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
	HAL036036	A. BUILDING: ______ B. WING ______	R 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS	**916 S. MARIETTA STREET 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 and the Gaston County DSS conducted a follow-up survey from 03/21/23 to 03/23/23.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 1 of 3 medication aides (Staff A) who administered medications independently had completed the 10-hour medication aide training within 60 days of completion of the clinical skills validation. The findings are: Review of Staff A, medication aide (MA) personnel record revealed: -She was hired on 05/03/22. -She completed the clinical skills validation on	D 125		

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09/12/22.
-She completed her 5-hour MA training on 10/02/19.
-She passed the written MA examination on 01/05/23.
-There was no documentation of a 10-hour MA training.

Interview with Staff A, MA on 03/23/23 at 10:55am revealed:
-She had not completed the 10-hour MA training since she started working at the facility.
-She used previous medication administration training and knowledge to administer medications.
-The facility had not offered the 10-hour training to her.

Review of February 2023 electronic Medication Administration Records (eMARs) revealed Staff A collected fingerstick blood sugars (FSBS) on 02/07/23, 02/08/23, 02/11/23, 02/12/23, 02/14/23, 02/17/23, 02/18/23, 02/19/23, 02/21/23, 02/22/23, 02/27/23, and 02/28/23.

Review of February 2023 eMARs revealed Staff A administered subcutaneous (SQ) injections on 02/07/23, 02/08/23, 02/11/23, 02/14/23, 02/17/23, 02/19/23, 02/21/23, 02/22/23, 02/27/23, and 02/28/23.

Review of March 2023 eMARs revealed Staff A collected fingerstick blood sugars (FSBS) on 03/01/23, 03/02/23, 03/05/23, 03/06/23, 03/07/23, 03/08/23, 03/09/23, 03/15/23, and 03/16/23.

Review of March 2023 eMARs revealed Staff A administered SQ injections on 03/01/23, 03/02/23, 03/05/23, 03/06/23, 03/07/23, 03/08/23, 03/09/23, 03/15/23, and 03/16/23.

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D 125	Continued From page 2 Interview with the Resident Care Director (RCD) on 03/22/23 at 4:28pm revealed: -She was responsible for maintaining all employee records. -She could not find the 10-hour medication training documents for Staff A, in the personnel records, and they did not have a licensed nurse to complete the training. -She was responsible for making sure all MA staff received the 10-hour medication training and maintaining the documentation in staff personnel records. -She was aware that the 10-hour training had not been completed. Telephone interview with the Administrator on 03/23/23 at 12:27pm revealed: -She hired a nurse to complete the 10-hour medication training for staff. -The nurse was to schedule the 5/10/15 hour medication training for staff, but never did. -The RCD was responsible for scheduling the needed training. -She was aware that staff needed the 10-hour medication training.	D 125		
D 162	10A NCAC 13F .0504(c) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (c) Evaluation and validation of competency shall be performed by the following licensed health professionals in accordance with his or her North Carolina occupational licensing laws: (1) A registered nurse shall validate the competency of staff who perform any of the	D 162		

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personal care tasks specified in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter;
(2) In lieu of a registered nurse, a licensed respiratory care practitioner may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(6), (a)(11), (a)(16), (a)(18), (a)(19), and (a)(21) of Rule .0903 of this Subchapter;
(3) In lieu of a registered nurse, a licensed pharmacist may validate the competency of staff who perform the personal care tasks specified in Subparagraph (a)(8) and (a)(11) of Rule .0903 of this Subchapter. An immunizing pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(15) of Rule .0903 of this Subchapter; and
(4) In lieu of a registered nurse, an occupational therapist or physical therapist may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(17) and (a)(22) through (a)(27) of Rule .0903 of this Subchapter.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled staff (Staff A, B, and C) had completed the competency evaluation and validation for Licensed Health Professional Support (LHPS) tasks.

The findings are:

1. Review of Staff A's, medication aide (MA), personnel record revealed:
-Staff A's hire date was 05/03/22.
-There was no documentation of a LHPS competency validation.

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Interview with Staff A, MA on 03/23/23 at 10:55am revealed:
-She had not completed the LHPS validation since she started working at the facility.
-She used previous training and knowledge to complete tasks for residents.

Review of February 2023 electronic Medication Administration Records (eMARs) revealed Staff A collected fingerstick blood sugars (FSBS) on 02/07/23, 02/08/23, 02/11/23, 02/12/23, 02/14/23, 02/17/23, 02/18/23, 02/19/23, 02/21/23, 02/22/23, 02/27/23, and 02/28/23.

Review of February 2023 eMARs revealed Staff A administered subcutaneous (SQ) injections on 02/07/23, 02/08/23, 02/11/23, 02/14/23, 02/17/23, 02/19/23, 02/21/23, 02/22/23, 02/27/23, and 02/28/23.

Review of March 2023 eMARs revealed Staff A collected fingerstick blood sugars (FSBS) on 03/01/23, 03/02/23, 03/05/23, 03/06/23, 03/07/23, 03/08/23, 03/09/23, 03/15/23, and 03/16/23.

Review of March 2023 eMARs revealed Staff A administered SQ injections on 03/01/23, 03/02/23, 03/05/23, 03/06/23, 03/07/23, 03/08/23, 03/09/23, 03/15/23, and 03/16/23.

Refer to interview with the Resident Care Director (RCD) on 03/22/23 at 4:28pm.

Refer to interview with the Administrator on 03/23/23 at 12:27pm.

2. Review of Staff B's, medication aide (MA), personnel record revealed:
-Staff B's hire date was 02/11/22.
-There was no documentation of a LHPS

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competency validation.

Interview Staff B on 03/22/23 at 5:03pm revealed:
-She had not completed the LHPS validation since she was hired.
-She had been a MA since September 2000, and used previous training and knowledge to complete tasks for residents.

Review of February 2023 electronic Medication Administration Records (eMARs) revealed Staff B collected fingerstick blood sugars (FSBS) on 02/08/23, 02/09/23, 02/10/23, 02/11/23, 02/12/23, 02/15/23, 02/16/23, 02/17/23, 02/20/23, 02/21/23, 02/22/23, 02/24/23, 02/25/23, 02/26/23, 02/27/23, and 02/28/23.

Review of February 2023 eMARs revealed Staff B administered subcutaneous (SQ) injections on 02/08/23, 02/09/23, 02/10/23, 02/11/23, 02/12/23, 02/15/23, 02/16/23, 02/17/23, 02/21/23, 02/22/23, 02/24/23, 02/25/23, and 02/26/23.

Review of March 2023 eMARs revealed Staff B collected fingerstick blood sugars (FSBS) on 03/03/23, 03/04/23, 03/05/23, 03/08/23, 03/10/23, 03/11/23, and 03/12/23.

Review of March 2023 eMARs revealed Staff B administered SQ injections on 03/03/23, 03/04/23, 03/05/23, 03/08/23, 03/10/23, 03/11/23, and 03/12/23.

Refer to interview with the RCD on 03/22/23 at 4:28pm.

Refer to interview with the Administrator on 03/23/23 at 12:27pm.

3. Review of Staff C's personnel record revealed:

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-Staff C's hire date was 04/22/22.
-There was no documentation of a LHPS competency validation.

Review of February 2023 electronic Medication Administration Records (eMARs) revealed Staff C collected fingerstick blood sugars (FSBS) on 02/09/23, 02/10/23, 02/12/23, 02/14/23, 02/15/23, 02/16/23, 02/18/23, 02/19/23, 02/20/23, and 02/23/23 to 02/27/23.

Review of February 2023 eMARs revealed Staff C administered subcutaneous (SQ) injections on 02/09/23, 02/10/23, 02/14/23, 02/15/23, 02/16/23, 02/18/23, 02/19/23, 02/20/23, and 02/23/23 to 02/27/23.

Review of March 2023 eMARs revealed Staff C collected fingerstick blood sugars (FSBS) on 03/02/23, 03/03/23, 03/04/23, 03/07/23, 03/09/23, 03/10/23, 03/11/23, 03/12/23, 03/13/23, 03/16/23, 03/17/23, 03/18/23, 03/20/23, and 03/21/23.

Review of March 2023 eMARs revealed Staff C administered SQ injections on 03/02/23, 03/03/23, 03/04/23, 03/07/23, 03/10/23, 03/13/23, 03/16/23, 03/17/23, 03/18/23, and 03/21/23.

Attempted telephone interview with Staff C on 03/22/23 at 4:28pm was unsuccessful.

Refer to interview with the RCD on 03/22/23 at 4:28pm.

Refer to telephone interview with the Administrator on 03/23/23 at 12:27pm.

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Interview with the RCD on 03/22/23 at 4:28pm revealed:

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D 162	Continued From page 7 -She was responsible for maintaining all employee records. -She could not find the LHPS competency validation sheets for the 3 sampled staff in the personnel records, and they did not have a licensed nurse to complete the check-off. -She was responsible for making sure all staff received the LHPS competency validation and maintaining the documentation in staff personnel records. -She was aware that they had not been completed for all 3 staff. Telephone interview with the Administrator on 03/23/23 at 12:27pm revealed: -She hired a contracted Registered Nurse (RN) to complete the LHPS competency validations for staff. -The contracted RN was supposed to give her copies of the training and check-off, but she never did. -The RCD was responsible for scheduling the needed LHPS competency validation, but in the future, said she would need to be responsible for that. -She was aware that staff needed the LHPS competency validation. -She thought the LHPS check-off had been completed on 02/14/23, but she never received the documents from the RN.	D 162		
D 235	10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination prior to admission to the facility and	D 235		

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annually thereafter.
(c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (Resident #3) had an FL2 that was updated annually.

The findings are:

Review of Resident #3's FL2 dated 10/18/21 revealed diagnoses included schizoaffective, diabetes mellitus type 2, hypertension, hyperlipidemia, glaucoma, high cholesterol, chronic obstructive pulmonary disease (COPD), and hallux vagus.

Review of Resident #3's resident register revealed an admission date of 06/01/10.

Interview with Resident #3's primary care provider (PCP) on 03/21/23 at 3:05pm revealed:
-She had not signed a new FL2 since 10/18/21.
-It was the responsibility of the facility staff to provide an FL2 to be signed yearly.
-The facility had hired someone to complete FL2s for all the residents, but that person was only employed for one week.
-Resident #3 "probably got missed".

Interview with the Resident Care Director (RCD)

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on 03/22/23 at 9:14am revealed she did not have an updated FL2 for Resident #3.

Interview with the RCD on 03/21/23 at 3:40pm revealed:
-She was responsible for ensuring the FL2s were completed, she had not audited the residents' records in the last month and was not sure the last time an audit was completed.
-She was responsible for monthly audits to check the status of FL2s but was busy with other duties.

Telephone interview with the Administrator on 03/23/23 at 12:27pm revealed:
-She was not aware that Resident #3 did not have a current FL2 and that his last one was dated 10/18/21.
-The RCD was responsible for ensuring FL2s were completed for all residents and verify new FL2s were sent after a hospital stay
-She had not audited the resident records for FL2, and this was supposed to be monthly.
-She had instructed the RCD to update FL2s as needed and every 3 months.
-She was to check behind the RCD regarding current FL2 status on a monthly basis.
-The RCD told her that the PCP would be in this week to sign FL2s.

D 254 10A NCAC 13F .0801(b) Resident Assessment D 254

10A NCAC 13F .0801Resident Assessment
(b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as

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required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource.

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure 1 of 5 sampled residents had an assessment and care plan completed within 30 days of admission (#2).

The findings are:

1. Review of Resident #2's current FL2 dated 04/25/22 revealed:
-Diagnoses included Type 2 diabetes, chronic kidney disease stage 3, major depressive disorder, hypertension, and morbid obesity.
-Resident #2 was intermittently disoriented.
-Resident #2 required personal care assistance with bathing, and dressing.

Review of Resident #2's Resident Register

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revealed:
-He was admitted to the facility on 06/16/22.
-Assistance was required for bathing and dressing.

Review of Resident #2's record revealed there was no care plan completed within 30 days after his admission.

Interview with Resident #2 on 03/22/23 at 11:45am revealed he required assistance with bathing and dressing due to his bilateral below the knee amputations.

Interview with a personal care aide (PCA) on 03/22/23 at 10:04am revealed:
-The PCAs used the residents' Personal Care Sheets to verify the care needs of each resident.
-Resident #2 did not have a current care sheet.
-Resident #2 required help with bathing and dressing.
-If a Personal Care Sheet was not available then he asked the medication aide (MA) or the Resident Care Director (RCD).

Interview with Resident #2's primary care provider (PCP) on 03/22/23 at 11:25am revealed:
-She was not aware there was no care plan for Resident #2.
-Resident #2 required assistance with bathing and dressing.
-The facility staff was responsible for making sure she received a care plan to review and sign when they were due, initially, annually and with a change in condition.

Interview with the RCD on 03/23/23 at 10:33am and revealed:
-She was responsible for completing the residents' care plans.

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-She was responsible for monthly chart audits to check for missing, incomplete and care plans within 30 days of admission.
-She did not complete any of the audits due to being so busy with other duties.
-She did not know Resident #2 did not have a care plan in his record at all.

Telephone interview with the facility's contracted Registered Nurse (RN) on 03/22/23 at 4:19pm revealed:
-She was contacted by the Administrator at the beginning of February 2023 about her completing care plans.
-She completed some training with the MAs but did not get to the other tasks because the Administrator did not call her back after several attempts to contact the Administrator to sign an agreement.
-She spoke with the Administrator last on 03/22/23, related to her services and getting a contract signed and was told by the Administrator that she would get back to her later.
-She has signed a contract or provided any other services since the beginning of February 2023.

Telephone interview with the Administrator on 03/23/23 at 12:27pm revealed:
-The RCD was responsible to complete care plans for all residents.
-She was to check behind the RCD regarding care plan status on a monthly basis.
-She had not audited all of the residents' records for care plans.
-She had completed several chart reviews, but was not aware care plan was missing for Resident #2.

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

10A NCAC 13F .0902 Health Care
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 1 of 5 sampled residents (Residents #1) related to the failure to notify the primary care provider (PCP) of a follow-up after hospitalization for aspiration pneumonia with new diet orders and an antibiotic.

The findings are:

Review of Resident #1's current FL2 dated 04/25/22 revealed:
-Diagnoses included schizophrenia, aphasia, anxiety, chronic kidney disease, cerebral vascular accident and hypertension.
-An order for a mechanical soft diet.
-The residents' functional limitation with speech.
-The residents' level of orientation was constantly disoriented.
-Resident #1 required assistance with eating.

Review of Resident #1's care plan dated 05/11/22 revealed:
-Resident #1 required extensive assistance with eating, bathing and dressing.
-Resident #1 required limited assistance with toileting, ambulation, grooming and transfers.

Review of Resident #1's nurses notes revealed:
-He was sent to the emergency department (ED) on 03/03/23 at 9:32am.
-Resident #1 was eating strawberries at breakfast

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and began to choke.
-Staff performed the Heimlich maneuver but was unable to get anything up but mucus.
-He returned to the facility from the hospital on 03/09/23 at 9:11am.

Review of Resident #1's hospital discharge summary revealed:
-Resident #1 was admitted on 03/03/23 to 03/09/23.
-On 03/03/23, Resident #1 was on a mechanical soft diet at the facility, ate a strawberry, choked and Resident #1 received the Heimlich maneuver.
-Resident #1's admission diagnoses included aspiration pneumonia, hypoxia, choking episode and sepsis without acute organ dysfunction.
-On 03/03/23, a computerized tomography (CT) of the chest without contrast was performed and a left lower lobe airspace consolidation suspicious for sequela of aspiration.
-On 03/04/23, a chest xray was performed and dense left lower lobe pneumonia and/or aspiration contents.
-On 03/04/23, speech therapy was consulted, evaluated Resident #1 and recommended a mechanical soft diet with honey thickened liquids and must be supervised with all meals.
-On 03/06/23, a modified barium swallow with speech xray was performed and aspiration identified with thin and nectar barium consistency swallows and to see speech pathology for dietary recommendations.

Review of Resident #1's hospital discharge summary dated 03/09/23 revealed:
-An order for Augmentin 875-125mg (an antibiotic to treat aspiration pneumonia) every 12 hours for four days.
-An order to follow-up with Resident #1's primary

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care provider (PCP) within one week.
-An order for a sodium 2gm (low sodium), low fat, low cholesterol, no caffeine, extra gravies and sauces and honey thickened liquids diet.

a. Review of Resident #1's record revealed:
-A hospital after visit summary dated 03/09/23 with instructions to start taking Augmentin, 1 tablet every 12 hours for four days.
-This document was not signed by a physician.

Review of Resident #1's March 2023 electronic Medication Administration Record (eMAR) revealed there was no entry for Augmentin.

Interview with Resident #1's PCP on 03/21/23 at 2:16pm revealed:
-She visits the facility to see residents every 2 weeks.
-She last saw Resident #1 on 02/28/23.
-She did not know about Resident #1's recent hospitalization from 03/03/23 to 03/09/23 until today (03/21/23) when she came to see residents.
-The Resident Care Director (RCD) informed her about Resident #1's hospitalization for aspiration pneumonia on 03/03/23 to 03/09/23 and asked about an incomplete order for Augmentin, follow-up and diet.
-The facility was responsible for notifying her about recent hospitalizations and questions about hospital discharge orders that were not complete, signed by a physician or missing.
-She was not notified about Resident #1's hospital after visit summary dated 03/09/23 with instructions to begin Augmentin.
-Resident #1 not completing his antibiotic could lead to an increased risk of symptoms worsening and another hospitalization for pneumonia.

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Interview with a first shift medication aide (MA) on 03/22/23 at 9:00am revealed:
-When Resident #1 came back from the hospital on 03/09/23, the MA on duty was responsible for faxing orders to the pharmacy and calling the PCP for orders that were not complete or questions related to Resident #1's care when he returned.
-The discharge paperwork was to be placed in the RCD folder for review and follow-up.
-On 03/10/23, she was the MA providing care for Resident #1.
-On 03/10/23, there was an order from the PCP to decrease another medication.
-She did not follow-up about Resident #1's hospital instructions because she was busy with doing other duties besides her MA duties because of being short staffed.

Refer to interview with the RCD on 03/23/23 at 10:33am.

Refer to telephone interview with the Administrator on 03/21/23 at 3:51pm.

b. Review of Resident #1's record on 03/21/23 revealed a hospital after visit summary dated 03/09/23 with instructions to follow-up with Resident #1's primary care provider (PCP) within one week.

Interview with Resident #1's PCP on 03/21/23 at 2:16pm revealed:
-She visited the facility to see residents every 2 weeks.
-She last saw Resident #1 on 02/28/23.
-She did not know about Resident #1's recent hospitalization from 03/03/23 to 03/09/23 until today (03/21/23) when she came to see residents.

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-The facility was responsible for notifying her about recent hospitalizations and questions about hospital discharge orders that were not complete, signed by a physician or missing.
-She should have seen Resident #1 within a week after being discharge from the hospital for aspiration pneumonia because there was an increase risk Resident #1 would rebound if the antibiotics were not working.

Interview with a first shift medication aide (MA) on 03/22/23 at 9:00am revealed:
-The discharge paperwork was to be placed in the RCD folder for review and follow-up.
-On 03/10/23, she was the MA providing care for Resident #1.
-She did not follow-up about Resident #1's hospital instructions because she was busy with doing other duties besides her MA duties because of being short staffed.

Refer to interview with the RCD on 03/23/23 at 10:33am.

Refer to telephone interview with the Administrator on 03/21/23 at 3:51pm.

c. Review of Resident #1's record on 03/21/23 revealed a hospital after visit summary dated 03/09/23 with no instructions for a diet.

Interview with Resident #1's PCP on 03/21/23 at 2:16pm revealed:
-She visited the facility to see residents every 2 weeks.
-She last saw Resident #1 on 02/28/23.
-She did not know about Resident #1's recent hospitalization from 03/03/23 to 03/09/23 until today (03/21/23) when she came to see residents.

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D 273	Continued From page 18 -The RCD informed her about Resident #1's hospitalization for aspiration pneumonia on 03/03/23 to 03/09/23. -The facility was responsible for notifying her about recent hospitalizations and questions about any hospital discharge orders. -Resident #1 required a mechanical soft diet with thin liquids before hospitalization and after the choking episode and the speech therapist's order, Resident #1 required honey thickened liquids to decrease the chance of choking again. -She was not notified about the hospital after visit summary not including a diet for someone who was admitted for choking and a history of swallowing issues. Interview with a first shift medication aide (MA) on 03/22/23 at 9:00am revealed: -The discharge paperwork was to be placed in the RCD folder for review and follow-up. -On 03/10/23, she was the MA providing care for Resident #1. -She did not follow-up about Resident #1's hospital instructions because she was busy with doing other duties besides her MA duties because of being short staffed. Refer to interview with the RCD on 03/23/23 at 10:33am. Refer to telephone interview with the Administrator on 03/21/23 at 3:51pm. ____________________________ Interview with the RCD on 03/23/23 at 10:33am revealed: -When a resident returned from the hospital, the MA was responsible for notifying her, about questions or concerns with the orders, faxing the orders to the pharmacy, and placing discharge paperwork in her folder for review.	D 273		

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D 273	Continued From page 19 -She would place a copy of the discharge paperwork in the PCP's folder for review after all of the orders were completed. -The hospital called two of the MAs with report during the hospitalization and around discharge. -The hospital faxed over the discharge summary but she threw it away because she knew there was one in her folder. -She did not know the discharge paperwork in the folder was the after visit summary instead of the discharge summary. -She was responsible for weekly audit of the orders but she was busy with other duties as a MA and PCA. -She and the MAs were responsible for notifying Resident #1's PCP about the incomplete orders and the follow-up needed but it was "just overlooked" and they "missed it". Telephone interview with the Administrator on 03/21/23 at 3:51pm revealed: -The MAs were responsible for faxing the orders to the pharmacy from the discharge paperwork from the hospital. -After faxing orders to the pharmacy, the MA was to place all discharge paperwork in a folder for the RCD to review and follow-up on. -If any orders were incomplete or missing then the MA was to notify the provider and the RCD. -The RCD was responsible for audits on all orders weekly to make sure they were complete. -She was responsible for weekly audits of all orders but she did not complete any yet. -She did not know why the orders for Resident #1 were missed. -The MA and or the RCD should have notified Resident #1's PCP regarding his follow-up appointment. -The MAs and the RCD were responsible for keeping all hospital discharge documents and to	D 273		

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D 273	Continued From page 20 make sure they received the correct documents with orders, and if not the MAs and the RCD were responsible for notification to the provider for recommendations.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure 3 of 5 sampled	D 280		

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residents (Resident #3, #4 and #5), with collecting and testing of finger stick blood sugars (#3 and #4), medication administration through injections, oxygen administration and monitoring (#3), and assistance/monitoring of an indwelling catheter (#5) had a Licensed Health Professional Support (LHPS) review completed quarterly by an appropriate licensed health professional.

The findings are:

1. Review of Resident #3's current FL2 dated 03/22/23 revealed:
-Diagnoses included schizoaffective disorder, diabetes mellitus type 2, hypertension, hyperlipidemia, glaucoma, high cholesterol, chronic obstructive pulmonary disease (COPD), and hallux vagus.
-There was an order for oxygen 4 liters per minute as needed.
-There was an order for humalog insulin 100units/ml vial inject subcutaneously (SQ) before meals per facility sliding scale.
-There was an order for Tresiba Flextouch 200units/ml inject 150 units SQ daily.

Review of Resident #3's record revealed:
-The most current LHPS was dated 12/22/21, and included personal care tasks documented as medication administration through injections, collecting and testing of finger stick blood sugars (FSBS), and oxygen administration and monitoring.
-The previous LHPS review was dated 09/08/21, and included personal care tasks documented as medication administration through injections, collecting and testing of FSBS, and oxygen administration and monitoring.

Interview with Resident #3's Primary Care

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Provider (PCP) on 03/21/23 at 3:05pm revealed:
-It was the facility's responsibility to have an appropriate licensed health professional complete the LHPS review quarterly for Resident #3.
-The facility had hired someone to complete the LHPS review for Resident #3, but that person was only employed for one week.
-Resident #3's LHPS review "probably got missed".

Refer to interview with the Resident Care Director (RCD) on 03/21/23 at 3:40pm.

Refer to telephone interview with the facility's contracted Registered Nurse (RN) on 03/22/23 at 4:19pm.

Refer to telephone interview with the Administrator on 03/23/23 at 12:27pm.
2. Review of Resident #4's current FL2 dated 07/29/22 revealed diagnoses included congestive heart failure and hypertension.

Review of Resident #4's physician orders revealed there was an order for finger stick blood sugars (FSBS) twice weekly.

Review of Resident #4's record revealed:
-The last LHPS review completed by a Registered Nurse (RN) was dated 12/02/21.
-Personal care tasks were documented as fall prevention.
-FSBS's were documented as refused at times.

Interview with Resident #4's Primary Care Provider (PCP) on 03/21/23 at 3:05pm revealed:
-It was the facility's responsibility to have an appropriate licensed health professional complete the LHPS review quarterly for Resident #4.
-The facility had hired someone to complete the

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LHPS review for Resident #4, but that person was only employed for one week.

Refer to interview with the RCD on 03/21/23 at 3:40pm.

Refer to telephone interview with the facility's contracted RN on 03/22/23 at 4:19pm.

Refer to telephone interview with the Administrator on 03/23/23 at 12:27pm.

3. Review of Resident #5's current FL2 dated 09/08/22 revealed:
-Diagnoses included pressure ulcer stage 3 to right buttocks, bronchitis, and chondrocalcinosis (crystal deposits on the joints causing pain) right knee.
-The resident was semi-ambulatory.
-The resident had an indwelling catheter.
-The resident required total care with bathing.

Review of Resident #5's Care Plan dated 06/02/22 revealed:
-He was totally dependent with toileting, ambulation, bathing, dressing, grooming and transfers.
-He required supervision with eating
-He required a wheelchair for ambulation.
-He had an indwelling catheter and, "not selfcare" was documented.

Review of Resident #5's quarterly review for LHPS tasks revealed:
-The last LHPS review completed by a Registered Nurse (RN) was dated 12/02/21.
-Documentation on the LHPS form indicated there was a suprapubic catheter intact with clear yellow urine.

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Interview with Resident #5's Primary Care Provider (PCP) on 03/21/23 at 3:05pm revealed:
-It was the facility's responsibility to have an appropriate licensed health professional complete the LHPS review quarterly for Resident #5.
-The facility had hired someone to complete the LHPS review for Resident #5, but that person was only employed for one week.

Interview with Resident #5 on 03/22/23 at 11:55am revealed:
-He was able to empty the catheter bag on his own and a nurse visited monthly to check on it.
-The catheter bag was fine where it was (up near his lap).
-The urine was draining down the tube, it was fine.
-The staff helped him occasionally with emptying his drainage bag.

Refer to interview with the Resident Care Director (RCD) on 03/21/23 at 3:40pm.

Refer to telephone interview with the facility's RN on 03/22/23 at 4:19pm.

Refer to telephone interview with the Administrator on 03/23/23 at 12:27pm.

____

Interview with the RCD on 03/21/23 at 3:40pm revealed:
-The Administrator was responsible for hiring an RN in February 2023 to complete the LHPS reviews on residents.
-She was told by the contracted RN, that she contacted the Administrator several times to get an appointment for signing the contract for the services offered and to get paid but the Administrator never followed- up with the

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contracted RN.
-The LHPS tasks were not completed since December 2022.

Telephone interview with the facility's contracted RN on 03/22/23 at 4:19pm revealed:
-She was contacted by the Administrator at the beginning of February 2023 about her completing Licensed Health Professional Support (LHPS).
-She completed some training with the MAs but did not get to the other tasks because the Administrator did not call her back after several attempts to contact the Administrator to sign an agreement.
-She spoke with the Administrator last on 03/22/23, related to her services and getting a contract signed and was told by the Administrator that she would get back to her later.

Telephone interview with the Administrator on 03/23/23 at 12:27pm revealed:
-The Administrator was ultimately responsible for ensuring LHPS reviews were completed for all residents within 30 days.
-She did not know residents were missing the LHPS reviews since 2021.
-There was no one in place to complete the reviews.
-The RCD was responsible for making sure LHPS reviews were completed.
-She had not audited the resident records for LHPS reviews, and this was supposed to completed monthly.
-She was responsible to ensure all information was maintained according to regulations.

D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service	D 285		

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10A NCAC 13F .0904 Nutrition And Food Service
(a) Food Procurement and Safety in Adult Care Homes:
(4) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to ensure there was a three-day supply of perishable food and a five-day supply of non-perishable food based on the planned menu for 36 residents.

The findings are:

Interview with a resident during the initial tour on 03/21/23 at 9:31am revealed the facility ran out of coffee and sugar last week.

Observation in the kitchen pantry and walk-in cooler on 03/21/23 at 10:03am revealed:
-Dairy in the facility consisted of 2 gallons of whole milk and thirty-four 4-ounce yogurt containers in the walk-in cooler.
-The fruit in the facility consisted of ninety 4-ounce containers of applesauce.

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-The non-starchy vegetables in the facility consisted of a half case of fresh green peppers, a half case of fresh Roma tomatoes, 3 half-gallon size bags of frozen broccoli florets, two 102-ounce cans of stewed tomatoes and one 102-ounce can of sliced beets.
-The starchy vegetables in the facility consisted of two 36-ounce boxes of au gratin potatoes, four 1 gallon bags of frozen tater tots, 1 gallon of frozen corn, five 15-ounce cans of sweet potatoes and one case of fresh sweet potatoes.
-Meat in the facility consisted of four 2-pound packages of deli ham, one 6-pound thawed lasagna with meat sauce in the walk in cooler, 3 individual pot pies, a 20 ounce bag of frozen meatballs, 1 frozen roast wrapped in plastic wrap with no identification and one 5-pound bag of chicken legs.

Review of the planned lunch menu for 03/21/23 revealed chefs' choice of entrée, starchy vegetable, vegetable, fruit and dinner roll with margarine was to be served.

Observation of the lunch meal service on 03/21/23 at 12:15pm revealed Italian Wedding soup, 4 saltine crackers, a tossed salad, and a piece of vanilla cake with chocolate icing was served to 36 residents.

Review of the planned dinner menu for 03/21/23 revealed Italian Wedding soup, pizza sticks, a Caesar salad with crackers, a piece of apple pie and milk was to be served.

Observation of the dinner meal service on 03/21/23 at 5:30pm revealed a fish sandwich, green beans, slaw and diced peaches was served to 36 residents.

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Interview with the Food Service Director 9FSD) on 03/21/23 at 9:54am and 03/22/23 at 11:15am revealed:
-The menu specified that she could cook what she wanted for lunch on 03/21/23.
-She chose to serve the planned dinner menu because she did not have anything else to serve.
-The food order was usually delivered on Wednesdays, but she put an order in on 03/20/23 because the facility was low on food, and she needed something to serve for dinner tonight.
-She did not know what time the food truck would deliver food today, but it would be in time to prepare dinner.
- To learn how to make orders and to keep purchases within the $1500.00 per week budget, the Administrator placed the food order last week.
-The Administrator used the menu to guide what was ordered but $1500.00 was not enough to purchase all the needed items.
-Prior to the Administrator placing the order she was responsible for placing all food orders.
-She did not have a computer available to enter the order, so she made a list of needed food items, gave the list to the representative with the food service distributor who in turn called her to inform her of the cost of the order and helped her delete items until the order was brought down to the $1500.00 range.
-If she exceeded the budget the owner became upset.
-If the residents needed something and it was unavailable, she would spend her own money for it before she asked the owner to buy it.
-The order the Administrator placed last week did not contain all the menu items needed to last through Wednesday's meals, so she had to place an extra order on Monday 03/20/23.
-The menu items she needed to serve dinner was scheduled to come on the truck later in the day.

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-A local church brought food donations to the facility most Thursdays and she used those items for snacks.
-The facility ran out of small sugar packets for several days last week, so bulk sugar was used instead.

Review of the regular menu compared to the food items available for use on 03/22/23, 03/22/23, 03/24/23 revealed:
-Vitamin C fortified juice was not available for breakfast on 03/23/23 and 03/24/23 and there were no other beverages available for appropriate substitution.
-Breakfast meat was not available breakfast on 03/23/23 and 03/24/23 and there was no other meat available for appropriate substitution.
-Meatloaf was not available for lunch on 03/22/23 and there was no other meat available for appropriate substitution.
-Ice cream was not available for lunch on 03/22/23 and there was no other dessert available for appropriate substitution.
-Pork chops were not available for lunch on 03/23/23 and there was no other meat available for appropriate substitution.
-Fish was not available for lunch on 03/24/23 and there was no other meat available for appropriate substitution.
-Pudding was not available for lunch on 03/24/23 and there was no other dessert available for appropriate substitution.
-Cole slaw was not available for lunch on 03/24/23 and there was no other vegetable available for appropriate substitution.

Observation of the kitchen on 03/21/23 from 4:18pm to 4:32pm revealed a truck from the contract food service distributor delivered the food order that was placed on 03/20/23.

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Telephone interview with a representative from the facility's contract food service provider on 03/22/23 at 9:21am revealed:
-The facility had a $1500.00/week food budget which was a pre-COVID amount, but food costs rose since then and that amount was no longer appropriate to meet the order needs for therapeutic menus.
-Menus were designed to meet nutritional needs not any particular budget.
-The FSD did not have access to a computer and did not know the prices, so the FSD gave her a list of items needed and then helped her eliminate items until the budget was met.
-Last week she received an email from the Administrator informing her that she would be ordering from now on.
-The FSD placed an order on 03/20/23 because the order that was placed last week by the Administrator was not adequate to provide meals through 03/22/23.

Interview with the facility's Owner on 03/22/23 at 8:19am revealed:
-He did not know the kitchen was running low on food and not purchasing all foods on all the menus.
-Running short on food was going to happen in the best of facilities and he did not think a low food supply was an issue and the FSD could just substitute with food that was available.
-He previously told the FSD that if she needed an item before the truck delivery, he would give her petty cash and she could get the needed items at the grocery store.
-He was aware of the 3- and 5-day food supply regulation but if he kept that much food in the kitchen the food was stolen.
-A $1500.00 food budget ($1.98/meal) should be

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D 285	Continued From page 31 sufficient to purchase food for 36 residents. -He did not use the menus to develop the budget. -The menu should be adjusted to meet his budget rather than his budget needing to be adjusted to meet the menu. -He requested the Administrator to start placing the food orders so the purchases could stay within the budget. -He never checked the food supply because he did not go looking for problems; he expected the staff to bring problems to him. Interview with the Administrator on 03/22/23 at 10:17am revealed: -She started placing the food orders last week because she wanted to be sure everything was available. -She did not refer to the menus when she placed the order but rather ordered what the FSD told her she needed. -She knew she needed to order enough food to get the 3- and 5-day food supply up. -She had a $1500.00 per week food budget but had only ordered one time so she did not know if that would be enough to purchase all necessary food items on both the regular menu and therapeutic menus. -She did not know the FSD had to remove items from the orders she placed in an effort to meet the budget.	D 285		
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: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3)	D 292		

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of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen 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 document substitutions made to the menu.

The findings are:

Interview with the Food Service Director (FSD) on 03/21/23 at 9:54am revealed:
-She was serving the scheduled dinner menu for lunch because the truck had not delivered the food yet.
-She substituted foods on the menu all the time because the budget was not large enough to purchase all the menu items.
-She made substitutions the best she knew how.
-The Administrator had a meeting with the dietary staff on 03/14/23 and instructed them to start documenting all meal substitutions beginning on 03/20/23.
-She had not gotten around to documenting substitutions in the book yet.

Review of the substitution log revealed there was no documentation of any substitutions.

Interview with the facility Owner on 03/22/23 at 8:19am revealed:
-He was told the staff started documenting food

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D 292	Continued From page 33 substitutions in January 2023. -He never checked to see if a food substitution log was initiated in January 2023. Interview with the Administrator on 03/22/23 at 10:17am revealed: -She met with all the dietary staff on 03/14/23 and instructed them to immediately start documenting food substitutions. -She thought the staff were documenting food substitutions because they had a book in the kitchen, but she did not know the book did not have any papers to document the substitutions, so she gave them the forms to put in the book.	D 292		
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: FOLLOW UP TO A TYPE B VIOLATION Based on these finding, the previous Type B Violation was not abated.	D 310		

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Based on observations, interviews, and record reviews the facility failed to ensure 3 of 5 sampled residents (Resident #1, #2 and #4) received therapeutic diets as ordered related to a low fat, low cholesterol, 2-gram sodium, mechanical soft with extra gravy and sauces and honey thickened liquids with no caffeine diet (#1), an order for a renal, low concentrated sweets diet (#4) and a low fat, low cholesterol, low sodium, 60-gram carbohydrate per meal, no caffeine diet (#2).

The findings are:

Observations of the kitchen during initial tour on 03/21/23 at 9:54am revealed:
-A regular menu was on the food preparation table.
-A therapeutic diet menu spreadsheet was not in the kitchen for reference by dietary staff.

Interview with the Food Service Director (FSD) on 03/21/23 at 9:54am and 12:15pm revealed:
-The Resident Care Director (RCD) was responsible for providing all current diet order cards to the dietary staff.
-The therapeutic menu spreadsheets that specified what was to be served for all therapeutic diets were not used because there was not enough money in the budget to purchase the items.
-She kept the spreadsheets in her office.
-The facility did not have any low sugar items to serve to residents with diabetes so the only change to that diet was they used artificial sweeteners.
-Low sugar foods were expensive and did not fit into the budget and were not purchased.

Review of the therapeutic menu spreadsheets revealed:

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-The spreadsheets were in the FSD's office.
-Therapeutic menu spreadsheets were available for mechanical soft, low concentrated sweets, carbohydrate control, low fat/low cholesterol, liberalized renal and 2-gram sodium diets.

1. Review of Resident #1's current FL2 dated 04/25/22 revealed diagnoses included hypertension, aphasia and coronary artery disease.

Review of Resident #1's hospital discharge summary revealed:
-Resident #1 was admitted from 03/03/23 to 03/09/23.
-On 03/03/23, Resident #1 was on a mechanical soft diet at the facility, ate a strawberry, choked and Resident #1 received the Heimlich maneuver.
-Resident #1's admission diagnoses included aspiration pneumonia, hypoxia, choking episode and sepsis without acute organ dysfunction.
-On 03/04/23, a chest xray was preformed and dense left lower lobe pneumonia and/or aspiration contents.
-On 03/04/23, speech therapy was consulted, evaluated Resident #1 and recommended a mechanical soft diet with honey thickened liquids and must be supervised with all meals.

Review of Resident #1's hospital discharge summary dated 03/09/23 revealed a low fat, low cholesterol, 2-gram sodium, mechanical soft with extra gravy and sauces and honey thickened liquids with no caffeine diet was ordered upon discharge.

Interview with the FSD on 03/21/23 at 9:54am revealed no residents at the facility received thickened liquids.

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Review of Resident #1's diet card revealed he was on a mechanical soft diet.

Review of the low fat/low cholesterol, mechanical soft therapeutic menu for breakfast on 03/22/23 revealed ground pork should be served instead of sausage.

Observation of the lunch meal service on 03/22/23 at 7:30am revealed Resident #1 received cold cereal with milk, cut up sausage, ½ of a banana and a glass of juice that was not thickened.

Review of the low fat/low cholesterol, mechanical soft therapeutic menu for lunch on 03/22/23 on 03/22/23 revealed ground meatloaf with gravy should be served.

Observation of the lunch meal service on 03/22/23 at 11:39am revealed Resident #1's meatloaf with gravy was delivered from the kitchen precut into bite size pieces and the PCA cut it further using the side of a spoon.

Interview with the FSD on 03/22/23 at 11:21am revealed:
-A mechanical soft diet specified ground meat, but the kitchen did not have a food processor.
-She requested a food processor for grinding meat in January 2023 from the Owner but never received one.

Interview with a PCA on 03/21/23 at 12:03pm revealed Resident #1's meat had to be cut into small pieces and his cake had to be crumbled because he was at risk for choking.

Interview with a dietary aide on 03/22/23 at

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7:59am revealed:
-Resident #1 received a mechanical soft diet which meant all his meat was cut.
-Dietary staff cut all meat on a cutting board in the kitchen before it was put on the plate.
-Meat was cut rather than ground because a food processor was not available.
-The FSD trained her to cut meats, but she had prior food service experience and had always been trained to grind meats for a mechanical soft diet.
-Since she did not have a food processor she cut meat as she was trained.

Interview with a PCA on 03/22/23 at 11:25am revealed:
-Resident #1 was at risk for choking so his meats were cut in the kitchen.
-All Resident #1's food needed to be bite size, so he cut any larger pieces of food.
-Meat was not ground because a food processor was not available for grinding.
-The Administrator and the Owner were both told by the FSD months ago that a food processor needed to be made available to grind food.

Interview with Resident #1's primary care provider (PCP) on 03/21/23 at 2:16pm and 03/23/23 at 9:31am revealed:
-Historically Resident #1 received a mechanical soft diet.
-If he did not receive a mechanical soft diet he was at increased risk of choking.
-She did not know the facility was chopping meat rather than grinding meat for a mechanical soft diet.
-He had a choking episode in early March 2023 and was admitted to the hospital.
-She did not know that he was discharged from the hospital on 03/09/23 on a low fat, low

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cholesterol, 2-gram sodium, mechanical soft with extra gravy and sauces and honey thickened liquids with no caffeine.
-If he did not get a mechanical soft, honey thickened liquids diet, he could aspirate and develop sepsis again.

Telephone interview with the Administrator on 03/22/23 at 10:17am revealed:
-She did not know Resident #1 was ordered a mechanical soft diet.
-She did not know the facility did not have a food processor to grind foods as specified on a mechanical soft diet.

Refer to telephone interview with a representative from the facility's contracted food service provider on 03/22/23 at 9:21am.

Refer to telephone interview with the Registered Dietitian from the facility's contracted food service provider on 03/22/23 at 9:30am and interview on 03/23/22 at 9:54am.

Refer to interview with the Resident Care Director (RCD) on 03/23/23 at 12:00pm.

Refer to telephone interview with the Administrator on 03/22/23 at 10:17am.

Refer to interview with the facility Owner on 03/22/23 at 8:19am.

2. Review of Resident #4's current FL2 dated 07/29/22 revealed:
-Diagnoses included hypertension and congestive heart failure.
-A diet order was not documented.

Review of Resident #4's physician orders dated

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(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
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06/02/22 revealed a low concentrated sweet, renal diet.

Review of Resident #4's diet card revealed she was on a low concentrated sweet, renal diet.

Interview with Resident #4 on 03/22/23 at 11:06am revealed:
-She had diabetes, but she was not on any special diet for it.
-She was served the same food that everyone else was served.
-The only thing she did differently was she used artificial sweetener instead of regular sugar.
-Her diet card that was delivered on her meal tray documented she was on a renal diet, but she did not know what that meant.

Review of the liberalized renal diet menu on 03/21/23 documented pizza sticks should be served instead of Italian Wedding soup.

Observation of the lunch meal service on 03/21/23 at 11:50am revealed Resident #4 received Italian Wedding soup, not pizza sticks.

Review of the liberalized renal diet menu for breakfast on 03/22/23 documented non-citrus juice should be served instead of citrus juice.

Observation of the breakfast meal service on 03/22/23 at 7:30am revealed Resident #4 received orange juice.

Review of the liberalized renal diet menu for lunch on 03/22/23 documented rice should be served instead of potatoes.

Observation of the lunch meal service on 03/22/23 at 11:39am revealed Resident #4

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received creamed potatoes.

Review of the liberalized renal diet menu for breakfast on 03/23/23 documented non-citrus juice should be served instead of citrus juice.

Observation of the breakfast meal service on 03/23/23 at 8:16am revealed Resident #4 received orange juice.

Review of the liberalized renal diet menu for lunch on 03/23/23 documented green peas should be served instead of black-eyed peas.

Observation of the lunch meal service on 03/23/23 at 11:50am revealed Resident #4 received black-eyed peas.

Interview with the FSD on 03/21/23 at 9:54am revealed:
-The facility did not have access to a renal menu.
-The staff knew Resident #4 was not allowed to have any fried foods, gravy, sweets or spicy foods but she was allowed to have any fruit and any vegetable.

Interview with a dietary aide on 03/22/23 at 7:59am revealed:
-A regular menu was followed because no other menus were available.
-Except for the use of artificial sweetened beverages, regular sugar items were served to residents on a low concentrated sweets diets.
-A renal diet was not available but someone from the food distributor was trying to provide information about that diet.

Interview with Resident #4's PCP on 03/21/23 at 2:30pm revealed:
-Resident #4 took a diuretic to reduce fluid

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accumulation associated with congestive heart failure.
-Resident #4's kidneys were at risk for being damaged due to her hypertension diagnosis.
-Renal problems usually developed after a heart failure diagnosis so Resident #4 was ordered a renal, low concentrated sweets diet to protect her kidneys.
-Not following a low concentrated sweet, renal diet could cause her blood sugars to increase and her kidney function to worsen.
-She did not know a renal diet was not being provided and that the facility did not purchase low sugar food items..

Refer to telephone interview with a representative from the facility's contracted food service provider on 03/22/23 at 9:21am.

Refer to telephone interview with the Registered Dietitian from the facility's contracted food service provider on 03/22/23 at 9:30am and interview on 03/23/22 at 9:54am.

Refer to interview with the Resident Care Director (RCD) on 03/23/23 at 12:00pm.

Refer to telephone interview with the Administrator on 03/22/23 at 10:17am.

Refer to interview with the facility Owner on 03/22/23 at 8:19am.

3. Review of Resident #2's current FL2 dated 07/01/22 revealed diagnoses included diabetes, stage 3 chronic kidney disease and hypertension.

Review of Resident #2's physician orders dated 08/15/22 revealed a diet order for a low fat, low cholesterol, 2-gram sodium and 60-gram

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D 310	Continued From page 42 carbohydrates per meal diet. Review of Resident #2's diet card revealed he was on a regular, Mediterranean diet. Review of the low fat/low cholesterol breakfast menu for 03/22/23 documented egg substitute should be served rather than sausage and skim milk should be served rather than whole milk. Observation of the breakfast meal service on 03/22/23 revealed Resident #2 received sausage and whole milk. Review of the low fat/low cholesterol breakfast menu for 03/23/23 documented egg substitute should be served rather than eggs and fresh pork should be served rather than liver mush. Observation of the breakfast meal service on 03/23/23 revealed Resident #2 received scrambled eggs and liver mush. Review of the low fat/low cholesterol lunch menu for 03/23/23 documented green peas should be served rather than black-eyed peas. Observation of the lunch meal service on 03/23/23 revealed Resident #2 received black-eyed peas. Interview with the FSD on 03/21/23 at 12:15pm revealed: -Resident #2 received a Mediterranean diet because he liked those kinds of foods. -Mediterranean diet meant health foods like fish and steamed foods rather than fried foods. -He was ordered that diet when he returned from the hospital 6 or 7 months ago.	D 310		

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Telephone interview with Resident #2's PCP on 03/23/23 at 9:44am revealed:
-She knew he was discharged from the hospital in June 2022 with a Mediterranean diet but did not know that he was changed on 08/15/22 to a low fat, low cholesterol, 2-gram sodium, 60-gram carbohydrates per meal diet after another hospital discharge.
-The Mediterranean diet was similar to the diet he was ordered on 8/15/22.
-His blood sugars and blood pressure would worsen if the correct diet was not provided.
-Earlier this week she ordered finger stick blood sugar checks twice a day and sliding scale insulin at the request of the RCD because Resident #2 was having elevated blood sugars.

Refer to telephone interview with a representative from the facility's contracted food service provider on 03/22/23 at 9:21am.

Refer to telephone interview with the Registered Dietitian from the facility's contracted food service provider on 03/22/23 at 9:30am and interview on 03/23/22 at 9:54am.

Refer to interview with the Resident Care Director (RCD) on 03/23/23 at 12:00pm.

Refer to telephone interview with the Administrator on 03/22/23 at 10:17am.

Refer to interview with the facility Owner on 03/22/23 at 8:19am.

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Telephone interview with the Registered Dietitian from the facility's contracted food service provider on 03/22/23 at 9:30am and interview on 03/23/22 at 9:54am revealed:
-Menus were developed to meet the nutritional

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needs of the residents and provided to the facility in September 2022.
-The FSD was instructed in September 2022 to set up an in-service to educate the staff on reading the menus if she thought that was necessary.
-An in-service on implementing the menus was never requested until last week when the Administrator requested one.
-She was unaware they were not following the menus provided.
-The facility's therapeutic menus spreadsheet contained dietary information for mechanical soft, low concentrated sweets, carbohydrate control, low fat/low cholesterol, liberalized renal and 2-gram sodium diets.
-Following the therapeutic menus would meet the nutritional guidelines intended for each therapeutic diet.

Interview with a representative from the facility's contracted food service provider on 03/23/23 at 9:54am revealed the FSD told her in January 2023 that she was unaware that she needed to purchase foods on the therapeutic menus.

Interview with the facility Owner on 03/22/23 at 8:19am revealed:
-He thought both the regular and the therapeutic menus were being used but did not check to confirm because he did not go looking for problems.
-The Administrator meet with all the dietary staff on 03/14/23 and reviewed the menus.
-He did not know the FSD was not purchasing the therapeutic menu items because she did not have enough money to include them in the order.
-He expected the dietary staff to provide the therapeutic diets and follow the menus.

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Telephone interview with the Administrator on 03/22/23 at 10:17am revealed:
-She was told the staff were using the therapeutic menus, but she did not check to be sure that was true.
-She met with all the dietary staff on 03/14/23 and instructed them to use the correct menus.
-She thought a regular diet and a renal diet were the only therapeutic diets at the facility.
-The RCD was responsible for informing the dietary staff of all therapeutic diet orders and making the resident's diet cards.

Interview with the RCD on 03/23/23 at 12:00pm revealed:
-She was responsible for providing dietary staff with the correct diet order and diet card for each resident.
-The FSD was responsible for providing the therapeutic diet once she was informed of them.
-She did not know the dietary staff were not providing the therapeutic diets as ordered.
-New therapeutic diet menus were provided by the contracted food service provider in the Fall of 2022, and she thought the staff knew how to read them and were using them.
-She knew the FSD was on a strict budget and was unable to purchase all the necessary special foods needed for the therapeutic diets.

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The facility failed to serve diets as ordered including a mechanical soft diet to Resident #1 resulting in a choking incident and hospital admission in March 2023 where he was diagnosed with aspiration; he was discharged back to the facility on a mechanical soft diet and honey thickened liquids which was not implemented putting him at risk for further choking incidents that could subsequently lead to aspiration; a renal diet to Resident #4 putting her

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D 310	Continued From page 46 at risk for kidney damage; and a low fat/low cholesterol, carbohydrate controlled diet to Resident #2 putting him at risk for elevated blood sugar and blood pressure. These failures were detrimental to the residents' health and safety and constitutes an unabated B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 03/22/23. THE CORRECTION DATE FOR THE TYPE UNABATED B VIOLATION SHALL NOT EXCEED APRIL 22, 2023.	D 310		