #6's diet order was changed to a pureed diet in September 2021.
-Each time he was given the pureed diet he refused it.
-Resident #6 was receiving a mechanical soft diet and she was careful to chop his food well.

Interview with Resident #6's PCP on 12/08/21 at 11:03am revealed:
-Resident #6 was ordered a pureed diet on 09/22/21 due to possible aspiration.
-He was not aware Resident #6 was not receiving the pureed diet.
-He did not want Resident #6 upgraded to a mechanical soft diet until a speech therapist

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determined it was safe.
-He expected staff to follow diet orders.
-Not following the diet order could cause Resident #6 to aspirate the food and develop aspiration pneumonia.

Refer to Interview with the Administrator on 12/08/21 at 11:45am.

3. Review of Resident #2's current FL2 dated 06/28/21 revealed:
-Diagnoses included intractable epilepsy, seizure disorder,, hypothyroidism and history of transient ischemic attack.
-There was a low glycemic, high protein, low carbohydrate epilepsy diet order.

Interview with the Dietary Supervisor on 12/07/21 at 12:23am revealed:
-Resident #2's diet order changed to a low glycemic, low carbohydrate, high protein, epilepsy diet about a year ago.
-She did not know what an epilepsy diet was.
-She used the internet to search for information about the diet but was unsuccessful.
-The Medication Aide (MA) who informed her of the diet change about a year ago was going to research the diet also, but she was also unsuccessful.
-She never asked the Primary Care Provider (PCP) about the diet.
-When she started working at the facility about 3 years ago, she did not receive much training on therapeutic diets.

Interview with the MA on 12/09/21 at 8:30am revealed:
-When Resident #2's diet order was changed to an epilepsy diet she printed up a packet of information for the kitchen staff.

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D 310	Continued From page 29 -She was not sure if the dietary staff followed the diet information provided to them. -Resident #2 was alert enough to tell the kitchen if the menu was incorrect. -All diet changes were communicated to the kitchen staff and a copy of the new diet order was placed in the kitchen's diet order book. Interview with Resident #2's PCP on 12/08/21 at 1:00pm revealed: -Resident #2's neurologist prescribed her diet. -He did not know specifically what an epilepsy diet consisted of but he would assume it limited caffeine, alcohol and other stimulants. -He renewed the diet order when he signed her FL2. Telephone interview with the medical assistant from Resident #2's neurologist office on 12/08/21 at 2:25pm revealed: -Resident #2 was prescribed a low glycemic, low carbohydrate, high protein epilepsy diet a year ago to help control her seizures. -Not having the prescribed diet increased her risk of having seizures. -Seizures could cause brain damage and increased falls. -Resident #2 was last seen at the office on 11/03/21 at which point she informed the neurologist her seizure rate was increasing. Interview with Resident #2 on 12/08/21 at 3:49pm revealed: -She was offered a ham and cheese tortilla wrap, broccoli pasta salad, potato chips and pudding for lunch. -She requested the tortilla be substituted with one slice of whole wheat bread. -She ate the broccoli out of the salad, a few bites of potato chips and declined the pudding.	D 310		

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-She returned to her room and ate some peanut butter which she purchased.
-She had been on the special diet for about a year.
-The kitchen staff told her they would try to accommodate it but did not know if they would always be able to adhere to it as it was different from the facility menu.
-She never knew what was going to be offered because the food did not match the published menu.

Refer to Interview with the Administrator on 12/08/21 at 11:45am.

____

Interview with the Administrator on 12/08/21 at 11:45am revealed:
-All diet orders were reviewed upon admission to see if the diet could be accommodated.
-All new diet orders were processed through the MA, who informed the dietary staff of the change.
-The kitchen had a book that all diet orders were kept in and she expected dietary staff to follow the correct diets.
-She was unaware ordered therapeutic diets were not being followed.
-She expected everyone to provide the correct diet to residents with therapeutic diet orders.
-The RCC or the Administrator should check monthly to be sure diets were being followed correctly.

____

The facility failed to ensure therapeutic diets were served as ordered to 3 of 7 sampled residents related to a resident who had an order for a low glycemic, low carbohydrate, high protein epilepsy diet which could result in a fall and brain damage due to a seizure (#2), a resident ordered pureed diet order which could lead to aspiration pneumonia (#6) and a resident who was ordered

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a pureed diet with nectar thickened liquids observed coughing after drinking thin liquids at a medication administration which could result in aspiration pneumonia (#8). This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.

____

The facility to provide a plan of protection in accordance with G.S. 131D-34 on 12/08/21 for this violation.

THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 23, 2021.

D 358 | 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 medications were administered as ordered for 2 of 7 sampled residents (#6, #5) related to two medications without a physician's order (#6 , #5).

The findings are:

1. Review of Resident #6's current FL2 dated 07/13/21 revealed diagnoses included pulmonary

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hypertension and hearing loss.

Observation during the initial tour on 12/07/21 at 9:24am revealed:
-Resident #6 had a plastic bag on his bedside table.
-Inside the bag was a bottle labeled Vitamin D3 (supplement) 25mcg 100 soft gels and two bottles labeled CoQ10 (supplement) 200mg 40 soft gels.
-The bottles did not have a pharmacy label on them.
-The bottles were half full.

Interview with Resident #6 on 12/07/21 at 9:24am revealed:
-He administered the Vitamin D3 to himself daily.
-He administered the CoQ10 to himself every other day.
-The staff would drive him to the store where he would purchase the supplements.

Review of physician's orders for Resident #6 revealed there were not any orders for the Vitamin D3 and
CoQ10.

Review of Resident #6's electronic Medication Administration Record (eMAR) for December 1-7, 2021 revealed there was not an entry for Vitamin D3 or CoQ10.

Interview with a Medication Aide (MA) on 12/07/21 at 3:58pm revealed:
-Resident #6 should not have had medications in his room without a physician's order.
-Activity staff would take the resident to the store and he must have bought the medications there.

Interview with the Resident Care Coordinator

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(RCC) on 12/08/21 at 11:15am revealed:
-She did not know Resident #6 had medications in his room.
-Residents are required to have a physician's order for all medications.

Telephone order with the facility's contracted Nurse Practitioner (NP) on 12/08/21 at 11:03am revealed residents are required to have a physician's order for all medications including supplements.

Interview with the Administrator on 12/09/21 at 11:15am revealed that the residents are required to have a physician's order for all medications.

2. Review of Resident #5's current FL2 dated 09/18/20 revealed diagnoses included history of head injury, allergic rhinitis and osteopenia.

Observation during the initial tour on 12/07/21 at 9:33am revealed:
-Resident #5 had a bottle of loratadine (allergy medication) and a bottle of Tums (antacid) on her dresser.
-The bottles did not have a pharmacy label on them.
-The bottles were half full.

Interview with the Medication Aide (MA) on 12/07/21 at 2:55pm revealed:
-Resident #5 had orders for self-administration of medications.
-Resident #5 purchased her own medications at a local pharmacy.
-Resident #5 should not have had medications in her room without a physician's order.

Interview with Resident #5 on 12/07/21 at 3:00pm revealed:

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-She administered the loratadine when her allergies were bothersome.
-She administered the Tums when she felt constipated.
-The staff obtained the two medications from the store for her.
-Her physician knew she used the medications.
-She had papers in her record to self-administer her medications.

Review of Resident #5's Self Administration Assessment revealed:
-Resident #5 was assessed on 01/09/19 and documented to be fully capable to administer her own medications.
-Resident #5's physician documented authorization self-administration of medications on 08/20/19.

Review of physician's orders for Resident #6 revealed there were not any orders for the loratadine or Tums.

Review of Resident #6's electronic Medication Administration Record (eMAR) for December 1-7, 2021 revealed there was not an entry for loratadine or Tums.

Telephone interview with a nurse from Resident #5's Primary Care Provider (PCP) on 12/08/21 at 11:34am revealed:
-There was no progress note in her chart to indicate the PCP knew Resident #5 was taking loratadine or Tums.
-There was no order for loratadine or Tums.

Interview with the Administrator on 12/09/21 at 11:15am revealed residents were required to have a physician's order for all medications.

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D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report to the local County Department of Social Services (DSS) for 2 of 6 sampled residents (#4, #9), who required emergency medical attention. The findings are: 1. Review of Resident #4's current FL2 dated 10/04/21 revealed diagnoses included dementia, and hypertension. Review of the Charting Notes for Resident #4 dated 11/22/21 revealed: -Resident #4 fell, hit her head, and sustained a large knot to the right side of her forehead. -Resident #4 was transported to the Emergency Department (ED) by Emergency Medical Services (EMS). -Resident #4 was transported back to the facility with a "closed head injury". Review of the Charting Notes for Resident #4 dated 12/02/21 revealed: -Resident #4 observed on the floor with her	D 451		

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hands "covered in blood" and blood dripping from her forehead area.
-Resident #4 was transported to the ED by EMS.
-Resident #4 was transported back to the facility.

Review of Accident and Incidents (A&I) reports for Resident #4 revealed there were not any.

Interview with a Medication Aide (MA) on 12/08/21 at 10:40am revealed:
-She had been told by a previous Resident Care Coordinator (RCC) to send the A&I reports to DSS only if a resident had been admitted to the hospital for an injury.
-She did not know if an A&I report had been completed for Resident #4 on 11/22/21 and 12/02/21.

Interview with a second MA on 12/09/21 at 9:45am revealed:
-There had been 4 different RCCs in the last 3 years and all required something different to be done with A&I reports.
-She had been told by a previous RCC not to send the A&I reports to DSS.

Interview with the Adult Home Specialist (AHS) from the local DSS on 12/08/21 at 12:04pm revealed:
-The facility should be sending her the A&I reports for all residents that are sent to the ED for an evaluation of an injury.
-She had not received any A&I reports from the facility since 10/11/21.

Refer to the interview with the Resident Care Coordinator (RCC) on 12/08/21 at 11:15am.

Refer to the interview with the Administrator on 12/09/21 at 11:15am.

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D 451	Continued From page 37 2. Review of the current FL2 for Resident #9 dated 06/14/21 revealed diagnoses included dementia, atrial fibrillation, hypothyroidism, and depression. Review of the Visit Summary Report from the local hospital for Resident #9 dated 11/02/21 revealed: -Reason for the visit to the emergency department (ED) was a closed head injury, fall, scalp laceration, closed fracture of the right elbow with malunion (when a bone heals in an abnormal position, subsequent encounter. Review of the Charting Notes for Resident #9 dated 11/02/21 at 7:08am revealed Resident #9 was found in the floor with a gash on the top of his head and was transported to the local ED. Review of the Visit Summary Report from the local hospital for Resident #9 dated 10/18/21 revealed: -The reason for visit to the ED was from elbow pain. -Diagnosis was a closed elbow fracture of olecranon process (forms the outer bump of the elbow) of the right ulna (one of the two bones that make up the forearm). Review of the Charting Notes for Resident #9 dated 10/18/21 at 10:27am revealed: -Staff notified the Power of Attorney (POA) Resident #9 had an elbow fracture and physician wanted resident sent out to the ED. Review of the Charting Notes for Resident #9 dated 10/18/21 at 12:53pm revealed POA transported Resident #9 to the local ED.	D 451		

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Review of the Visit Summary Report from the local hospital for Resident #9 dated 08/26/21 revealed The reason for visit to the ED was for a fall with facial lacerations and laceration repair.

Review of the Charting Notes for Resident #9 dated 08/26/21 revealed there was no documentation of the fall with Resident #9 being sent to the hospital.

Review of Accident and Incidents (A&I) reports for Resident #9 revealed there were not any.

Interview with the Adult Home Specialist (AHS) from the local DSS on 12/08/21 at 10:25am revealed:
-The facility should be sending her the A&I reports for all residents that are sent to the ED for an evaluation of an injury.
-She had not received any A&I reports from the facility since 10/11/21.
-There had been no incidents reports received for Resident #9.

Interview with a medication aide (MA) on 12/08/21 at 10:35am revealed:
-Incident and accident reports were only sent to the local Department of Social Services (DSS) if a resident was admitted to the hospital or if a resident died.
-She did not have any notifications for DSS.
-In the past the Resident Care Coordinator (RCC) was responsible for sending the A&I reports to the local DSS.

Refer to the interview with the RCC on 12/08/21 at 11:15am.

Refer to the interview with the Administrator on 12/09/21 at 11:15am.

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D 451	Continued From page 39 ____ Interview with the RCC on 12/08/21 at 11:15am revealed she did not know that A&I reports were required to be sent to the local DSS if a resident was sent to the ED for an evaluation of an injury. Interview with the Administrator on 12/09/21 at 11:15am revealed: -The staff that witnessed the accident was responsible for completing the A&I reports. -The MA would send the report to DSS if the resident went to the ED for an evaluation of an injury. -She did not know staff had not been sending the reports to DSS.	D 451		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present to meet the needs of the residents in a Special Care Unit (SCU) on 1st, 2nd, and 3rd shifts for 10 of 24 sampled shifts on 11/25/21 and 12/01/21 to 12/07/21.	D 465		

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The findings are:

The facility was licensed by the Division of Health Service Regulation as having a SCU with a capacity of 24 beds.

Review of the facility resident census for 11/25/21 and 12/01/21 to 12/07/21 revealed there was a SCU census of 21 residents which required 21 staff hours on 1st and 2nd shift and 16.8 hours on 3rd shift.

Review of the individual staff time sheets dated 11/25/21 revealed:
-On 2nd shift from 7:00pm to 8:30pm there were 1.5 staff hours provided, with a shortage of 19.5 hours.
-On 2nd shift from 8:30pm to 11:00pm there were 5.0 staff hours provided, with a shortage of 16 hours.

Review of the individual staff time sheets 12/01/21 to 12/07/21 revealed:
-On 12/01/21, on 2nd shift there were 18.5 staff hours provided, with a shortage of 2.5 hours.
-On 12/02/21, on 1st shift there were 19.5 staff hours provided, with a shortage of 1.5 hours.
-On 12/04/21, on 1st shift there were 14.5 staff hours provided, with a shortage of 6.5 hours.
-On 12/04/21, on 2nd shift there were 18 staff hours provided, with a shortage of 3 hours.
-On 12/05/21, on 1st shift there were 15.75 staff hours provided, with a shortage of 5.25 hours.
-On 12/05/21, on 2nd shift there were 14.5 staff hours provided, with a shortage of 6.5 hours.
-On 12/05/21, on 3rd shift there were 12 staff hours provided, with a shortage of 4.8 hours.
-On 12/06/21, on 2nd shift there were 12 staff hours provided, with a shortage of 9 hours.
-On 12/07/21, on 1st shift there were 18 staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL075010	A. BUILDING: ______ B. WING ______	12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOODS	1062 WEST MILLS STREET COLUMBUS, NC 28722

(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 465	Continued From page 41 hours provided, with a shortage of 3 hours. Interview with a medication aide (MA) on 12/08/21 at 8:30am revealed: -Sometimes the facility would be short of staff. -A local staffing agency was providing staff and it had gotten better but the facility was still short of staff occasionally. Interview with the Administrator on 12/09/21 at 11:15am revealed: -She was not aware of the facility being short of staff in the last month. -She was not always aware when staff called out of work for the shift. -Two local staffing agencies were providing staff for the facility. -Two MAs would stay past the end of their shifts if staff called out of work for the shift.	D 465		
D 467	10A NCAC 13F .1308 (c) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (c) In units of 16 or more residents and any units that are freestanding facilities, there shall be a care coordinator as required in Paragraph (b) of this Rule in addition to the staff required in Paragraph (a) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interview the facility failed to have a Special Care Coordinator (SCC) working in the facility's 24 bed special care unit (SCU) for 8 hours per day, 5 days a week, to	D 467		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL075010	A. BUILDING: ______ B. WING ______	12/09/2021

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D 467	Continued From page 42	D 467		

supervise the care of the residents residing in the special care unit.

The findings are:

The facility was licensed by the Division of Health Service Regulation as having a SCU with a capacity of 24 beds.

Review of the facility resident census for 12/01/21 to 12/07/21 revealed there was a SCU census of 21 residents.

Interview with the Administrator on 12/08/21 at 9:22am revealed:
-She became the Administrator 1 month ago.
-The facility employed one Resident Care Coordinator (RCC) who supervised both the assisted living unit and the SCU.
-There currently was not anyone assigned specifically to the SCU as a SCC.
-The current RCC had been in her position for 2 1/2 weeks.
-The previous RCC was in that position for 2-3 months and she was not sure if she had an assistant for the SCU.
-There had been a lot of turnover in the RCC position.
-She was currently interviewing to fill a position to help the RCC.
-She thought they were in compliance with the regulation because they had an RCC who supervised the entire building.

Interview with a Medication Aide (MA) on 12/09/21 at 8:30am revealed:
-The current RCC started just over 2 weeks ago.
-There had been a lot of turnover in that position since summer.
-There was an RCC that worked here for 3 years

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	HAL075010	A. BUILDING: ______ B. WING ______	12/09/2021

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D 467	Continued From page 43 and she supervised the whole building. -There was never anyone assigned as a SCC. -At one time the RCC had an assistant but she was not the SCC, she just assisted the RCC.	D 467		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and regulations as related to health care referrals and therapeutic diets. The findings are: 1. Based on observations, record reviews, and interviews the facility failed to ensure referral and follow up to meet the acute healthcare needs for 4 of 7 sampled residents (Residents #2, #6, #8, #9) related to a physician follow up to evaluate pain (#2), a speech therapy referral to evaluate swallowing (#6, #8) and no orders for the care of an open tracheostomy (#9). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 2.Based on observations, record reviews and interviews the facility failed to ensure therapeutic diet orders were served as ordered for 3 of 7	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D912	Continued From page 44 residents (#2, 6, 8) who had orders for a low glycemic, low carbohydrate, high protein, epilepsy diet (#2), a puree diet (#6) and a puree diet with nectar thickened liquids (#8). [Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)].	D912		