STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL027003	A. BUILDING: _____ B. WING _____	R-C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on March 30, 2022 through March 31, 2022.	{D 000}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to serve therapeutic diets as ordered by the primary care provider (PCP) for 1 of 5 sampled residents who had a diet order for a pureed diet and honey thickened liquids (#1). The findings are: Resident #1's current FL-2 dated 03/24/22 revealed: -Diagnoses included dementia and gastroesophageal reflux disease (GERD). -The resident was intermittently disoriented. -Her level of care was Special Care Unit (SCU). -Resident #1 had a diet order of pureed foods with honey thickened liquids. Review of a facility therapeutic diet list dated 03/30/22 revealed:	{D 310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL027003	A. BUILDING: _____ B. WING _____	R-C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(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 310}	Continued From page 1 -Resident #1 had an order for a diet of pureed foods that was ordered by the primary care provider (PCP) on 01/21/22. -Resident #1 had an order for a diet of honey thickened liquids that was ordered by the PCP on 01/25/22. Observation of a printed diet order list in the kitchen for residents on the SCU on 03/30/22 at 11:30am revealed Resident #1 was listed as having a pureed diet with honey thickened liquids. Review of the facility's weekly diet menu revealed: -The lunch menu for 03/30/22 listed turkey deli sandwich, capri blend, milk, and ice cream sandwich. -Kielbasa sausage was substituted for the turkey deli sandwich, broccoli was substituted for the capri blend, and jello was substituted for the ice cream sandwich. -Baked beans were added to the menu. -The lunch menu for 03/31/22 listed chicken patty sandwich, mixed vegetables, sweet potato tots, milk, and fresh pears. -Sweet potato fries were substituted for sweet potato tots and pineapple upside down cake was substituted for fresh pears. Observation of Resident #1's meal preparation in the main kitchen on 03/30/22 at 11:31am revealed a dietary aide poured water and tea for Resident #1 that was prepackaged and labeled as honey thickened liquids. Observation of Resident #1 on 03/30/22 from 11:56am-12:14pm revealed: -She was seated in a wheelchair at a table in the SCU dining room. -She was served a lunch which consisted of	{D 310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL027003	A. BUILDING: _____ B. WING _____	R-C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(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 310}	Continued From page 2 Kielbasa sausage which was a pureed consistency, broccoli which was a pureed consistency, and baked beans which was a pureed consistency. -She was served water and tea which was a honey thickened consistency. -The resident was being fed by a medication aide (MA). -The resident took one bite of the pureed sausage and stated she did not like it. -The resident took one bite of the baked beans and stated she did not like it. -The resident refused to try the broccoli. -The MA made attempts to get Resident #1 to try the food again. -At 12:04pm the MA asked the resident if she wanted jello instead of the food she had. -A facility staff member brought jello which was not well formed to the resident's table in a bowl. -At 12:05pm Resident #1 coughed while eating the jello and the MA gave her honey thickened water to drink. -The resident ate 100 percent of the jello. Observation of the SCU kitchen on 03/30/22 at 12:12pm revealed: -There was jello in the refrigerator. -There was not an alternative dessert in the refrigerator or on the food cart. Interview with the DM on 03/30/22 at 11:31am revealed: -The meals were prepared in the main kitchen and then taken to SCU to be served to the residents there. -The facility was serving jello for dessert. -He did not know if jello could be served as part of Resident #1's ordered diet. -He was providing a pudding cup to be served to Resident #1 instead of jello.	{D 310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL027003	A. BUILDING: _____ B. WING _____	R-C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(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 310}	Continued From page 3 Interview with the DM on 03/30/22 at 12:17 pm revealed: -The SCU staff knew that if jello was served Resident #1 should receive pudding instead. -He was not sure how the SCU staff knew this but it was the "general consensus". -A pudding pack was sent back to the SCU kitchen at lunch to be served to Resident #1 but it was not labeled with Residents #1's name. Observation of Resident #1 on 03/31/22 from 12:02pm-12:07pm revealed: -The resident was seated in a wheelchair at a table in the SCU dining room. -The resident was served a lunch which consisted of a chicken patty which was a pureed consistency, mixed vegetable which was a pureed consistency, and sweet potato fries which was a pureed consistency. -She was served water and tea which was a honey thickened consistency. -She was served peaches which were a pureed consistency which were labeled with Resident #1's name and labeled as pureed. -The resident was being fed by a personal care aide (PCA). -There was no coughing noted. Interview with a MA on 03/31/22 at 10:15am revealed: -Residents' food was delivered to the SCU by kitchen staff. -The meals were labeled according to what type of diet it was. -The meals were not labeled with residents' names. -The SCU staff knew which diets to serve to the residents because they had been working with the residents long enough to know which diets to	{D 310}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL027003	A. BUILDING: _____ B. WING _____	R-C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(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 310}	Continued From page 4 serve to them. -If she saw that a resident received the wrong diet she would see if something else was available for the resident and if there was not an alternative available in the SCU kitchen she would go to the main kitchen to get an alternative which fit the resident's diet. -Resident #1 was on a pureed diet with thickened liquids. -Jello was not a thickened liquid. -She fed Resident #1 jello on 03/30/22 because it was the only dessert provided for the resident. -She did not look to see if there was an alternative dessert available for Resident #1 and fed her what was given to her by another staff member. Interview with the Administrator on 03/31/22 at 1:40pm revealed: -She expected residents to receive their therapeutic diets as ordered by the PCP. -It was important that the residents received their therapeutic diets as ordered by the PCP because the diets are ordered based on the resident's conditions. -Resident #1 was placed on a pureed diet with thickened liquids by the PCP because the resident was aspirating her food. (Aspiration is the accidental breathing in of food or fluid into the lungs.)	{D 310}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name;	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL027003	A. BUILDING: _____ B. WING _____	R-C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(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 367}	Continued From page 5 (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the electronic medication administration records were accurate for 1 of 5 sampled residents including errors with insulin administration (#4). The findings are: Review of Resident #4's current FL-2 dated 03/14/22 revealed diagnoses included diabetes mellitus. Review of Resident #4's physician order sheet dated 02/03/22 revealed there was an order for Lantus Solostar Insulin give 35 units at 8:00am, hold if blood sugar is less than 150 (Lantus is a long acting insulin used to treat high blood sugar). Review of Resident #4's February 2022 electronic medication administration record (eMAR) revealed:	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL027003	A. BUILDING: _____ B. WING _____	R-C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(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 367}	Continued From page 6 -There was an entry for Lantus Solostar Insulin, administer 35 units, with instructions to hold if blood sugar was less than 150, scheduled for administration at 8:00am. -On 02/06/22 at 8:00am, Resident #4's blood sugar was 123 and Lantus Solostar Insulin was documented as administered. -On 02/09/22 at 8:00am, Resident #4's blood sugar was 135 and Lantus Solostar Insulin was documented as administered. -On 02/22/22 at 8:00am, Resident #4's blood sugar was 132 and Lantus Solostar Insulin was documented as administered. -On 02/06/22, 02/09/22, and 02/22/22 at 8:00am the medication aide (MA) documented the blood sugar result in the area for parameters noted, previous site used, and site. Review of Resident #4's March 2022 eMAR revealed: -There was an entry for Lantus Solostar Insulin, administer 35 units, with instructions to hold if blood sugar was less than 150, scheduled for administration at 8:00am. -On 03/07/22 at 8:00am, Resident #4's blood sugar was 139 and Lantus Solostar Insulin was documented as administered. -On 03/13/22 at 8:00am, Resident #4's blood sugar was 143 and Lantus Solostar Insulin was documented as administered. -On 03/23/22 at 8:00am, Resident #4's blood sugar was 149 and Lantus Solostar Insulin was documented as administered. -On 03/26/22 at 8:00am, Resident #4's blood sugar was 100 and Lantus Solostar Insulin was documented as administered. -On 03/28/22 at 8:00am, Resident #4's blood sugar was 142 and Lantus Solostar Insulin was documented as administered. -On 03/07/22, 03/13/22, 03/23/22, and 03/26/22	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL027003	A. BUILDING: _____ B. WING _____	R-C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(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 367}	Continued From page 7 at 8:00am the MA documented the blood sugar result in the area for parameters noted, previous site used, and site. Interview with Resident #4 on 03/30/22 at 9:15am revealed: -The MA was responsible for administering her insulin. -The MA always checked her blood sugar before giving her insulin. -She was not able to recall if there were times when the MA held her insulin because of a lower result. Interview with an MA on 03/31/22 at 11:57am revealed: -She was responsible for administering Resident #4 her medications on 02/22/22, 03/07/22, 03/13/22, 03/23/22, and 03/26/22. -When Resident #4's blood sugar was below 150, she held her Lantus Solostar Insulin per the order. -When a medication was held, there was an option on the computerized charting to hold and state the reason such as parameters not met. -For insulin documentation, she was not able to choose that option so she would document the blood sugar in the area for parameters noted, previous site used, and site to show that she did not administer the insulin. -She had not notified the Resident Care Coordinator (RCC) that insulin documentation was an issue when parameters were not met. Interview with the RCC on 03/31/22 12:36pm revealed: -She expected MA to document on the eMAR accurately and completely. -When a medication was held it would print on the eMAR in parenthesis to show it was held and	{D 367}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL027003	A. BUILDING: _____ B. WING _____	R-C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(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 367}	Continued From page 8 there would be a reason listed such as parameters not met. -She was not aware that MAs were documenting the blood sugar results under parameter notes, previous site used, and results rather than documenting that the medication was held. Interview with the Administrator on 03/31/22 at 12:40pm revealed she expected the MA to document completely and accurately on the eMAR.	{D 367}		