STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on January 3, 2024 and January 4, 2024.	D 000		
D 156	10A NCAC 13F .0503 Medication Administration Competency 10A NCAC 13F .0503 Medication Administration Competency (a) The competency evaluation for medication administration required in Rule .0403 of this Subchapter shall consist of a written examination and a clinical skills evaluation to determine competency in the following areas: (1) medical abbreviations and terminology; (2) transcription of medication orders; (3) obtaining and documenting vital signs; (4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications; (5) infection control procedures; (6) documentation of medication administration; (7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions; (8) medication storage and disposition; (9) regulations pertaining to medication administration in adult care facilities; and (10)the facility's medication administration policy and procedures (b) An individual shall score at least 90% on the written examination which shall be a standardized examination established by the Department. (c) Verification of an individual's completion of the written examination and results can be obtained at no charge on the North Carolina Adult	D 156		

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D 156	Continued From page 1 Care Medication Aide Testing website at https://mats.ncdhhs.gov/test-result. (d) The clinical skills validation portion of the competency evaluation shall be conducted by a registered nurse or a licensed pharmacist who has a current unencumbered license in North Carolina. The registered nurse or licensed pharmacist shall conduct a clinical skills validation for each medication administration task or skill that will be performed in the facility. Competency validation by a registered nurse is required for unlicensed staff who perform any of the personal care tasks related to medication administration listed in Subparagraphs (a)(4), (a)(7), (a)(11), (a)(14), and (a)(15) as specified in Rule .0903 of this Subchapter. (e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. The form requires the following: (1) name of the staff and adult care home; (2) satisfactory completion date of demonstrated competency of task or skill with the instructor's initials or signature; (3) if staff needs more training on skills or tasks, it should be noted with the instructor's signature; and (4) staff and instructor signatures and date after completion of tasks. Copies of this form and instructions for its use may be obtained at no cost on the Adult Care Licensure website, https://info.ncdhhs.gov/dhsr/acls/pdf/medchklst.pdf. The completed form shall be maintained and available for review in the facility and is not transferable from one facility to another.	D 156		

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D 156	Continued From page 2	D 156		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff, who administered medications, completed a medication clinical skills competency validation checklist (Staff B), and 2 of 3 sampled staff (B and C) completed the 5, 10, or 15-hour medication aide training course or had verification of previous employment as a medication aide (MA) before administering medication to the residents.

The findings are:

1. Review of Staff B's, MA personnel record revealed:
-Staff B was hired on 10/27/23.
-Staff B passed the written medication aide examination on 08/08/23.
-There was no documentation she had verification of previous employment as a MA.
-There was documentation she completed the 5 hours and 10 hours medication aide training courses on 01/03/24.
-There was no documentation she completed the 5, 10, or 15-hour medication aide training courses prior to 01/03/24.
-There was no documentation Staff B completed a medication clinical skills competency validation checklist until 01/03/24.

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D 156	Continued From page 3 Review of residents' December 2023 and January 2024 electronic medication administration record (eMAR) revealed: -There was documentation Staff B administered medications on 1 day (12/25/23) from 12/01/23 through 12/31/23. -There was documentation Staff B administered medications, including checking fingerstick blood sugars (FSBS) on 01/02/24 and 01/03/24. Interview with Staff B on 01/04/24 at 5:25 pm revealed: -She worked as a MA at another facility. -She had worked part-time as a MA at the facility administering medications to the residents on a few days since November 2023. -She completed some online computer training when she was hired. -She was called by the Administrator to come to the facility to complete the 5 and 10-hour MA training and medication clinical skills competency validation checklist on 01/03/24 after 5:00pm when the licensed Nurse from the contracted pharmacy was at the facility. Telephone interview with the licensed Nurse from the contracted pharmacy on 01/04/24 at 4:30pm revealed: -Staff B completed computer workbook training for the 5/10-hour MA training online in November 2023. -The Administrator called her on 01/03/24 to come to the facility to complete Staff B's MA training competencies and a medication clinical skills competency validation checklist. -She completed the 5/10-hour competencies and issued the training certificates on 01/03/24. -In addition, she completed Staff B's MA clinical skills competency validation checklist on	D 156		

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 156	Continued From page 4	D 156		

01/03/24.
-She was not aware Staff B had already been administering medications at the facility.

Interview with the Administrator on 01/04/24 at 5:00 pm revealed:
-She was responsible for hiring all staff at the facility.
-She was responsible for ensuring all requirements were met prior to MAs administering medications.
-Staff B worked as a MA at another facility.
-The Administrator routinely had new MA staff complete the 5, 10-hour training when hired.
-Staff B completed computer online training for the 5, 10-hour MA training.
-The Administrator thought that was sufficient and the contracted Nurse just filled out the certificates for training when she came to the facility.
-The Administrator did not realize that Staff B was not approved to pass medications independently until she had the completed MA clinical skills competency validation checklist and at least the 5-hour MA training.

2. Review of Staff C's, medication aide (MA) personnel record revealed:
-Staff C was hired on 02/14/22 as a personal care aide (PCA).
-Staff C had a medication clinical skills competency validation checklist completed on 05/30/23.
-Staff C had documentation for 5 hours MA training completed on 05/30/23.
-Staff C passed the written medication aide examination on 06/27/23.
-There was no documentation Staff C completed 10 hours of MA training as of 01/04/24.

Review of residents' November 2023, December

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D 156	Continued From page 5 2023, and January 2024 electronic medication administration records (eMAR) revealed: -There was documentation Staff C administered medications on 21 days from 11/01/23 through 11/30/23. -There was documentation Staff C administered medications on 25 days from 12/01/23 through 12/31/23. -There was documentation Staff C administered medications on 01/03/24. Interview with Staff C on 01/04/23 at 5:20pm revealed: -The Administrator had hired her and completed all her paperwork when she was hired. -She worked at the facility administering medications as a MA for most of the last year (2023). -When she was hired, she had completed a MA training course but could not remember if it was a 5 and 10-hour or a 15-hour training. -She remembered completing a medication clinical skills competency validation checklist with a Nurse. -She thought the licensed Nurse at the completed all the required paperwork. Interview with the Administrator on 01/04/24 at 5:00 pm revealed: -She was responsible for hiring all staff at the facility. -She had not audited staff competencies and new hire paperwork recently due to turnover in administrative staff that assisted with new hire paperwork. -She was responsible for ensuring all requirements were met prior to MAs administering medications. -The Administrator routinely had new MA staff complete the 5 and 10-hours MA training when	D 156		

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 156	Continued From page 6 hired. -She had contacted the contracted Nurse for a copy of the 10 hour MA training, but there was not a copy available. -The Administrator did not realize that Staff B was missing verification of completion of the 10 hour MA training. _____ The facility failed to ensure two staff who worked as MAs and administered medications to residents had verification they had previously worked as a MA, or completed the 5, 10, or 15-hour medication aide training and medication clinical skills competency validation checklist before administering medications (Staff B and Staff C). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/04/24 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 18, 2024.	D 156		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner.	D 164		

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 164	Continued From page 7 (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled medication aides (Staff B) had completed training on the care of diabetic residents prior to administering insulin. The findings are: Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B was hired on 10/27/23. -Staff B passed the written medication aide examination on 08/08/23. -There was no certification of training on care of diabetic residents. Review of a resident's December 2023 and January 2024 electronic medication administration records (eMARs) revealed: -There was documentation Staff B administered	D 164		

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D 164	Continued From page 8	D 164		

insulin on 12 days from 12/01/23 through 12/31/23.
-There was documentation Staff B administered insulin on 01/02/24 and 01/03/24.

Interview with Staff B on 01/04/24 at 5:25 pm revealed:
-She worked as a MA at another facility.
-She had worked part-time as a MA at the facility administering medications to the residents on a few days since November 2023.
-She administered long-acting insulin to residents if it was scheduled on the evening shift when she worked.
-The Administrator contacted her on 01/03/24 to come to the facility to complete training.
-She completed training on the care of diabetic residents with the facility's contracted licensed Nurse on 01/03/24.

Telephone interview with the licensed Nurse from the contracted pharmacy on 01/04/24 at 4:30pm revealed:
-The Administrator called her on 01/03/24 to come to the facility to complete Staff B's MA training competencies and a training in the care of diabetics.
-She completed competencies for Staff B, plus training on the care of diabetic residents and issued the training certificates on 01/03/24.
-She was not aware Staff B had already been administering medications at the facility.

Interview with the Administrator on 01/04/24 at 5:00 pm revealed:
-She was responsible for hiring all staff at the facility.
-She was responsible for ensuring all requirements were met prior to MAs administering medications.

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D 164	Continued From page 9 -Staff B worked as a MA at another facility. -The Administrator routinely had new MA staff complete all training, including training on the care of diabetic residents. -The Administrator thought Staff B completed training on the care of diabetics on the computer online training but there was no documentation for completion. -The contracted licensed Nurse completed training and filled out the certificates for training when she came to the facility monthly.	D 164		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (#3) related to the resident having a diagnosis of diabetes and not receiving foot care for 11 months. The findings are: Review of Resident #3's current FL2 dated 03/02/23 revealed diagnoses included diabetes mellitus type 1. Review of Resident #3's care plan dated 01/16/23 revealed Resident #3 was totally dependent for bathing, dressing, and personal hygiene. Review of Resident #3's licensed health professional support review dated 12/12/23 revealed:	D 273		

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-Resident #3's last podiatry visit was 02/08/23.
-There was no documentation regarding Resident #3's feet or toenails.

Observation of Resident #3 on 01/03/24 at 9:46am revealed:
-Resident #3 was sitting in his motorized wheelchair in his room.
-Resident #3 had socks and shoes on and had each foot on a footrest.

Interview with Resident #3 during the tour of the facility on 01/03/24 at 9:47am revealed:
-His toenails were so long they hurt especially when he crossed his legs at the feet to put one shoe on top of the other.
-He did not remember when the podiatrist last came out to the facility; he remembered he did not need podiatry care the last time the podiatrist visited, but he did now.
-He could not see his toenails, but he knew they hurt.
-He needed his toenails trimmed so his toes would not hurt.

Interview with the Administrator on 01/03/24 at 4:27pm revealed:
-She looked through Resident #3's thinned files and saw documentation Resident #3 was last seen by the podiatrist in February 2023.
-The podiatrist that was coming out to the facility stopped providing services to the facility in February 2023.
-She had been trying to find another provider for podiatry care, but she had not found anyone yet.

Interview with a personal care aide (PCA) on 01/04/24 at 3:33pm revealed:
-The PCAs assisted Resident #3 with bathing and dressing.

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-She did not know the condition of his toenails, but she knew his socks stuck to his toenails when she put them on or took them off.

Observation of Resident #3's feet on 01/04/24 at 3:36pm revealed:
-The toenails on Resident #3's left foot were thickened, and extended minimally beyond the tip of his toes.
-The nail on Resident #3's left big toe was about ½ inch thick and was jagged.
-The skin on the right side of Resident #3's right foot was darkened and scaly and about an inch of the darkened skin fell off onto the bed when the PCA pulled his sock off.
-The toenails on Resident #3's right foot were thickened and extended about ¼ inch beyond the tip of his toe.

Interview with Resident #3's primary care provider (PCP) on 01/04/24 at 4:18pm revealed:
-The facility did not have a podiatry provider who visited the facility.
-She had been trimming the residents' toenails.
-She saw Resident #3 every month and he had not said anything to her about needing his toenails trimmed or cared for.
-She expected staff to check Resident #3's feet when they bathed him and to reach out to her if he complained about his toenails hurting or needing care.

A second interview with the Administrator on 01/04/24 at 5:07pm revealed:
-The facility's previous podiatry provider, who last visited in February 2023, was coming out to the facility at least twice a year.
-Since February 2023, if a resident needed foot care, she would let the PCP know.
-She expected PCAs to check Resident #3's feet

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D 273	Continued From page 12 during baths and let her know if he needed foot care. -No staff informed her Resident #3 needed his toenails trimmed or that his toenails hurt him.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and records reviews, the facility failed to ensure implementation of physician's orders for 3 of 5 sampled residents (#1, #2, and #4) related to a resident who had orders for compression hose (#1), a resident who had orders for daily blood pressure checks (#2), and a resident who had orders for continuous oxygen and did not have a portable oxygen tank. The findings are: 1. Review of Resident #1 current FL2 dated 04/20/23 revealed: -Diagnoses included cerebral vascular accident (CVA), hemiplegia, hemiparesis, osteoarthritis, diabetes mellitus, and closed fracture proximal end of the right humerus. -There was an order for compression hose apply every morning and remove at bedtime.	D 276		

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D 276	Continued From page 13	D 276		

Review of Resident #1's electronic Medication Administration Record (eMAR) for November 2023 revealed:
-There was an entry for compression hose apply every morning and remove at bedtime scheduled for 8:00am and 8:00pm.
-There was documentation Resident #1's compression hose were applied for 30 of 30 opportunities at 8:00am and were removed for 28 of 30 opportunities between 11/01/23 and 11/30/23.

Review of Resident #1's eMAR for December 2023 revealed:
-There was an entry for compression hose apply every morning and remove at bedtime scheduled for 8:00am and 8:00pm.
-There was documentation Resident #1's compression hose were applied for 30 of 31 opportunities at 8:00am and were removed for 28 of 31 opportunities between 12/01/23 and 12/31/23.

Review of Resident #1's eMAR for 01/01/24 through 01/04/24 revealed:
-There was an entry for compression hose apply every morning and remove at bedtime scheduled for 8:00am and 8:00pm.
-There was documentation Resident #1's compression hose were applied for 4 of 4 opportunities at 8:00am and were removed for 3 of 3 opportunities between 01/01/24 and 01/04/24.

Observation of Resident #1 during the tour of the facility on 01/03/24 at 9:24am revealed she was not wearing compression stockings.

Observation of Resident #1 on 01/04/24 at 11:57am revealed:

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D 276	Continued From page 14 -Resident #1 was wearing regular, mid-calf, white socks and did not have on compression hose. -Se had on shoes and swelling was observed in both of her ankles. Interview with Resident #1 on 01/04/24 at 11:58am revealed: -She did not have on compression hose on 01/04/24. -She used to have a white pair and a black pair of compression hose. -The white pair of compression hose were missing, and the black pair did not fit anymore as they had been stretched due to washing in a machine rather than by hand. -Staff had to assist her with applying the compression hose, and it had been a long time since staff had applied them; she did not remember when staff last applied the compression hose. -She told the Administrator and her primary care provider (PCP) multiple times that she needed new compression hose, but she had not received them yet. Interview with a PCA on 01/04/24 at 2:56pm revealed: -Resident #1 was supposed to have compression hose applied daily, but she had not had them applied lately because the hose had been washed and were loose on her legs. -She told a medication aide (MA) around October 2023 that Resident #1 needed a new pair of compression hose, but Resident #1 had not received a new pair yet. -Resident #1's feet looked a little swollen on 01/04/24. Interview with a first shift MA on 01/04/24 at 3:07pm revealed:	D 276		

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-She thought Resident #1 had an order for compression hose.
-Neither Resident #1 nor any PCAs told her Resident #1 needed new compression hose.
-If she had known Resident #1 needed new compression hose, she would have told the Administrator and the Administrator would have reordered them from the pharmacy.
-She did not check to see if Resident #1 had compression hose on during her shift.
-Resident #1 was already up and dressed when she started her shift.
-Third shift was responsible for getting Resident #1 up out of bed, dressed, and for applying the compression hose.
-She did not know which shift was responsible for removing the compression hose.

Interview with a third shift MA on 01/04/24 at 5:50pm revealed:
-Resident #1's compression hose were not applied on third shift.
-She did not know if Resident #1's compression hose had been applied or removed daily because when she started her shift, she did not see Resident #1's compression hose on.
-She had only seen Resident #1 with compression hose on once around the end of November 2023 and the compression hose were white.
-Resident #1 got up daily at 3:00am and dressed herself; third shift staff only assisted Resident #1 with putting her shoes on.

Interview with Resident #1's PCP on 01/04/24 at 4:18pm revealed:
-She did not know Resident #1's compression hose had not been applied or that she needed a new pair.
-She expected staff to apply Resident #1's

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compression hose in the morning and remove them at bedtime as ordered.

Interview with the Administrator on 01/04/24 at 5:07pm revealed:
-Resident #1's compression hose should have been applied in the morning when she got up and removed at bedtime.
-She did not know Resident #1's compression hose had not been applied as ordered.
-If Resident #1's compression hose were missing or did not fit, the MAs were responsible for reordering them.
-If the compression hose were not delivered to the facility within 24 hours of ordering, then the MAs should have let her know.
-MAs were able to reach out to Resident #1's PCP as well to get a new order for compression hose if needed.
-She thought Resident #1 had a white pair of compression hose on the last time she worked as a MA.

Observation of Resident #1's room on 01/04/24 at 5:12pm revealed the Administrator looked through Resident #1's dresser drawers and found the stretched, black compression hose, but she could not find Resident #1's white compression hose.

2. Review of Resident #2's current FL2 dated 11/09/23 revealed:
-Diagnoses included hypertension, chronic obstructive pulmonary disease, and neuropathy.
-There was an order for monthly blood pressures.

Review of Resident #2's physician's orders dated 11/30/23 revealed an order to check Resident #2's blood pressure daily for 30 days.

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Review of Resident #2's electronic Medication Administration Record (eMAR) for November and December 2023 revealed there was not an entry for daily blood pressure checks.

Review of Resident #2's chart revealed there was no documentation of daily blood pressure checks for Resident #2.

Interview with Resident #2 on 01/04/24 at 2:34pm revealed:
-He was admitted to the facility around the first of November 2023.
-Staff checked his blood pressure about once a month, but they had not checked his blood pressure daily since he was admitted.

Interview with the Administrator on 01/04/24 at 9:41am revealed:
-She was responsible for keying treatment orders, including blood pressures, onto the eMAR for all residents.
-She remembered seeing the order for Resident #2 to check his blood pressure daily for 30 days, but she did not know why she did not enter the order onto the eMAR.
-She reviewed the eMARs when she printed them for the PCP to review, but she did not compare the eMARs to the resident's current orders.

Interview with a medication aide (MA) on 01/04/24 at 3:07pm revealed:
-The Administrator was responsible for entering treatment orders onto the eMAR.
-She had not checked Resident #1's blood pressure daily and did not remember seeing the entry to check Resident #1's blood pressure daily on his eMAR in November or December 2023.

Interview with Resident #2's primary care provider

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D 276	Continued From page 18 (PCP) on 01/04/24 at 4:18pm revealed: -She stopped one of Resident #2's blood pressure medication in November 2023 and she ordered daily blood pressure checks for 30 days to ensure his blood pressure did not go up. -She did not know Resident #2's blood pressure had not been checked daily. -She expected that Resident #2's blood pressure was checked daily for 30 days as ordered to ensure he did not have any elevated blood pressures after the discontinuance of his blood pressure medication. 3. Review of Resident #5's FL2 dated 05/25/23 revealed: - Diagnoses included chronic obstructive pulmonary disease (COPD). - There was an order for continuous oxygen at 2 liters/minute (Lpm). Review of Resident #5's November 2023 electronic Medication Administration Records (eMAR) revealed: -There was an entry for oxygen 2 Lpm continuously scheduled for 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am. -There was documentation Resident #5 used oxygen continuously for all three shifts daily from 11/01/23 to 11/30/23. Review of Resident #5's December 2023 eMAR for revealed: -There was an entry for oxygen 2 Lpm continuous scheduled for 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am. -There was documentation Resident #5 used oxygen continuously for all three shifts daily from 12/01/23 to 12/31/23. Review of Resident #5's January 2024 eMAR	D 276		

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from 01/01/24 through 01/02/24 revealed:
-There was an entry for oxygen 2 Lpm continuous scheduled for 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am.
-There was documentation Resident #5 used oxygen continuously for all three shifts daily from 01/01/24 to 01/02/24.

Review of Resident #5's care plan dated 05/25/23 revealed:
-There was documentation for continuous oxygen at 2 Lpm for oxygen QHS-continuous.
-There was no documentation for portable oxygen.

Review of Resident #5's licensed health professional support (LHPS) evaluation dated 12/12/23 revealed:
-Continuous oxygen at 2 Lpm for oxygen administration and monitoring at O2 at 2 Lpm continuous was a marked task.
-There was no documentation for portable oxygen.

Observation of Resident #5's room on 01/03/24 at 4:50pm revealed Resident #5 had an oxygen concentrator, but there were no portable oxygen tanks available.

Observation of Resident #5 on 01/03/24 at 4:52pm revealed:
- Resident #5 walked down the hallway from his room to the outside smoking area and did not have portable oxygen with him.
- Resident #5 did not appear to be short of breath.

Interview with Resident #5 on 01/04/24 at 8:35am revealed:
-He wore oxygen during the nighttime and at

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times during the day.
-He took off the oxygen when he went to the bathroom and when he left his room.
-He did not have a portable oxygen tank available to use when he left his room, but did not request a portable oxygen tank.
-He returned to his room to use his oxygen when he was out of his room and experienced shortness of breath at times.

Interview with the Administrator on 01/04/24 at 9:45am revealed:
-She knew about Resident #5's physician's orders for continuous oxygen.
-Resident #5 used his oxygen when he wanted to, and he did not use the oxygen when he left his room.
-She knew Resident #5 should have a portable oxygen tank since he had orders for continuous oxygen, and she thought he had one.

Interview with a personal care aide (PCA) on 01/04/24 at 10:30am revealed:
-She saw Resident #5 with oxygen on in the mornings when he was awake in his room.
-She saw Resident #5 wear oxygen at random times throughout the day and he took the oxygen off when he went to the dining hall or outside.
-She had not seen Resident #5 short of breath when outside or in the dining hall.
-She was not aware of any portable oxygen tank for Resident #5.

Interview with another PCA on 01/04/24 at 10:40am revealed:
-Resident #5 wore his oxygen only at times when he was in his room, and she had never seen him wear oxygen outside of his room and had not seen him become short of breath.
-She had not seen Resident #5 with portable

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D 276	Continued From page 21 oxygen and was not aware if he had portable oxygen available to use. Interview with a medication aide (MA) on 01/04/24 at 10:50am revealed: -She knew Resident #5 was supposed to use oxygen continuously because continuous oxygen was documented for him on the eMAR, but he only used his oxygen when he was in his room. -Resident #5 did not use a portable oxygen tank when he left his room, but she was not aware that he should have one in his room. -She knew Resident #5 should have had portable oxygen available and the portable oxygen tanks were stored in the medication room. Observation of the facility on 01/04/24 at 10:55am revealed: -The MA searched for Resident #5's portable oxygen tanks in the medication room, but she was unable to locate them. -The MA left the medication room and went to ask the Administrator to assist her with locating Resident #5's portable oxygen tanks. -The Administrator did not search in the medication room or Resident #5's room but located a portable oxygen tank in resident room #19 which was used for all residents who were on continuous oxygen. Interview with the primary care physician (PCP) on 01/04/24 at 4:18pm revealed: -Resident #5 had orders for continuous oxygen. -She thought she may have discontinued Resident #5's order for continuous oxygen due to his tobacco use, but she was not sure. -She expected residents with physician's orders for continuous oxygen to have portable oxygen available for use outside of their rooms.	D 276		

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D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to have matching therapeutic diet menus for food service guidance for 3 of 5 sampled residents (#1, #2, and #3) who had an physician's orders for a consistent carbohydrate diet (CC). The findings are: 1. Review of Resident #1's current FL2 dated 04/20/23 revealed: -Diagnoses included diabetes mellitus. -There was an order for a reduced concentrated sweets (RCS) diet. Review of resident #1's diet order sheet dated 08/18/23 revealed: -Diets provided by the facility included regular, consistent carbohydrate (CC), and mechanical soft (MS) diet, and modifications included chopped meat and double portions. -Resident #1 had an order for a CC diet.	D 296		

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Review of the facility's therapeutic diet list posted in the kitchen dated 05/30/24 revealed Resident #1 was to be served a RCS diet.

Review of the facility's therapeutic menus revealed there were no menus available.

Review of the facility's week-at-a-glance menu for the lunch meal on 01/03/24, for regular diets, revealed fried chicken red potatoes, spinach souffle, wheat dinner roll, margarine, strawberries with topping, 2% milk, and coffee were to be served.

Observation of the lunch meal service on 01/03/24 between 12:35pm and 1:08pm revealed:
-Resident #1 was served barbeque chicken drumsticks, rice, green beans, coffee cake and water.
-Resident #1 consumed 25% of the meal.

Based on observation of the lunch meal service on 01/03/24, it could not be determined if Resident #1 was served the correct therapeutic diet due to no CC diet menu available for staff guidance.

Interview with Resident #1 on 01/04/24 at 11:10am revealed:
-She did not know she was on a special diet.
-She was served the same meals the other residents were served.

Refer to the interview with a cook on 01/03/24 at 11:12am.

Refer to the interview with the Dietary Manager (DM) on 01/04/24 at 7:51am.

Refer to the interview with the facility's primary

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care provider (PCP) on 01/04/24 at 4:18pm.

Refer to the interview with the Administrator on 01/04/24 at 5:07pm.

2. Review of Resident #2's current FL2 dated 11/09/23 revealed:
-Diagnoses included type 2 diabetes mellitus.
-Diet was checked in the nutrition status section, but there was no diet order documented.
-There were signed physician's orders dated 11/09/23 attached to the FL2 with an order for a consistent carbohydrate (CC) diet.

Review of resident #2's diet order sheet dated 11/09/23 revealed:
-Diets provided by the facility included regular, CC, and mechanical soft (MS) diet, and modifications included chopped meat and double portions.
-Resident #2 had an order for a CC diet.

Review of the facility's therapeutic diet list posted in the kitchen dated 05/30/24 revealed Resident #2 was not listed on the therapeutic diet list.

Review of the facility's therapeutic menus revealed there were no menus available.

Review of the facility's week-at-a-glance menu for the lunch meal on 01/03/24, for regular diets, revealed fried chicken red potatoes, spinach souffle, wheat dinner roll, margarine, strawberries with topping, 2% milk, and coffee were to be served.

Observation of the lunch meal service on 01/03/24 between 12:35pm and 1:08pm revealed:
-Resident #2 was served barbeque chicken drumsticks, rice, green beans, coffee cake, sugar

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free punch, and water.
-Resident #2 consumed 75% of the meal.

Based on observation of the lunch meal service on 01/03/24, it could not be determined if Resident #2 was served the correct therapeutic diet due to no CC diet menu available for staff guidance.

Interview with Resident #2 on 01/04/24 at 11:20am revealed:
-He did not know he was supposed to be served a special diet.
-He was served the same meal as the other residents at his dining table.

Refer to the interview with a cook on 01/03/24 at 11:12am.

Refer to the interview with the Dietary Manager (DM) on 01/04/24 at 7:51am.

Refer to the interview with the facility's primary care provider (PCP) on 01/04/24 at 4:18pm.

Refer to the interview with the Administrator on 01/04/24 at 5:07pm.

3. Review of Resident #3's current FL2 dated 03/02/23 revealed:
-Diagnoses included diabetes mellitus type 1.
-There was an order for a reduced concentrated sweets (RCS) diet.

Review of resident #3's diet order sheet dated 08/18/23 revealed:
-Diets provided by the facility included regular, consistent carbohydrate (CC) and mechanical soft (MS) diet, and modifications included chopped meat and double portions.

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D 296	Continued From page 26 -Resident #3 had an order for a CC diet. Review of the facility's therapeutic diet list posted in the kitchen dated 05/30/24 revealed Resident #3 was to be served a RCS diet. Review of the facility's therapeutic menus revealed there were no menus available. Review of the facility's week-at-a-glance menu for the breakfast meal on 01/04/24, for regular diets, revealed oatmeal, fresh whole apples, pancakes, sausage patty, margarine, syrup orange juice, 2% milk, and coffee were to be served. Observation of the breakfast meal service on 01/04/24 between 7:45am and 8:45am revealed: -Resident #3 was served cereal with milk, 2 sausage links, a pancake, grits, coffee, orange juice, and water. -Resident #3 consumed 75% of the meal. Based on observation of the breakfast meal service on 01/04/24, it could not be determined if Resident #3 was served the correct therapeutic diet due to no CC diet menu available for staff guidance. Interview with Resident #3 on 01/04/24 at 3:10am revealed: -He thought he was on a regular diet and did not know he had physician's orders for a CC diet. -He was served the same meal items as the other residents in the dining hall. Refer to the interview with a cook on 01/03/24 at 11:12am. Refer to the interview with the Dietary Manager (DM) on 01/04/24 at 7:51am.	D 296		

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D 296	Continued From page 27 Refer to the interview with the facility's primary care provider (PCP) on 01/04/24 at 4:18pm. Refer to the interview with the Administrator on 01/04/24 at 5:07pm. _____ Interview with a cook on 01/03/24 at 11:12am revealed: -He prepared barbeque chicken, green beans, rice, and coffee cake for the lunch meal on 01/03/24. -He used the regular week-at-a-glance menu for regular diets to prepare all the meals for the residents. -He did not have any therapeutic menus available including a menu for a CC diet. -Resident with a diagnosis of diabetes were served sugar free drinks and condiments. Interview with the Dietary Manager (DM) on 01/04/24 at 7:51am revealed: -He used the week-at-a-glance menu when preparing meals. -He did not have a therapeutic menu for a CC diet. -He served smaller portions of carbohydrates to residents who had orders for a CC diet. Interview with the facility's primary care provider (PCP) on 01/04/24 at 4:18pm revealed: -She did not know residents had physician's orders for CC diets and did not think the facility offered CC diets. -She did not realize she signed the residents diet order sheets for a CC diet. -She did not think the facility was capable of serving a CC diet, so all the residents should have been served a regular diet.	D 296		

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	HAL034104	A. BUILDING: _____ B. WING _____	01/04/2024

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D 296	Continued From page 28 Interview with the Administrator on 01/04/24 at 5:07pm revealed: -She was responsible for ensuring the facility had therapeutic menus in place for dietary staff for guidance in preparing meals. -She did not know the dietary staff needed a therapeutic menu for a CC diet. -She had not provided any therapeutic diet menus to the dietary staff for guidance in preparing meals. -She thought she had therapeutic menus available on her computer, but she could not find them.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to serve a therapeutic diet as ordered for 1 of 5 sampled Resident (#6) who had an order for a regular diet with chopped meats. The findings are: Review of Resident #6's current FL2 dated 4/20/23 revealed: -Diagnoses included mitral regurgitation (MR), seizure D/O, high blood pressure (HTN), hypothyroidism, chronic obstructive pulmonary disorder (COPD), hypokalemia, vitamin D deficiency, and peripheral vascular disease	D 310		

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D 310	Continued From page 29 (PVD). -There was an order for a regular diet with chopped meats. Review of Resident #6's diet order form dated 8/18/23 revealed there was an order for a regular diet with chopped meats. Review of Resident #6's Licensed Health Professional Support (LHPS) evaluation dated 11/14/23 revealed a regular diet with chopped meats diet and feeding techniques for residents with swallowing problems as marked task. Review of the therapeutic diet list posted in the kitchen dated 05/30/23 revealed Resident #6 was to be served a regular diet with chopped meats. Review of the facility's regular menu for breakfast meal revealed Resident #6 was to be served orange juice, oatmeal, fresh whole apple, sausage patty, margarine, pancakes, syrup, 2% milk, and coffee, Observation of Resident #6's breakfast meal service on 01/04/24 between 7:45am and 8:30am revealed: -Resident #6 was served sausage links, pancakes, grits, syrup, margarine, coffee, milk, and water. -The sausage links were not chopped. -Resident #6 ate 100% of the meal without difficulty. Review of the facility's regular menu for the lunch meal on 01/04/24 revealed Resident #6 was to be served braised beef stew tips with gravy, buttered noodles, roasted carrots, wheat dinner roll, margarine, chocolate chip bread, pudding, 2% milk, and coffee.	D 310		

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D 310	Continued From page 30 Observation of the Dietary Manager (DM) for the lunch meal service on 01/04/24 at 12:50pm revealed: -The dietary manager took the beef from the hot bar and chopped it into (size) pieces for a resident (not #6). Observation of Resident #6's lunch meal service on 01/04/24 between 12:45pm and 1:15pm revealed: -Resident #6 was served stewed beef with gravy, a slice of bread, buttered penne noodles, roasted carrots, water, and milk. -The size of the stewed beef was large chunks and un-chopped. -Resident #6's was served stewed beef with gravy. -Resident #6 made a sandwich out of the bread and the whole pieces of stewed beef. -Dietary manager prepared an additional chopped stewed beef for the resident. -Resident #6 ate about 65% of the meal without difficulty. Interview with Resident #6 on 01/04/24 at 9:25am revealed: -She was aware she had a chopped meat diet. -She took her time to eat because she did not always get meals served chopped. -The reason she was supposed to be served chopped meat was because she had a procedure where her throat was stretched in previous years but could not recall the exact timeframe. Interview with the DM on 01/04/24 at 12:55pm revealed: -He relied on the personal care aides (PCAs) and medication aides (MAs) to tell him which residents were to be served chopped meats.	D 310		

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D 310	Continued From page 31	D 310		

-He has the diet list available for all meals for the floor staff to review which included instructions for chopped meats.
-He knew Resident #6 was on a regular diet with chopped meat due to the diet orders posted in the kitchen, but relied on the PCAs and MAs to tell him which residents were to be served chopped meats.

Interview with a MA on 01/04/24 at 3:00pm revealed:
-She served meals to residents in the dining room during her shift and knew Resident #6 was to be served a regular diet with chopped meats.
-She thought the stewed beef the dietary manager prepared for Resident #6 during the lunch meal was chopped meat.
-She did not review the diet list in the kitchen prior to serving the meals.

Interview with Resident #6's primary care physician (PCP) on 01/04/24 at 4:18pm revealed:
-She was aware of Resident #6's diet order for a regular diet with chopped meats from her orders related to swallowing issues due to Resident #6's throat being stretched previously.
-She expected the facility to serve Resident #6 a regular diet as ordered.
-Resident #6 could aspirate or choke as a possible outcome with the facility not following her orders for the regular diet with chopped meats.

Interview with the Administrator on 01/04/24 at 5:06pm revealed:
-She was aware of Resident #6's diet order for a regular diet with chopped meat.
-She was responsible for clarifying all dietary orders and for providing the diet lists to the dietary manager.
-She expected the facility to serve the residents

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D 310	Continued From page 32 meals according to the therapeutic diet list and as ordered by the PCP.	D 310		