STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036023	A. BUILDING: ______ B. WING ______	09/16/2022

NAME OF PROVIDER OR SUPPLIER: **TERRACE RIDGE ASSISTED LIVING**

STREET ADDRESS, CITY, STATE, ZIP CODE: **1251 E HUDSON BLVD, GASTONIA, NC 28054**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 09/15/22 to 09/16/22.	D 000		
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 interviews and record reviews, the facility failed to maintain an accurate and current list of residents that required physician ordered therapeutic diets for 2 of 3 sampled residents related to a mechanical soft with ground meats diet (#2) and a dental soft diet with 80 grams of protein that was limited to 60 grams of carbohydrates, 2 grams of sodium, 1 gram of phosphorus, 2 grams of potassium and 1500 milliliters of fluid per day (#4). The findings are: 1. Review of Resident #2's current FL2 dated 07/19/22 revealed: -Diagnoses included generalized muscle weakness. -A cardiac diet order. Review of Resident #2's FL2 Verification Form dated 08/03/22 revealed an order for a mechanical soft diet with ground meat.	D 309		

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Review of the therapeutic diet list posted in the kitchen on 09/15/22 revealed Resident #2 was not on the list.

Review of the diet binder in the kitchen on 09/15/22 at 11:00am revealed:
-All of the diet orders were written on a facility specific diet order form.
-Resident #2 had a regular diet order according to the facility diet order form.

Interview with a cook on 09/16/22 at 3:45pm revealed:
-Resident #2 took a long time to eat her meals but she did not think Resident #2 was on a therapeutic diet.
-If the resident was on a therapeutic diet then the doctor would have given an order and Resident #2 would be on the therapeutic diet list.

Refer to the interview with the Food Service Director (FSD) on 09/15/22 at 10:45am.

Refer to the telephone interview with the Facility's Registered Nurse (RN) on 09/16/22 at 10:12am.

Refer to the interview with the Administrator on 09/16/22 at 4:26pm.

Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 09/16/22 at 4:08pm was unsuccessful.

2. Review of Resident #4's current FL2 dated 08/02/22 revealed:
-Diagnoses included inlcuded hypervolemia, hypertensive urgency, end stage renal disease on hemodialysis and insulin dependent diabetes mellitus.

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-A diet order was not documented.

Review of Resident #4's FL2 Verification Form dated 08/04/22 revealed discharge diet restrictions included a dental soft diet with 80 grams of protein that was limited to 60 grams of carbohydrates, 2 grams of sodium, 1 gram of phosphorus, 2 grams of potassium and 1500 milliliters of fluid per day.

Review of the therapeutic diet list posted in the kitchen on 09/15/22 revealed:
-Resident #4 was on a consistent carbohydrate diet.
-"No bologna, no hotdog, no biscuit, no cornbread" was noted next to Resident #4's name.

Review of the diet binder in the kitchen on 09/15/22 revealed:
-All of the diet orders were written on a facility specific diet order form.
-Resident #4 had a consistent carbohydrate diet order according to the facility's diet order form.

Interview with the cook on 09/16/22 at 3:45pm revealed:
-Resident #4 was on a consistent carbohydrate diet but was particular about what she ate.
-The kitchen would not serve her certain foods since she was on dialysis.
-The FSD told her what Resident #4 was allowed to eat.

Refer to the interview with the FSD on 09/15/22 at 10:45am.

Refer to the telephone interview with the Facility's RN on 09/16/22 at 10:12am.

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D 309	Continued From page 3 Refer to the interview with the Administrator on 09/16/22 at 4:26pm. Attempted telephone interview with Resident #4's PCP on 09/16/22 at 4:07pm was unsuccessful. ____________________________ Interview with the FSD on 09/15/22 at 10:45am revealed: -She made the therapeutic diet list but could not remember the last time it was updated. -She kept all of the diet order forms that the Facility's RN gave her in a binder located in the kitchen. -The Facility's RN told her she needed to update the board but she had not gotten around to it. -Residents on a regular diet where not listed on the board.. Telephone interview with the Facility's RN on 09/16/22 at 10:12am revealed: -She was responsible for giving the residents' diet orders to the kitchen. -She processed the orders on FL2 Verification Forms. -She thought the resident's PCP had to sign a facility specific diet order form for the resident's diet order to change. -She was not aware that the diet order on a resident's FL2 Verification Form was an active order. -She had only been working at the facility for two months and was not sure if anyone audited the therapeutic diet list. Interview with the Administrator on 09/16/22 at 4:26pm revealed: -The Facility's RN was responsible for giving the residents' diet orders to the FSD or lead cook. -The FSD was responsible for updating the therapeutic diet list.	D 309		

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D 309	Continued From page 4 -She expected the diet orders to be written on the facility's diet order form but if diet orders were written on a different document they were still considered orders that the facility needed to follow. -The Facility's RN should have communicated the new diet orders to the kitchen on the days they were received.	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: Based on observations, record reviews and interviews, the facility failed to ensure therapeutic diets were served as ordered for 2 of 3 sampled residents related to a mechanical soft diet with ground meats (#2) and a dental soft diet with 80 grams of protein that was limited to 60 grams of carbohydrates, 2 grams of sodium, 1 gram of phosphorus, 2 grams of potassium and 1500 milliliters of fluid per day (#4). The findings are: 1. Review of of Resident #2's current FL2 dated 07/19/22 revealed: -Diagnoses included generalized muscle	D 310		

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weakness.
-A cardiac diet order.

Review of Resident #2's FL2 Verification Form dated 08/03/22 revealed an order for a mechanical soft diet with ground meat.

Review of the therapeutic diet list posted in the kitchen on 09/15/22 revealed Resident #2 was not on the list.

Review of the diet binder in the kitchen on 09/15/22 revealed Resident #2 had a regular diet order.

Review of the posted regular diet diet menu for lunch on 09/15/22 revealed pork roast, pinto beans, cooked cabbage and pineapple.

Observation of the lunch meal service for Resident #2 on 09/15/22 from 12:17pm to 12:47pm revealed:
-Resident #2 was served iced tea, pinto beans, corn bread, cooked cabbage and pork roast that was cut into pieces.
-Resident #2 ate less than 50% of her lunch and chewed the food for long periods of time.

Review of the therapeutic diet menus for lunch on 09/15/22 revealed there was not a therapeutic diet menu for a mechanical soft diet with ground meat.

Interview with the cook on 09/16/22 at 3:45pm revealed:
-Resident #2 took a long time to eat her meals and sat at a table with other residents that required assistance with meals.
-She did not think Resident #2 was on a therapeutic diet since she was not on the

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therapeutic diet list.
-She served Resident #2 a regular diet meal and was not aware that Resident #2 had a diet order for a mechanical soft diet with ground meats.

Telephone interview with the Facility's Registered Nurse (RN) on 09/16/22 at 10:12am revealed:
-Resident #2's overall condition had recently changed including her nutritional status.
-She asked the Primary Care Provider (PCP) to change Resident #2's diet from a regular diet.
-The PCP wrote an order for a soft diet on 08/30/22 but she wanted more details on what kind of soft diet Resident #2 required.
-She was waiting on the PCP to clarify the diet order before she informed the kitchen of Resident #2's diet order change.
-She did not realize the diet order on Resident #2's FL2 Verification form was an active order.

Interview with the Speech Therapist on 09/16/22 at 9:50am and 2:12pm revealed:
-She originally started seeing Resident #2 for cognitive therapy.
-When she visited the facility last week, she noticed that Resident #2 was still eating her breakfast after 9:00am.
-Staff at the facility reported Resident #2 had been eating less at meals than she usually did.
-She thought Resident #2 was on a regular diet but a medication aide (MA) informed her that the kitchen served mechanical soft foods to Resident #2.
-She was not aware that Resident #2 had an order for a mechanical soft diet with ground meat on 08/03/22.
-She observed Resident #2 eat bolonga at breakfast this morning (09/16/22) and noticed that it took her a long time to chew it.
-The bolonga that was served this morning

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(09/16/22) was considered soft and the kitchen cut it up but it was not considered to be chopped or ground.
-Resident #2's lunch on 09/15/22 of pinto beans, corn bread, cooked cabbage and pork roast that was cut into pieces would be appropriate for a mechanical soft diet; however, the pork roast should have been ground to match her diet order.
-When Resident #2 had to spend a lot of time chewing food it caused her to use more energy and she would end up eating less food due to being tired.

Refer to the interview with the Food Service Director (FSD) on 09/15/22 at 10:45am.

Refer to the interview with the Administrator on 09/16/22 at 4:26pm.

Attempted telephone interview with the facility's contracted registered dietitian on 04/16/22 at 4:06pm was unsuccessful.

Attempted telephone interview with Resident #2's PCP on 09/16/22 at 4:08pm was unsuccessful.

Based on interviews and record review it was determined that Resident #2 was not interviewable.

2. Review of Resident #4's current FL2 dated 08/02/22 revealed:
-Diagnoses included hypervolemia, hypertensive urgency, end stage renal disease on hemodialysis and insulin dependent diabetes mellitus.
-A diet order was not documented.

Review of Resident #4's FL2 Verification Form dated 08/04/22 revealed discharge diet

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restrictions included a dental soft diet with 80 grams of protein that was limited to 60 grams of carbohydrates, 2 grams of sodium, 1 gram of phosphorus, 2 grams of potassium and 1500 milliliters of fluid per day.

Review of the therapeutic diet list posted in the kitchen on 09/15/22 revealed Resident #4 was on a consistent carbohydrate diet and could not have bolonga, hotdogs, corn bread or biscuits.

Review of the diet binder in the kitchen on 09/15/22 revealed Resident #4 was on a consistent carbohydrate diet.

Review of the posted regular diet menu for breakfast on 09/16/22 revealed grits, eggs, bolonga and toast.

Observation of the breakfast meal service on 09/16/22 at 8:30am revealed Resident #4 was served grits, two hard boiled eggs, toast and coffee.

Review of the therapeutic diet menus posted in the kitchen on 09/15/22 revealed:
-There was a therapeutic diet menu for a soft diet.
-The planned breakfast for a soft diet on 09/16/22 included orange juice, cream of wheat, Mandarin orange slices, ground sausage and pancakes.
-There was not a therapeutic diet menu for a diet that included 80 grams of protein that was limited to 60 grams of carbohydrates, 2 grams of sodium, 1 gram of phosphorus, 2 grams of potassium and 1500 milliliters of fluid per day.

Interview with Resident #4 on 09/16/22 at 12:35pm revealed she thought the facility served her a salt free, sugar free diet and also limited the

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amount of fluid she was allowed to drink.

Interview with the cook on 09/16/22 at 3:45pm revealed:
-She only cooked dinner and somedays Resident #4 did not come to dinner due to being at dialysis.
-Resident #4 was on a consistent carbohydrate diet but she was also limited on certain foods due to being on dialysis.
-The FSD told the cook what Resident #4 was allowed to have but she did not have anything written to follow.

Telephone interview with the Clinic Manager at Resident #4's dialysis center on 09/16/22 at 11:36am revealed:
-The clinic's dietitian was out on leave.
-Resident #4's record at the dialysis clinic revealed that she should be following a renal diet.
-The renal diet was limited to 2 grams of sodium, 2 grams of potassium, limited high phosphorus items (dark colas, biscuits and hot dogs) and limited fluid intake to 1500 mL per day.
-Resident #4 should also be on a high protein diet which would be 110 grams of protein per day, based on her body frame.
-Foods such as bananas and oranges should be avoided due to their high potassium content.
-If Resident #4 did not follow the high protein, renal diet then it could alter the levels of phosphorus, potassium and albumin (protein) in her blood stream.

Telephone interview with the Facility's RN on 09/16/22 at 10:12am revealed:
-She processed the orders on Resident #4's FL2 Verification Form.
-She thought the diet order needed to be signed by the PCP and did not realize the diet order on the FL2 Verification form was an active order.

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-She did not transcribe Resident #4's diet order dated 08/03/22 onto a facility specific diet order form for the kitchen.

Refer to the interview with the FSD on 09/15/22 at 10:45am.

Refer to the interview with the Administrator on 09/16/22 at 4:26pm.

Attempted telephone interview with the facility's contracted registered dietitian on 04/16/22 at 4:06pm was unsuccessful.

Attempted telephone interview with Resident #4's PCP on 09/16/22 at 4:07pm was unsuccessful.

____

Interview with the FSD on 09/15/22 at 10:45am revealed:
-She made the therapeutic diet board and had not updated it recently; however, all of the updated diets that the Facility's RN gave her were in a binder in the kitchen.
-Sometimes it was difficult to serve the planned meals due to food not arriving on the delivery truck or residents' food preferences.
-The therapeutic diet menus that she followed were posted on the wall.

Interview with the Administrator on 09/16/22 at 4:26pm revealed:
-She was not aware that the therapeutic diet list posted in the kitchen was not up to date.
-The diet order did not have to be signed by the residents' PCP to be considered an active diet order.
-She expected the kitchen staff to follow the therapeutic diets as ordered.
-If anyone had questions related to a resident's diet then the Facility's RN or physician should

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D 310	Continued From page 11 have been contacted.	D 310		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a medication aide (MA) observe a resident take their medications for 1 of 5 sampled residents (#5). The findings are: Observation of Resident #5's room during the initial tour on 09/15/22 between 8:30am and 9:45am revealed: -There was a paper medication cup on Resident #5's nightstand. -Inside the medication cup were 4 medications. Review of Resident #5's current FL2 dated 12/29/21 revealed: -Diagnoses included dementia, hypertension, depression and major neurocognitive disorder. -Orders for amlodipine 5mg (used to treat elevated blood pressure) every day, Pradaxa 150mg (used to treat blood clots) twice per day, Trintellix 10mg (used to treat depression) every	D 366		

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day, Perindopril 4mg (used to treat high blood pressure) every day, memantine 5mg (used to treat alzheimer's disease) every day, multivitamin 1 tablet once per day, vitamin B12 500mcg every day, and lutein 20mg (used to treat vision) 1 tablet every day.

Review of a physician's order for Resident #5 dated 01/10/22 revealed increase memantine to 10mg twice daily.

Review of Resident #5's September 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for amlodipine 5mg daily at 9:00am and the documentation the amlodipine was administered at 9:00am.
-There was an entry for lutein 20mg mg daily at 9:00am and the documentation the lutein was administered at 9:00am.
-There was an entry for Memantine 10mg daily at 9:00am and the documentation the Memantine was administered at 9:00am.
-There was an entry for multi-vitamin 1 tablet daily at 9:00am and the documentation the multi-vitamin was administered at 9:00am.
-There was an entry for Perindopril 4mg daily at 9:00am and documentation the Perindopril was administered at 9:00am.
-There was an entry for Pradaxa 150 mg twice daily at 9:00am and 9:00pm and there was documentation the Pradaxa was administered at 9:00am
-There was an entry for Trintellix 10mg daily at 9:00am and the documentation the Trintellix was administered at 9:00am.
-There was an entry for vitamin B-12 500mcg daily at 9:00am and the documentation the vitamin B-12 was administered at 9:00am.
-All medications were documented as

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administered for the month of September 2022.

Interview with Resident #5 on 09/15/22 at 9:04am revealed the medication aide (MA) typically left medication in a paper cup for her to take when she was ready.

Interview with Resident #5's primary care provider (PCP) on 09/15/22 at 11:30am revealed she did not feel like Resident #5 had the ability to take her medications without supervision due to her cognitive decline.

Interview with the MA on 09/15/22 at 3:30pm revealed:
-They had been told by the nurse that it was ok to leave Resident #5's medications for her to take and then to check back on her to make sure she took them.
-They had left all medications in Resident #5's room that morning.
-Resident #5 did not like any staff in her room or to help her with anything.

Telephone interview with the Facility's Registered Nurse (RN) on 09/16/22 at 10:12am revealed:
-She had never told the MAs it was ok to leave medication in the residents' rooms.
-It was her expectation that the MAs observed the residents take their medications.
-She did not feel like it would be safe for them to leave Resident #5's medications in her room for her to take on her own.

Interview with the Administrator on 09/16/22 at 4:30pm revealed:
-It was her expectation that the MAs observed the resident take the medication they administered.
-She did not feel like it was safe for the medications to be left in a resident's room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036023	A. BUILDING: ______ B. WING ______	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE RIDGE ASSISTED LIVING	1251 E HUDSON BLVD GASTONIA, NC 28054

(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 366	Continued From page 14 -They were taught in medication aide training that you should never leave medications in a residents room.	D 366		