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PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and a complaint investigation from 11/01/23 through 11/03/23. The complaint was initiated by Yadkin County Department of Social Services on 10/20/23.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#3) who had a history of falls which resulted in an ankle fracture. The findings are: Review of the facility's policies on 11/02/23 revealed there was no policy on resident falls or supervision available for review. Review of Resident #3's current FL2 dated 05/23/23 revealed: -Diagnoses included chronic pain syndrome, major depressive disorder, bipolar disorder, dementia, and chronic obstructive pulmonary disease. -She required personal care assistance with	D 270		

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bathing, feeding, and dressing, and she was incontinent of bowel and bladder.
-She was semi-ambulatory.

Review of Resident #3's care plan dated 05/09/23 revealed:
-She was ambulatory with the use of an assistive device (walker).
-She was sometimes disoriented and forgetful and she needed reminders.
-She required limited staff assistance with toileting, ambulation/locomotion, and transferring.

a. Review of Resident #3's incident and accident reports revealed there was no incident/accident report dated 09/28/23 available for review.

Review of Resident #3's progress notes dated 09/28/23 revealed:
-At 10:35pm, the medication aide (MA) documented that Resident #3 fell in her room.
-Resident #3 told the MA that when she stood up, her legs were asleep which caused her to fall.
-The MA documented that Resident #3's right ankle was swollen from the fall, but she refused to go to the hospital and did not want an ice pack or any as-needed pain medications.
-There was no documented fall prevention intervention implemented after the fall on 09/28/23.

Attempted telephone interview with the MA who documented Resident #3's 09/28/23 fall on 11/02/23 at 4:30pm was unsuccessful.

Review of Resident #3's physician's progress note dated 10/03/23 revealed:
-There was no documentation regarding Resident #3's fall on 09/28/23.
-Resident #3 had a documented fall on 10/03/23,

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which resulted in x-ray imaging of her right ankle showing there was no fracture.

Interview with Resident #3 on 11/02/23 at 8:50am revealed:
-She had several falls within the previous months' time.
-She could not specifically remember her fall from 09/28/23.
-She was being treated for a urinary tract infection (UTI) at the end of September 2023, but did not think that caused her to fall.
-She did not know how often staff checked on her.

b. Review of Resident #3's incident and accident report dated 10/03/23 revealed:
-Resident #3 had a fall at 2:00am in her room.
-The MA documented that Resident #3 was on the floor wheezing and had shortness of breath and a swollen ankle.
-Resident #3 reported to the MA that she was getting up to change and slipped in her urine.
-There was documentation Resident #3's oxygen saturation level was 85% and she was wheezing and reporting shortness of breath, her right ankle was swollen and she reported having generalized weakness.
-Resident #3 was transported to the Emergency Department (ED) via Emergency Medical Services (EMS) at 2:30am and returned later that same morning.
-There was no documented fall prevention intervention implemented after the fall on 10/03/23.

Review of Resident #3's progress notes dated 10/03/23 revealed:
-The MA documented at 2:36am that Resident #3 was found on her floor at 2:00am when the staff

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were doing their routine checks on the residents.
-When Resident #3 was asked why she did not yell out for help, she told the staff that she knew someone would come down the hall eventually.
-Staff asked Resident #3 how long she had been on the floor, and Resident #3 stated she had just fallen before staff walked into the room.
-Resident #3 was complaining about pain to her right ankle and it was swollen and starting to bruise.
-The MA sent Resident #3 to the ED because her blood pressure was 91/50 (normal range 120/80), heart rate was 120 beats per minute (bpm) (normal range 60-100 bpm), oxygen saturation level was 84% (normal range greater than 90%), along with her complaint of right ankle pain and weakness.
-The MA documented at 5:46am that the hospital called and stated Resident #3's ankle was not broken or sprained, and she was ready to be discharged back to the facility.

Attempted telephone interview with the MA who documented Resident #3's 10/03/23 fall on 11/02/23 at 12:05pm was unsuccessful.

Review of Resident #3's physician's progress note dated 10/03/23 revealed:
-Resident #3's primary care provider (PCP) was seeing her that day for a hospital ED follow-up along with her being positive for COVID-19.
-The PCP documented that Resident #3 was evaluated at the ED earlier that day for a right ankle contusion, and per the discharge notes the x-ray did not show obvious signs of fracture or dislocation.
-Staff reported to the PCP that Resident #3 had tested positive for Covid-19 upon return from the ED.
-Resident #3 was clinically stable at the time of

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the PCP's assessment, but she had a congested cough, so she was going to prescribe treatment for Resident #3's Covid-19 symptoms and advised staff to monitor her right ankle.

Interview with Resident #3 on 11/02/23 at 8:50am revealed:
-She fell on 10/03/23 and went to the ED because she was really sick.
-She had tested positive for Covid-19 the day she fell and she was weak from being sick.
-She did not physically injure herself during the fall.
-Upon return from the ED, the staff checked her oxygen levels due to her respiratory illness but did not check on her more frequently than every couple of hours.

c. Review of Resident #3's incident and accident report dated 10/19/23 revealed:
-Resident #3 had an unwitnessed fall at 7:30pm.
-She was found on the floor in her room and was yelling for help.
-Resident #3 told the MA that she was bending over to pick up clothes and tipped over.
-There were no reported injuries.
-There was no documented fall prevention intervention implemented after the fall on 10/19/23.

Attempted telephone interview with the MA who documented Resident #3's 10/19/23 fall on 11/02/23 at 4:30pm was unsuccessful

Review of Resident #3's triage note dated 10/19/23 revealed:
-The facility reported to the on-call provider at Resident #3's PCP office that Resident #3 was found on the floor in her room.
-Resident #3 reported she fell over while bending

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down to pick up clothes.
-Resident #3 did not complain of any pain and refused to go to the ED.
-The EMS went to the facility to evaluate Resident #3, but nothing out of the ordinary was found.
-The provider who reviewed the facility's report advised to monitor Resident #3 per facility protocol, notify of any acute change in condition, and follow up with the PCP.

Review of Resident #3's progress notes dated 10/19/23 revealed:
-The MA documented at 8:48pm that Resident #3 was calling for help and was found on the floor in her room.
-Resident #3 reported to the MA that she tipped over while bending down to pick up laundry.
-Resident #3's guardian was notified, and EMS came to the facility to evaluate Resident #3, but she had no complaints of pain or visible injury.

Interview with Resident #3 on 11/02/23 at 8:50am revealed:
-She remembered falling while trying to pick clothes up from her floor.
-Sometimes when she was moving too fast she lost her balance and fell.
-She did not remember obtaining any injuries during her fall on 10/19/23.
-The staff did not do anything differently for her after her fall on 10/19/23.

d. Review of Resident #3's incident and accident report dated 10/27/23 revealed:
-At 6:00pm, Resident #3 was laying on her bed complaining about her right ankle hurting.
-The MA documented that the day shift staff reported Resident #3 had fallen that morning and her right ankle was swollen and tender to the touch.

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-Resident #3 told the MA that she was getting changed earlier that morning and her knee buckled, she fell, and felt her ankle snap.
-The EMS came to the facility to evaluate Resident #3 and placed a splint on her right ankle then transported her to the ED.
-There was no documented fall prevention intervention after the fall on 10/27/23.

Review of Resident #3's progress notes dated 10/27/23 revealed:
-The MA documented at 7:40pm, Resident #3 told her she had fallen that morning and felt her right ankle snap.
-Since the fall, Resident #3 had been in her bed.
-Resident #3 had complained to her on night shift that her ankle was really hurting, so she assessed the ankle and since it was swollen, bruised, and tender she sent her to the ED.

Review of Resident #3's triage note dated 10/27/23 revealed:
-The MA notified Resident #3's PCP that her right ankle was swollen, bruised and tender and that Resident #3 had reported to the MA that she had fallen that morning.
-The MA was sending Resident #3 to the ED.
-The provider who reviewed the facility's report advised to have Resident #3 follow up with her PCP upon Resident #3's return to the facility.

Review of Resident #3's triage note dated 10/28/23 revealed:
-The MA notified Resident #3's PCP's office that she had a diagnosis of a fracture to her ankle and that the ankle was currently wrapped.
-The provider who reviewed the facility's report advised to have Resident #3 follow up with her PCP upon her return to the facility.

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Interview with Resident #3 on 11/02/23 at 8:50am revealed:
-She fell earlier in the day on 10/27/23 when she broke her ankle, but did not go to the ED until later in the day.
-She could not remember the circumstances leading up to her fall, but she thought she was alone in her room changing when she fell.
-She remembered feeling her ankle snap when she fell on it.
-After she fell on 10/27/23, the staff did not do anything differently for her other than encourage her to rest in her bed that day.

Interview with the Resident Care Coordinator (RCC) on 11/03/23 at 11:03am revealed:
-Resident #3 fell during day shift on 10/27/23 when she sustained the ankle fracture.
-One of the personal care aides (PCA) had reported Resident #3's fall to her, but she did not know if the PCA had been with Resident #3 at the time of her fall, or if she was the one who found Resident #3 on the floor.
-There was no fall report from 10/27/23, only an incident report from later that evening when the MA sent Resident #3 to the ED due to complaints of her ankle and foot hurting from the fall she had earlier that day.
-The Operations Manager (OM) was responsible for ensuring the staff completed incident reports after falls.

Attempted telephone interview with the PCA who reported Resident #3's 10/27/23 fall on 11/03/23 at 12:15pm was unsuccessful.

e. Review of Resident #3's incident and accident report dated 10/29/23 revealed:
-At 8:00pm, a resident yelled down the hall for staff to assist Resident #3.

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-Resident #3 was on the floor between her bed and her wheelchair.
-Resident #3 stated she slid onto the floor while trying to transfer from her bed to her wheelchair.
-She had no complaints of pain or discomfort and denied needing medical attention.
-There was documentation Resident #3 was placed on 15-minute checks from 6:00am on 10/30/23 to 6:00am the following day.

Review of Resident #3's progress notes dated 10/29/23 revealed:
-The MA documented at 9:09pm, that Resident #3 was trying to get out of her bed and into her wheelchair and she slipped.
-Resident #3 reported that she slowly slid to the floor once she realized she was not going to make it into the chair.
-Another resident was in the room with her and yelled for staff.
-The RCC and MA got the resident off the floor after asking her if she was hurt.
-Resident #3 told staff she was not hurt and did not need medical attention.

Review of Resident #3's triage note dated 10/29/23 revealed:
-The MA reported to the PCP's office that Resident #3 was trying to transfer from her bed to her wheelchair and fell, stating she slid onto the floor when she realized she could not make the transfer.
-Resident #3's right ankle was wrapped from her hospital visit on 10/27/23, and she reported it was hard to move with her ankle wrapped.
-The provider who reviewed the facility's report advised to implement checks per facility protocol due to the fall, follow up for any acute changes, and have Resident #3 follow up with her PCP.

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D 270	Continued From page 9 Interview with Resident #3 on 11/02/23 at 8:50am revealed: -She had gone several months without having a fall, until she fell on 09/28/23. -She remembered falling on 10/29/23. -Since fracturing her ankle, it was hard for her to get around like she did previously. -On 10/29/23, she was trying to transfer herself and when she realized she was not able to make it to her wheelchair, she sat on the floor and waited for someone to come and help her. -When she fell, she either had to yell for staff or wait for someone to walk by her room because she did not have a call bell. -She did not injure herself on 10/29/23. -There was nothing that happened or changed to cause her to start having frequent falls between 09/28/23 and 10/29/23. -Falls had been a part of her life for as long as she could remember. -Before she fell, she usually felt "fuzzy brained," but she had been evaluated by a neurologist earlier in the year for that and there was nothing wrong. -The MAs checked her blood pressure often and it was never low. -The only thing staff did to try to prevent her from falling was to encourage her to sit down whenever she felt dizzy or off-balance. -She wanted to maintain some independence. -She did not always listen to their advice. -The staff checked on her at least every couple of hours, but she did not know how often. -She had been receiving physical therapy (PT) services, but she was discharged from PT about one month prior. Interview with the RCC on 11/03/23 at 11:03am revealed: -She completed Resident #3's fall report on	D 270		

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10/29/23.
-Resident #3 had a follow-up visit with her PCP about her fractured ankle the following week.
-At the time of Resident #3's fall on 10/29/23, she reported it was hard to transfer and move around with her foot wrapped.
-Resident #3 did not have any injuries from her fall on 10/29/23; Resident #3 reported she slowly lowered herself to the floor.
-After Resident #3's fall on 10/29/23, she implemented 15-minute checks on Resident #3 for 24 hours post-fall.
-After each of Resident #3's falls, except her fall on 10/29/23 where she implemented 15-minute checks, the staff just monitored her.
-Monitoring Resident #3 meant that one of the PCAs should check on her every 30-minutes to an hour.
-There was no documentation from the PCAs checking on Resident #3 more frequently.

Attempted telephone interview with Resident #3's guardian on 11/02/23 at 12:10pm was unsuccessful.

Attempted telephone interview with Resident #3's physical therapist (PT) on 11/03/23 at 10:15am was unsuccessful.

Attempted telephone interview with the Operations Manager (OM) on 11/03/23 at 12:20pm was unsuccessful.

Refer to the interview with a medication aide (MA) on 11/02/23 at 11:25am.

Refer to the interview with a personal care aide (PCA) on 11/02/23 at 2:45pm.

Refer to the telephone interview with Resident

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D 270	Continued From page 11 #3's mental health provider (MHP) on 11/02/23 at 3:00pm. Refer to the interview with a second medication aide/personal care aide (MA/PCA) on 11/02/23 at 3:45pm. Refer to the interview with Resident #3 on 05/03/23 at 9:50am. Refer to the interview with a PCA on 11/03/23 at 10:20am. Refer to the telephone interview with Resident #3's primary care provider (PCP) on 11/03/23 at 8:30am. Refer to the interview with the Resident Care Coordinator (RCC) on 11/03/23 at 11:03am. Refer to the interview with the Administrator on 11/03/23 at 12:47pm. _____ Interview with a MA on 11/02/23 at 11:25am revealed: -She was not aware of any fall prevention measures in place for Resident #3 other than helping her with ambulation. -Resident #3 usually called for help from staff with walking so the PCAs or MAs would supervise her while walking, or have her sit on her walker seat and push her down the hall. -Resident #3 had increased supervision checks, but she only remembered doing it one day on 10/30/23. -When a resident had a fall, the MAs were expected to check them for pain or visible injuries, then notify the guardian and the PCP. -After each fall, a resident was supposed to be placed on 15-minute checks for 24 hours post-fall	D 270		

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by the MA on duty, but it did not always happen.

Interview with a PCA on 11/02/23 at 2:45pm revealed:
-Prior to Resident #3's ankle fracture, the PCAs only had to help her to the bathroom; she was able to ambulate with her walker independently.
-Since Resident #3's ankle fracture, she needed help with transfers into a wheelchair, and to be propelled down the hall in her wheelchair by staff either to the smoking patio or to the dining room.
-The PCAs checked on Resident #3 every 2 hours or as-needed if she said she needed help as they walked past her room.
-Resident #3 was on 15-minute checks for one day following her most recent fall, but she could not recall the date.
-She did not find Resident #3 on the floor for any of the falls she had.

Telephone interview with Resident #3's MHP on 11/02/23 at 3:00pm revealed:
-Resident #3's psychiatric medications were low-dose and did not place her at risk for falls.
-Resident #3 was taking a diuretic medication which could lower her blood pressure and potentially contribute to falls.

Interview with a second MA/PCA on 11/02/23 at 3:45pm revealed:
-Resident #3 needed assistance from staff with transfers prior to her ankle fracture, because Resident #3 said she could not keep her balance.
-Since Resident #3 fractured her ankle, she needed help with transfers and wheelchair mobility.
-To try to prevent Resident #3 from falling, she tried to walk with Resident #3 as she was ambulating with her walker.
-She thought all of Resident #3's falls happened

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while she was trying to transfer herself.
-Resident #3 was not currently on increased supervision anymore, but staff did 15-minute checks on Resident #3 on 10/30/23 after a fall.
-Nobody had told her to do anything different or additional for Resident #3 for fall prevention since 9/28/23.

Interview with Resident #3 on 11/03/23 at 9:50am revealed:
-The Administrator had given her a hand-held call bell to ring for help yesterday on 11/02/23, which had never been offered to her in the past.
-She was happy to have a bell and to have the option to ring for help if she needed it.
-Prior to fracturing her ankle, she was independent with transfers and ambulating with her walker.
-She now had to use a wheelchair and needed staff to propel her around in it, because she did not have the upper body strength to do it herself.

Interview with another PCA on 11/03/23 at 10:20am revealed:
-Prior to Resident #3 fracturing her ankle, he had to help her with showers and with ambulating with her walker.
-Resident #3 never complained of feeling dizzy or weak to him.
-Resident #3 needed assistance from two staff to help her with transfers since her ankle was fractured, and previously she had been independent.
-He had not received any new instructions in the previous month regarding fall prevention for Resident #3.
-He checked on Resident #3 every 30 minutes, because he knew she needed extra help, but he did not document his checks anywhere.

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D 270	Continued From page 14 Telephone interview with Resident #3's PCP on 11/03/23 at 8:30am revealed: -She was aware of Resident #3's falls. -Resident #3 had been evaluated by neurology for falls in the past, and recently completed physical therapy (PT) as well. -Resident #3 was a high risk for falls due to her multiple diagnoses. -The facility had not contacted her to ask about implementing anything new for fall prevention measures for Resident #3. Interview with the RCC on 11/03/23 at 11:03am revealed: -She planned to refer Resident #3 back to PT, but she had not requested or received an order for PT yet. -At the end of September 2023, Resident #3 was being treated for a urinary tract infection (UTI), and on 10/03/23 after she fell, Resident #3 was diagnosed with Covid-19. -Other than Resident #3's two acute illnesses of UTI and Covid-19 which made her weak and more short of breath, nothing had changed with her medications or level of care which would explain her recent frequent falls. -Resident #3 always said that she either slipped, lost her footing, or sat down on the floor as the reason for her falls rather than reporting any symptom of dizziness of weakness. -Resident #3 had completed PT in August 2023 and was discharged because she had met her goals. -Prior to fracturing her ankle, Resident #3 was independent, but sometimes needed assistance with walking. -Resident #3 was currently a two-person assist for transfers and one-person assist with wheelchair mobility. -Resident #3's PCP was aware of all of her falls	D 270		

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and had not suggested any additional fall prevention measures.
-The MAs were supposed to document increased supervision 15-minute checks for 24 hours after each of Resident #3's falls.
-The only documented 15-minute checks the facility had for Resident #3 was on 10/30/23.
-She had noticed at the beginning of October 2023, that the MAs had not been documenting 15-minute checks for Resident #3 after her falls, so she told the MAs they needed to start doing those after each fall.
-The MAs had not increased supervision for Resident #3 after her falls on 09/28/23, 10/03/23, 10/19/23 or 10/27/23 because staff never gave her the increased supervision form documenting their checks.
-She had asked the MAs why they did not implement the 15-minute checks after Resident #3's falls, and staff told her that they checked on Resident #3 more often, but did not have time to document their checks.
-The Operations Manager (OM) was responsible for ensuring incident and accident reports were filled out for each fall.

Interview with the Administrator on 11/03/23 at 12:47pm revealed:
-She was aware of Resident #3's falls.
-Fall prevention measures for Resident #3 included educating her about wearing her as-needed oxygen more to prevent shortness of breath or dizziness, asking staff for help, and transferring from her bed to her chair slowly.
-Resident #3 was non-compliant with wearing her oxygen continuously so her PCP changed the order to as-needed, but she did not wear it as often as she probably needed to, which she thought contributed to her falls.
-Resident #3 had been to a neurologist regarding

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D 270	Continued From page 16 frequent falls in the past but there were no abnormal findings. -Resident #3 recently completed PT services. -The MAs should have implemented increased supervision and 15-minute checks after each of Resident #3's falls. -She was not aware that 15-minute checks post-fall were not being completed for Resident #3. -Resident #3's falls seemed to be happening more frequently, but she did not know what caused the change. -The OM was responsible for communicating with the PCP regarding causes of falls or new fall prevention measures. _____ The facility failed to ensure supervision for 1 of 5 residents related to a resident who had five falls in one month, resulting in two visits to the ED and a fractured ankle, and a decrease in independence and mobility of the resident (#3). This failure placed the residents at substantial risk for physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/02/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 3, 2023.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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D 273	Continued From page 17 This Rule is not met as evidenced by: Based on observations, interview, and record reviews, the facility filed to ensure referral and follow-up to meet the acute health care needs for 2 of 5 sampled residents (#1 and #3) related to refusal of a pain medication patch and a pain medication not available for administration (#1) and not notifying the primary care provider about weight increases as ordered (#3). The findings are: Review of Resident #1's Resident #1's date of admission was 10/24/23. 1. Review of Resident #1's current FL2 dated 11/01/23 revealed diagnoses included degenerative disc lumbar. a. Review of resident #1's current FL2 dated 11/01/23 revealed here was an order for lidocaine patch 4% (used to treat pain) apply 1 patch topically to the lower back and remove after 12 hours. Review of Resident #1's previous FL2 dated 10/23/23 revealed: -Diagnoses included degenerative disc lumbar. -There was an order for lidocaine patch 4% apply 1 patch topically to the lower back and remove after 12 hours. Review of Resident #1's electronic medication administration record (eMAR) for 10/24/23 through 10/31/23 revealed: -There was an entry for lidocaine pain relief 4% patch apply 1 patch topically to the lower back daily, remove after 12 hours scheduled for 6:00am and 6:00pm.	D 273		

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-There was documentation Resident #1 refused the lidocaine patch 3 of 7 times at 6:00am between 10/25/23 and 10/31/23 and 8 of 8 times at 6:00pm between 10/24/23 and 10/31/23.

Review of Resident #1's eMAR for 11/01/23 through 11/02/23 revealed:
-There was an entry for lidocaine pain relief 4% patch apply 1 patch topically to the lower back daily, remove after 12 hours scheduled for 6:00am and 6:00pm.
-There was documentation Resident #1 refused the lidocaine patch 2 of 2 times at 6:00am between 11/01/23 and 11/02/23 and 1 of 1 time at 6:00pm on 11/01/23.

Observation of medications available for Resident #1 on 11/02/23 at 3:27pm revealed:
-Lidocaine patches were not available on the medication cart.
-The lidocaine patches were located in the Operations Manager's (OM) office.
-The lidocaine patches were dispensed to the facility on 10/24/23 with a quantity of 30 patches.
-There was a quantity of 33 patches available.

Telephone interview with the facility's contracted pharmacy on 11/03/23 at 8:23am revealed:
-Resident #1 had an order for lidocaine pain relief 4% patch apply 1 patch topically to the lower back daily, remove after 12 hours.
-A 30-day supply of lidocaine patches was dispensed to the facility on 10/24/23.

Interview with Resident #1 on 11/02/23 at 11:27am revealed:
-She had refused the pain patch daily since she was admitted to the facility.
-She refused the patch because it was blue in color and she did not believe it was a lidocaine

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patch.
-The blue pain patch did not stick on her skin and did not help with her pain.

Telephone interview with a nurse from Resident #1's primary care provider's (PCP) office on 11/02/23 at 2:19pm revealed:
-Resident #1 had an order for lidocaine patches daily for pain.
-The facility had not reported to the PCP that Resident #1 had refused to have lidocaine patches applied since 10/24/23.
-The PCP would have expected to be notified Resident #1 was refusing to have the lidocaine patch applied daily as ordered.
-Possible outcomes of not having the lidocaine patches applied daily included continued pain.

Interview with a medication aide (MA) on 11/02/23 at 2:58pm revealed:
-She had not applied Resident #1's lidocaine patch because she refused to wear them.
-Resident #1 told her the patches did not work and she did not want to wear them.
-She had not contacted Resident #1's PCP regarding her refusing to wear the lidocaine patches.

Interview with the OM on 11/02/23 at 3:09pm revealed:
-She knew Resident #1 refused to have lidocaine patches applied.
-Resident #1's lidocaine patches were kept in her office and if Resident #1 wanted to have them applied, the MA had to come to the office to get the patch.
-She had not contacted Resident #1's PCP regarding her refusing to have lidocaine patches applied because she felt they did not work.

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D 273	Continued From page 20 Interview with a MA/personal care aide (PCA) on 11/02/23 at 3:33pm revealed: -Resident #1 refused to have her lidocaine patch applied when she worked as a MA on Friday, 10/27/23. -She went back to Resident #1 at a later time and Resident #1 refused again stating that she did not want the patch because the patch did not help her. -She told the OM and the Resident Care Coordinator (RCC) that Resident #1 refused to have the patch applied. -MAs should have notified the residents PCP of refusals if a resident refused a medication 2 to 3 days in a row. -She did not look to see if Resident #1 had refused to have her lidocaine patch applied on the days prior to 10/27/23. -She did not know if Resident #1's PCP was notified that she refused to have her lidocaine patch applied. -Resident #1 had not complained to her about having pain. Interview with the RCC on 11/03/23 at 11:45am revealed: -MAs were to document refusals and notify her or the Operations Manager (OM). -If a resident refused medications for 3 days in a row, she or the OM were responsible for notifying the resident's PCP. -She also accessed the medication exception report every Monday, which provided information regarding resident refusals. -They waited until Mondays when the PCP visited the facility to inform her of refusals for residents who refused frequently. -She did not know Resident #1 was refusing her lidocaine patch until Sunday, 10/29/23 when a MA asked her what she needed to do because	D 273		

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Resident #1 had been refusing the medication.
-She had not contacted Resident #1's PCP regarding her refusing her lidocaine patch.

Interview with the Administrator on 11/03/23 at 12:26pm revealed:
-The RCC or the OM were expected to contact Resident #1's PCP after 3 refusals.
-The RCC was supposed to run the medication exceptions report daily to identify residents who had refused medications.
-She did not know Resident #1 had refused her lidocaine patches.

b. Review of Resident #1's current FL2 dated 11/01/23 revealed there was an order for Hydromorphone 4mg 1 tablet every 4 hours as needed for pain.

Review of Resident #1's previous FL2 dated 10/23/23 revealed:
-Diagnoses included degenerative disc lumbar.
-There was an order for Hydromorphone 4mg 1 tablet every 4 hours for pain.

Review of Resident #1's eMAR for 10/24/23 through 10/30/23 revealed:
-There was an entry for Hydromorphone 4mg 1 tablet every 4 hours as needed for pain scheduled for administration as needed.
-There was no documentation Hydromorphone was administered between 10/24/23 and 10/30/23.

Review of Resident #1's eMAR for 11/01/23 through 11/02/23 revealed:
-There was an entry for Hydromorphone 4mg 1 tablet every 4 hours as needed for pain scheduled for administration as needed.
-There was no documentation Hydromorphone

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D 273	Continued From page 22 was administered between 11/01/23 and 11/02/23. Observation of medications available for Resident #1 on 11/02/23 at 3:27pm revealed Hydromorphone was not available on the medication cart. Interview with Resident #1 during the initial tour of the facility on 11/01/23 at 9:12am revealed: -She ran out of one of her pain medications 2 to 3 days ago and she needed to go to a pain clinic. -She had previously broken her pelvic bone and had constant pain. -She had been in pain since she was admitted to the facility about a week ago and her pain level was currently greater than a 10 on a pain scale from 1 to 10. Interview with Resident #1 on 11/03/23 at 9:34am revealed: -She had been trying to go to the pain clinic since she was admitted to the facility, but the facility staff would not send her to one. -She had issues with a few pain clinics, but she did not think staff was looking for a pain clinic where she could be seen. Telephone interview with the facility's contracted pharmacy on 11/03/23 at 8:23am revealed: -Hydromorphone 4mg 1 tablet every 4 hours as needed for pain was profiled at the pharmacy, but it had not been dispensed to the facility because there was no hard copy of the order for Hydromorphone. -Hydromorphone was profiled from the pharmacy from an FL2 dated 10/24/23. -A pharmacy representative faxed a note to the facility on 10/24/23 requesting a hard copy of the order.	D 273		

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D 273	Continued From page 23 -The pharmacy received a reorder request on 10/29/23, and the pharmacy sent a note back to the facility stating a hard copy of the order for Hydromorphone was needed. -The pharmacy had not received a hard copy of the order for Hydromorphone yet. Interview with a medication aide (MA) on 11/02/23 at 2:58pm revealed: -Hydromorphone was not available on the medication cart for Resident #1. -She last administered Hydromorphone to Resident #1 on 10/30/23 and there were 2 tablets remaining. -She did not reorder Hydromorphone because there was not a refill for the medication. -Resident #1 would have to be seen in a pain clinic to receive a new order for Hydromorphone. -She had not contacted Resident #1's PCP or a pain clinic for Resident #1. -The RCC was responsible for ensuring Resident #1 was seen at a pain clinic. -Resident #1 had not requested Hydromorphone from her for pain. Interview with the OM on 11/02/23 at 3:09pm revealed: -Resident #1 ran out of Hydromorphone, but she did not know remember when. -She did not contact Resident #1's PCP or her pain clinic regarding her being out of Hydromorphone. -She or the RCC was responsible for contacting Resident #1's PCP or pain clinic. Interview with the RCC on 11/02/23 at 3:19pm revealed: -Resident #4 had an order for Hydromorphone which was prescribed by a pain clinic provider. -Usually Resident #1 had to be seen by the	D 273		

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provider in the pain clinic 3-4 days prior to her running out of Hydromorphone.
-She did not know when Resident #1 ran out of Hydromorphone.
-She called Resident #1's pain clinic on Monday, 10/30/23, and left a voice message requesting a return call regarding Resident #1.
-She had not made any additional calls to the pain clinic or any other pain clinic for Resident #1.
-She had not contacted Resident #1's PCP to advise that Resident #4 was out of Hydromorphone.

Interview with the RCC on 11/03/23 at 11:45am revealed:
-Resident #1 had complained about getting into a pain clinic, but she had not complained about having pain.
-She reached out to Resident #1's pain clinic on 11/02/23 and they told her they were going to discontinue Resident #1's order for Hydromorphone and they were going to discharge her from the pain clinic.
-She contacted Resident #1's former pain clinic on Monday, 10/30/23, to see if they would see Resident #1, but they did not seem promising about seeing her again.
-She called Resident #1's PCP on 11/02/23 and the PCP advised that Resident #1 should take Tylenol.
-She had not reached out to Resident #1's PCP prior to 11/02/23.

Telephone interview with a nurse at Resident #1's PCP's office on 11/03/23 at 11:24am revealed:
-Hydromorphone was listed as one of Resident #1's medications, but the PCP did not prescribe it.
-There was a visit note from Resident #1's pain clinic provider dated 09/20/23 with documentation Resident #1 had an order for Hydromorphone

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4mg 1 tablet every 4 hours as needed.
-There was no documentation Resident #1 was discharged from the pain clinic.
-There was no documentation the facility had contacted the PCP's office.

Interview with the Administrator on 11/03/23 at 12:26pm revealed:
-She expected the RCC or the OM to follow up with Resident #1's PCP or pain clinic regarding Resident #1's Hydromorphone.
-There had been an issue with getting the pain clinic on the phone, but she expected the follow-up to be done.
-She did not know Resident #1 was out of her Hydromorphone.

Attempted telephone interviews with Resident #1's pain clinic provider on 11/02/23 at 4:15 and on 11/03/23 at 9:16am were unsuccessful.

Review of a memo from Resident #1's pain clinic dated 11/02/23 revealed:
-The memo was faxed to the facility on 11/02/23 at 5:06pm.
-Per the pain clinic's policy, a patients opioid morphine milligram equivalents (MME) per day with medications will not exceed 90 MMEs per day.
-Resident #1 was deemed inappropriate for the pain clinic with the MME guidelines. (There was no effective date Resident #1 was deemed inappropriate.)
-Resident #1 needed medication management at a higher risk facility.

2. Review of Resident #3's current FL2 dated 05/23/23 revealed diagnoses included bipolar disorder, chronic obstructive pulmonary disease (COPD), dementia, hypertension, coronary artery

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disease and respiratory failure.

Review of Resident #3's physician's progress note dated 09/05/23 revealed:
-The primary care provider (PCP) was seeing Resident #3 for a hospital follow-up.
-Resident #3 had a new diagnosis of congestive heart failure (CHF).
-Resident #3 had no signs or symptoms of fluid overload during the visit on 09/05/23.
-There was an order to check Resident #3's weight three times weekly and notify the PCP if more than a 3-pound weight gain between weight checks.

Review of Resident #3's September 2023 electronic medication administration record (eMAR) revealed:
-There was an entry to check weight three times a week and notify PCP if more than a 3-pound gain, scheduled from 8:00am to 3:00pm.
-On 09/08/23, there was a documented weight gain of 4.4 pounds.
-On 09/11/23, there was a documented weight gain of 6.6 pounds.
-On 09/22/23, there was a documented weight gain of 5.0 pounds.
-On 09/27/23, there was a documented weight gain of 3.2 pounds.
-Resident #3's weights from 09/01/23 through 09/30/23 ranged from 220.0 pounds to 231.8 pounds.
-There was no documentation that the PCP was notified of Resident #3's weight increases of 3 pounds or more.

Review of Resident #3's October 2023 eMAR revealed:
-There was an entry to check weight three times a week and notify PCP if more than a 3-pound

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gain, scheduled from 8:00am to 3:00pm.
-On 10/06/23, there was a documented weight gain of 6.6 pounds.
-On 10/13/23, there was a documented weight gain of 6.0 pounds.
-Resident #3's weights from 10/01/23 through 10/31/23 ranged from 219.6 pounds to 228.0 pounds.
-There was no documentation that the PCP was notified of Resident #3's weight increases of 3 pounds or more.

Review of Resident #3's physician's progress note dated 09/26/23 revealed:
-Resident #3 had chronic bilateral lower extremity edema of 2+ pitting edema.
-Resident #3 was on a daily diuretic to treat and manage the edema.
-The PCP would continue to monitor.

Review of Resident #3's cardiology visit note dated 10/02/23 revealed:
-Resident #3 was seeing cardiology due to a new diagnoses of CHF.
-Resident #3 had mild edema present.
-There were no new order changes.

Review of Resident #3's physician's progress note dated 10/10/23 revealed:
-Staff reported that Resident #3 had a weight increase of about 6 pounds in the previous week.
-Resident #3's edema had increased to 2-3+ pitting edema.
-The PCP ordered a dose increase for Resident #3's diuretic due to the weight increase and worsening edema.
-There was no documentation that staff notified the PCP about weight increases in September 2023.

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D 273	Continued From page 28 Review of Resident #3's progress notes revealed there was no documentation from September or October 2023 that staff followed up with the PCP regarding the days Resident #3's weight had increased 3 pounds or more during her weight checks. Interview with Resident #3 on 11/02/23 at 8:50am revealed: -Staff checked her weight a few times each week. -Her weight checks were not always at the same time of day, but staff did use the same scale each time. -Sometimes her weight checks were before she ate a meal and sometimes they were after. -She did not know if staff notified her PCP regarding the days her weight had increased because she was not aware of any medication changes related to her swelling. -She did not keep track of what her weight was each time the staff checked it. -On the days where her weight was increased, she did not feel any differently and did not notice any increased shortness of breath. -Her legs were more swollen some days than others; it depended on how much time she spent sitting up rather than elevating her legs. Interview with a medication aide (MA) on 11/02/23 at 11:25am revealed: -When Resident #3's weight had increased more than 3 pounds, she always notified the Resident Care Coordinator (RCC) and the RCC was responsible for notifying the PCP. -She sometimes notified the PCP herself if it was a day the PCP was doing rounds at the facility and she could tell her in person. -She had never received any additional or new orders for Resident #3 regarding her weight increases.	D 273		

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D 273	Continued From page 29 -Resident #3 had never complained to her about increased edema or having shortness of breath on the days her weight had increased more than 3 pounds. -When she notified the RCC or PCP about Resident #3's weight increases, she did not document it. Interview with a second MA on 11/02/23 at 3:45pm revealed: -The MAs used the same scale to weigh Resident #3 because there was only one scale available. -Resident #3 was weighed at different times because it depended on when the MA had time to weight her and when Resident #3 was agreeable to going to the scale. -She had checked Resident #3's weight on a day where it had increased 6 pounds. -She did not notify the RCC or the PCP about Resident #3's weight gain, because she did not know if the scale was accurate and she did not see the instruction in the order to notify the PCP of a 3-pound or more weight increase. -Resident #3 did not complain about having shortness of breath on the day her weight had increased, but she did observe swelling to Resident #3's legs. -She had advised Resident #3 to elevate her legs to reduce the swelling. Telephone interview with Resident #3's PCP on 11/03/23 at 8:30am revealed: -She had been notified in person by one of the MAs about Resident #3's weight increase of around 6 pounds during her visit in October 2023. -She had not been notified about any of the days Resident #3's weight had increased 3 or more pounds in September 2023. -The staff always notified her about Resident #3's weights in-person on the days she went to the	D 273		

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facility, but they never paged her on the day the weight was checked.
-Possible adverse effects for a weight increase in a resident with CHF included shortness of breath or worsening edema.
-The MAs should be weighing Resident #3 at the same time each morning.
-She expected staff to notify her each time Resident #3's weight had increased 3 pounds or more so that she could ask staff if Resident #3 was having any symptoms and determine if she needed to change her medications.

Interview with the RCC on 11/03/23 at 11:03am revealed:
-She did not follow up with Resident #3's PCP each time her weight increased 3 or more pounds because the PCP always just advised her to continue monitoring it.
-Resident #3's PCP asked about her weight each week when she was at the facility, so she notified her about the weight increases in person whenever the PCP asked for an update.
-The MAs used the same scale each time they obtained Resident #3's weight, but sometimes they weighed her before breakfast, and sometimes it was after breakfast.
-The MAs only notified her about Resident #3's weight if she also had increased edema which happened only one or two times in September 2023.
-She had advised the MAs to document the edema on her skin assessment for that week and she notified the PCP in person during her next visit to the facility.
-She did not receive any new orders from the PCP for Resident #3 regarding her weight increases.
-She did not document her notifications to the PCP regarding Resident #3's weight increases.

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D 273	Continued From page 31 Interview with the Administrator on 11/03/23 at 12:47pm revealed: -She was not aware Resident #3's PCP was not being notified each time her weight had increased 3 or more pounds as ordered. -Resident #3's edema fluctuated but she had not complained of any worsening symptoms of edema or shortness of breath. -She expected the MA who checked Resident #3's weight and found it to be 3-pounds or more increased from the last weight check to report it to the RCC so the PCP could be updated that same day. -The MAs also were able to notify the PCP directly and the expectation was for them to report the weight increase to the RCC, and for the RCC to contact the PCP that day.	D 273		
D 281	10A NCAC 13F .0903 (d) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (d) The facility shall assure action is taken in response to the licensed health professional review and documented, and that the physician or appropriate health professional is informed of the recommendations when necessary. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure a follow up on recommendations written by the Licensed Health Professional Support (LHPS) nurse for 1 of 5 sampled residents (#3) related to oxygen	D 281		

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monitoring.

The findings are:

Review of Resident #3's current FL2 dated 05/23/23 revealed:
-Diagnoses included bipolar disorder, dementia, chronic obstructive pulmonary disease (COPD), hypertension and respiratory failure.
-There was an order for continuous oxygen at 2 liters (L) per minute .

Review of Resident #3's physician's order dated 08/08/23 revealed:
-Resident #3 was refusing to wear her oxygen continuously as ordered.
-The primary care provider (PCP) was changing Resident #3's oxygen order to as-needed (PRN) for oxygen saturations 90%.

Review of Resident #3's LHPS evaluation dated 09/20/23 revealed:
-The LHPS task of oxygen administration and monitoring was documented as a marked task by the LHPS nurse.
-Resident #3's oxygen order changed on 08/08/23 to as-needed for oxygen saturation levels less than 90%.
-The LHPS nurse wrote a recommendation to either have the PCP order oxygen saturation monitoring every shift or change the oxygen order to PRN for shortness of breath.
-There was a line at the bottom of the LHPS evaluation sheet for "Facility review of LHPS and follow-up to consultant nurse recommendations" that the Resident Care Coordinator (RCC) signed on 09/20/23.

Review of Resident #3's September 2023 electronic medication administration record

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(eMAR) revealed:
-There was an entry for as needed (PRN) oxygen at 2L for oxygen level of 90% or below.
-There were no documented oxygen saturation level checks.
-There was no documented use of oxygen from 09/01/23 through 09/30/23.

Review of Resident #3's October 2023 eMAR revealed:
-There was an entry for PRN oxygen at 2L for oxygen level of 90 or below.
-There were no documented oxygen saturation level checks.
-There was no documented use of oxygen from 10/01/23 through 10/31/23.

Interview with Resident #3 on 11/02/23 at 8:50am revealed:
-She had an order to use oxygen as needed.
-She wore her oxygen at night or if she started feeling tired during the day.
-She had her own pulse oximeter to check oxygen saturation level, but she did not use it often.
-When she checked her oxygen saturation level with her own pulse oximeter, her oxygen level was usually around 88-89%, but she never reported it to the staff.
-The medication aides (MA) occasionally checked her oxygen saturation level if she requested it.

Interview with a MA on 11/02/23 at 11:25am revealed:
-There was not an order for scheduled pulse oximeter checks for Resident #3.
-Resident #3 used her oxygen PRN, but she thought it was mostly at night because she did not see her use oxygen during the day.
-The MAs did not participate in the LHPS nurse's

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evaluations or take any of the paperwork from the LHPS nurse.

Telephone interview with the LHPS nurse on 11/02/23 at 3:30pm revealed:
-When she evaluated a resident for LHPS tasks, she gave her evaluation sheet to either the RCC or the Operations Manager (OM) prior to leaving the facility.
-The bottom of the LHPS evaluation should be signed by either the RCC or OM indicating they reviewed the LHPS evaluation for any recommendations.
-She had recommended the facility staff contact Resident #3's PCP to change her oxygen order because it was ordered PRN if Resident #3's oxygen saturation levels were less than 90%.
-The MAs would need to be checking her oxygen saturation levels to know if the PRN oxygen was needed.
-She did not know if the facility had followed up on her recommendation or not, because Resident #3 was not due for another LHPS evaluation yet.

Telephone interview with Resident #3's PCP on 11/03/23 at 8:30am revealed:
-She was not aware of the LHPS nurse's recommendation to change Resident #3's oxygen order.
-She thought either the OM or RCC had contacted her the previous week to ask her if she could change Resident #3's oxygen order to PRN for shortness of breath, but she had not written an order to change the oxygen order yet.
-She expected the facility staff to contact her right away to follow up on any recommendations from the LHPS nurse.

Interview with the RCC on 11/02/23 at 11:03am revealed:

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D 281	Continued From page 35 -The LHPS nurse usually gave her the LHPS evaluations once she had completed them. -She saw the recommendation from the LHPS nurse regarding Resident #3's oxygen order. -She signed Resident #3's LHPS evaluation dated 09/20/23. -Once she signed Resident #3's LHPS evaluation she gave it to the OM to follow up on the nurse's recommendation. -The OM told her that she had taken a verbal order from Resident #3's PCP to change her oxygen order to 2L PRN for shortness of breath. -She was not aware that Resident #3's oxygen order was never changed on her eMAR. Interview with the Administrator on 11/03/23 at 12:47pm revealed: -When the LHPS nurse completed her evaluations, she gave the paperwork to the OM to follow up on or to file in the resident's record. -The OM was responsible for reviewing the LHPS evaluations for any recommendations and then completing the necessary follow-up even if the RCC had already signed it. -She was not aware of the LHPS nurse's recommendation to change Resident #3's oxygen order. -She was not aware that Resident #3's oxygen order had not been changed as recommended by the LHPS nurse. Attempted telephone interview with the OM on 11/03/23 at 12:20pm was unsuccessful.	D 281		
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:	D 310		

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(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 for 1 of 5 sampled residents (#4) who had an order for a no concentrated sweets (NCS) diet, no added table salt (NATS), second servings of green vegetables, and 2% milk with each meal.

The findings are:

Review of Resident #4's current FL2 revealed diagnoses included hyperlipidemia, chronic renal insufficiency, and hyponatremia.

Review of Resident #4's diet order sheet revealed an order for a NCS diet with special instruction for no added table salt, seconds on green vegetables, and 2% milk or less at every meal.

Review of the facility's therapeutic diet list dated 10/24/23 revealed Resident #4 was to be served a NCS diet with NATS, seconds on green vegetables, and 2% milk or less with every meal.

Review of Resident #4's electronic medication administration record (eMAR) for September 2023 revealed:
-Diagnoses included diabetes mellitus.
-Resident #4's fingerstick blood sugars (FSBSs) ranged from 80 to 280.

Review of Resident #4's eMAR for October 2023 revealed:
-Diagnoses included diabetes mellitus.
-Resident #4's FSBSs ranged from 119 to 360.

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D 310	Continued From page 37 Review of the NCS menu for the lunch meal service on 11/01/23 revealed Resident #4 was to be served spaghetti noodles with meat sauce, tossed salad with dressing, Italian bread, diet dessert of the day, margarine, diet beverage of choice, water, and 2% milk. Observation of the beverages available for service to residents for the lunch meal on 11/01/23 at 12:40pm revealed water, tea, and 2% milk were available on the beverage cart. Observation of Resident #4's lunch meal service on 11/01/23 between 12:41pm and 1:18pm revealed: -Resident #4 was served spaghetti with meat sauce, 2 servings of salad with salad dressing, a second serving of salad with salad dressing, a cookie, and water. -Resident at 75% of her meal and took a bite of her cookie. -Resident #4 should have been served 2% milk with her lunch meal, but no milk was offered or served to Resident #4. Interview with Resident #4 on 11/01/23 at 1:26pm revealed: -She thought the cookie she was served for the lunch meal on 11/01/23 was a regular cookie because it was sweet. -She did not eat the whole cookie because she was diabetic, and she did not want her blood sugar to go up. -She was not served milk with her lunch meal on 11/01/23. -She could get milk if she asked for it, and staff only served her milk when she asked for it. -She was served milk for breakfast when cereal was served.	D 310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

(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 38 Interview with a dietary staff on 11/01/23 at 3:17pm revealed: -She filled in for the dietary manager (DM), and she had not cooked for the facility in a while prior to 11/01/23. -The cookies that were served for the lunch meal on 11/01/23 were regular chocolate chip cookies. -She served all residents the regular chocolate chip cookies, because there were no other sugar free options available. -The DM manager ordered food items for the facility each week and the food truck was scheduled to deliver food items on tomorrow on 11/02/23. -She knew residents who had orders for a NCS diet were to be served a sugar free dessert. -She would have served the residents fruit, but there was none available. Interview with a dietary staff on 11/01/23 at 3:17pm revealed staff should have looked at the therapeutic diet list to know that Resident #4 was to be served milk with each meal. Interview with a personal care aide (PCA) on 11/03/23 at 10:40am revealed: -Resident #4 was supposed to be served milk with every meal. -Staff asked her if she wanted milk and she usually said no. -Resident #4 told her that if she did not want the milk, she did not want staff to bring it to her because she did not want it to go to waste. Review of the NCS menu for the lunch meal service on 11/01/23 revealed Resident #4 was to be served cereal of choice, egg of choice, hash browns, toast, margarine, diet jelly, 2% milk, and juice of choice.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099018	A. BUILDING: _____ B. WING _____	11/03/2023

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D 310	Continued From page 39 Observation of Resident #4's breakfast meal service on 11/02/23 between 7:37am and 7:59am revealed: -Resident #4 was served cereal with 2% milk, eggs, hash browns, butter, and regular grape jelly. -Resident #4 ate 50% of her meal and ate a spoonful of jelly. Observation of the kitchen area on 11/02/23 at 8:06am revealed there was a basket which contained regular and sugar free jelly in the kitchen. Interview with Resident #4 on 11/03/23 at 10:05am revealed she was served a regular jelly with her breakfast meal on 11/02/23. Interview with a dietary staff on 11/02/23 at 8:07am revealed: -The dietary staff plated the meals for residents and the facility staff were responsible for serving meals including condiments to the residents. -Staff should have looked at the therapeutic diet list to see if a resident was to be served a NCS diet prior to serving them jelly. -Residents who had physician's orders for a NCS diet were to be served sugar free jelly. Interview with the Operations Manager (OM) on 11/02/23 at 8:08am revealed: -Resident #4 was to be served a NCS diet, 2 servings of green vegetables, and milk at every meal. -Resident #4 should have been served sugar free jelly with her breakfast meal. -She did not realize she picked up a regular jelly packet and served it to Resident #1.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099018	A. BUILDING: _____ B. WING _____	11/03/2023

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PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

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D 310	Continued From page 40 Interview with the facility's dietary consultant on 11/02/23 at 11:39am revealed: -The facility's meals were prepared in the main kitchen and brought down to the facility to be served. -Usually with NCS diets, the desserts, drinks, snacks, jelly, and syrups were the only food items modified. -Staff were supposed to check the therapeutic diet list to ensure the residents diets prior to serving the meal to ensure the correct meal was being served. Interview with the dietary manager (DM) on 11/02/23 at 1:44pm revealed: -He ordered food for the facility weekly based on the menus. -There were sugar free lemon cookies available in the pantry for Resident #4's lunch meal on 11/01/23. -The fill-in staff should have known where the sugar free lemon cookies were, because he tried to keep them in the same place. -He thought the staff who filled in for him on 11/01/23 was looking for a box of sugar free cookies rather than a bag of sugar free cookies. -The dietary staff were responsible for plating food items for residents according to their diet orders including desserts, but sometimes the correct plates were not served to the residents. -The facility staff was responsible for serving the plates as well as condiments including jelly packets and for serving beverages. -The facility staff should have reviewed the therapeutic diet list to know that Resident #4 was to be served 2% milk with each meal. Telephone interview with a nurse at Resident #4's primary care provider's (PCP) office on 11/02/23 at 2:19pm revealed:	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 310	Continued From page 41 -Resident #4 had an order for a NCS diet with no added table salt, a second serving of vegetables, and 2% milk with each meal. -Resident #4 had an order for a NCS diet due her diagnoses of diabetes. -She assumed the order for the 2% milk was related to Resident #4's diagnosis of diabetes because the 2% milk had less sugar than whole milk. Interview with the RCC on 11/03/23 at 11:45am revealed: -She expected staff to serve Resident #4 according to her diet orders for a NCS diet and 2% milk with each meal. -She did not know Resident #4 was served a regular dessert for the lunch meal on 11/01/23 and regular jelly on 11/02/23. -Staff offered Resident #4 milk and she refused it, so staff did not place the milk on the table for her -She had not reached out to Resident #4's PCP regarding her refusing the milk. Interview with the Administrator on 11/03/23 at 12:26pm revealed she expected staff to serve Resident #4 according to her diet orders including a NCS diet and pouring milk with each meal.	D 310		