PRINTED: 03/25/2024
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041089	A. BUILDING: _____ B. WING _____	R 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND SQUARE	3823 LAWNDALE DRIVE GREENSBORO, NC 27455

(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 and follow-up survey on 03/19/24 through 03/20/24.	D 000		
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, record reviews, and interviews, the facility failed to have matching therapeutic diet menus for food service guidance for 1 of 5 sampled residents (#2) who had a physician's orders for a heart healthy/low sodium diet. The findings are: Review of Resident #2's current FL2 dated 01/24/24 revealed: -Diagnoses included hypercholesterolemia, hyperthyroidism, hypertension and chronic kidney disease stage 3. -There was an order for a regular diet. Review of Resident #2's diet order sheet dated 02/06/24 revealed: -Diets provided by the facility included regular, no	D 296	Resident #2's diet order was updated by the Primary Care Provider to a No Added Salt (NAS) diet. A comprehensive Resident Diet order audit was completed and no additional descrepancies were noted. Re-education was completed by the Corporate DIning Director with the Executive Director, Director of Clinical Services, Resident Care Coordinator, and DIetary Manager regarding timely updates of diet orders when changed, providing the kitchen staff with timely orders for changes, and the current diets that are offered. In order to prevent recurrence, QA/QI will occur for resident diet orders. New diet and diet order changes will be audited weekly for 4 weeks, and then monthly for 3 months. Audit results will be reviewed in the QA/QI meetings to ensure sustained compliance.	3/20/24 4/15/24 4/4/24 4/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Brian O'Hara Executive Director 4/05/2024

Reviewed and Acknowledged Keisha Banks 04/08/24

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D 296	Continued From page 1 added salt (NAS), no concentrated sweets (NCS consistent carbohydrate (CC), and mechanical soft (MS) diets and modifications included finger foods mechanical soft, and pureed. -Resident #2 had an order for a regular Review of Resident 2's hospital discharge summary dated 02/08/24 revealed: -Resident was hospitalized due to heart failure. -There were discharge instructions for a heart healthy/low sodium diet. Review of Resident #2's physician's orders dated 02/19/24 revealed there was an order for a heart healthy/low sodium diet. Review of Resident #2's physician's orders dated 03/11/24 revealed there was an order for a heart healthy/low sodium diet. Review of the facility's undated therapeutic diet list posted in the kitchen revealed Resident #2 was to be served a regular diet. Review of the facility's therapeutic menu spreadsheet revealed there was no menu available for a heart healthy/low sodium diet. Review of the facility's therapeutic menu spread sheet for the lunch meal on 01/19/24, for regular diets, revealed ham & potatoes au gratin, green beans, a biscuit, apple dump cake, whipped butter cup, coffee, and tea were to be served. Observation of the lunch meal service on 03/19/24 between 12:00pm and 12:36pm revealed: -Resident #2 was served ham and potatoes au gratin, green beans, a roll, banana cream pie, water, and tea.	D 296		

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D 296	Continued From page 2 -Resident #2 consumed 50% 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 heart healthy/low sodium diet menu was available for staff guidance. Based on observations, record reviews, and interviews, it was determined that Resident #2 was not interviewable. Interview with the Dietary Manager (DM) on 03/20/24 at 8:59am revealed: -The Resident Care Coordinator (RCC) and the Director of Clinical Service (DCS) were responsible for updating the therapeutic diet list for the kitchen. -He served Resident #2 a regular diet as she was listed to receive a regular diet on the therapeutic diet list. -He did not know Resident #2 had a physician's order for a heart healthy/low sodium diet. -There were no menus available for a heart healthy/low sodium diet. Interview with the DCS on 02/20/24 at 10:02am revealed: -She and the RCC were responsible for updating the therapeutic diet list upon admission of new residents and when there were changes in a resident's diet. -The facility offered regular, MS, finger foods, and pureed diets. -She did not know about Resident #2's physician's order for a heart healthy/low sodium diet and had not told Resident #2's primary care provider (PCP) that the facility did not offer a heart healthy/low sodium diet. -The facility only served diets listed on the diet	D 296		

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D 296	Continued From page 3 order sheet and the diet order sheet did not include a heart healthy/low sodium diet. Telephone interview with the RCC on 03/20/24 at 3:30pm revealed: -The facility served regular, NAS, NCS, finger foods, puree, and MS diets and had menus for all diets served. -She knew Resident #2 returned to the facility from a hospital visit in February 2024 with orders for a heart healthy/low sodium diet. -She told Resident #2's PCP that the facility did not serve a hearth healthy/low sodium diet and the PCP was supposed to change Resident #2's diet order. -She did not know Resident #2's PCP wrote orders on 02/19/24 and 03/11/24 for a heart healthy/low sodium diet. -The facility did not have menus for a heart healthy/low sodium diet. Interview with Resident #2's PCP on 03/20/24 at 10:30am revealed: -She expected the facility to Resident #2 to serve a heart healthy/low sodium diet due to heart issues. -She wrote an order on 02/19/24 and 03/11/24 for Resident #2 to be served a heart healthy/low sodium diet. -She had not been notified that the facility did not offer a heart healthy/low sodium diet nor had menus for a heart healthy/low sodium diet. Interview with the Executive Director (ED) on 03/20/24 at 2:36pm revealed: -The facility did not have menus for a heart healthy/low sodium diet. -The facility did not offer a heart healthy/low sodium diet. -The DCS or the RCC should have followed up	D 296		

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D 296	Continued From page 4 with Resident #2's PCP to let her know the facility did not offer a heart healthy/low sodium diet.	D 296		
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 8 ounces of milk or other equivalent dairy products were served three times daily to residents in the Special Care Unit (SCU). The findings are: Review of the facility's SCU census revealed a census of 45 residents. Review of the facility's daily menu for 03/20/24 revealed: -Milk was listed to be served for the breakfast and lunch meal service. -Assorted snacks and beverages were listed to	D 299	The 14 Residents who did not recieve the serving of milk at breakfast could not be corrected. Thickened milk was ordered to provide milk for any resident that is on thickened liquids. An inventory of serving supplies was completed and additional 9.5 ounce cups and 8 ounce cups were ordered and recieved in order to have ample supplies to serve beverages at meals. Re-education was completed by the Corporate Dining Director with the Executive Director and Dietary Manager regarding the supply that should always be on hand for use and also when to re-order supplies to ensure that a supply of each size cup is available for meals. Also, re-education regarding having a supply of varying choices of thickened liquids including milk is available for meals and snacks In order to prevent recurrence, QA/QI will occur related to supply inventory weekly for 4 weeks, then monthly for 3 months. Audit results will be reviewed in the QA/QI meetings to ensure sustained compliance.	3/20/24 3/26/24 4/4/24 4/15/24

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D 299	Continued From page 5 be served for the morning and evening snacks. -There were no equivalent dairy products listed on the menu to be served on 03/20/24. Observation of the breakfast meal service on 03/20/24 between 8:00am and 8:45am revealed: -There were 25 residents in the dining room. -There were 9 residents who were not served milk, including a resident with a diet order for thickened liquids, and there were no other dairy products offered or served to the 9 residents. -There were 6 place settings prepared for residents who had not entered the dining room. -Five of the prepared place settings did not include milk. Observation of the kitchen on 03/20/24 at 8:59am revealed: -There were 4 unopened gallons of milk (64 servings) in the walk in cooler and ¼ of a gallon of milk in the reach in cooler. -There were containers of prethickened water and tea, but there was no prethickened milk available. -There were 82 clean cups in crates that were washed after the breakfast meal. -There were 3 dirty cups that had been brought into the kitchen to be washed. -There were 3 residents still eating in the dining room with an unknown number of cups. -In order to serve a census of 45 residents milk, water, and another beverage at any meal setting, there needed to be at least 135 cups available. Interview with a personal care aide (PCA) on 03/20/24 at 8:24am revealed: -All 25 residents in the dining room during the breakfast meal service on 03/20/24 were not served milk because they ran out of cups. -She had not been told to serve the residents who	D 299		

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D 299	Continued From page 6 did not receive milk, any other dairy products. Interview with a second PCA on 03/20/24 at 8:35am revealed: -The cups were already on the table when she entered the dining room for the breakfast meal service on 03/20/24. -She guessed some residents were not served milk because they ran out of cups for milk. Interview with a third PCA on 03/20/24 at 1:19pm revealed: -All residents were not served milk for the breakfast meal service on 03/20/24 because there were not enough cups for milk. -She told the Dietary Manager (DM) a few days ago there were not enough cups for all residents to have milk, water, and another beverage. Interview with the DM on 03/20/24 at 8:59am revealed: -Residents were to be served milk, water, and juice for the breakfast meal service. -Milk was not served to all the residents for the breakfast meal service on 03/20/24 because there were not enough cups available. -Residents put cups in their pockets, took them to their rooms, and sometimes cups were not brought back to the kitchen when residents were served meals in their rooms. -He ordered at least 48 cups every 2 weeks and the cups kept ending up missing. -He brought the last box of cups out of storage on yesterday, 03/19/24, and they were still short on cups. -He told the Regional Nurse and the Executive Director (ED) this morning that he needed more cups. -He received a food delivery on 03/19/24 and 4 gallons of milk were delivered.	D 299		

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D 299	Continued From page 7 -He did not order a lot of milk because it ended up being wasted. -If he needed more milk, he would purchase milk from the store. -He was aware of the dietary requirements of 3 8-ounce cups of milk daily or a dairy equivalent. Interview with the ED on 03/20/24 at 2:36pm revealed: -He was not aware there were not enough cups for all residents to be served milk with the breakfast meal until this morning, 03/20/24. -He expected for milk or an equivalent dairy substitution to be served to all residents with each meal.	D 299		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure water was served in addition to other beverages to each resident in the Special Care Unit (SCU). The findings are: Review of the facility's daily menu for 03/20/24 revealed water was not listed on the menu to be	D 306	Upon discovery, water was added to the daily menu. The 14 residents that did not recieve a serving of water could not be corrected. An inventory of serving supplies was completed and additional 9.5 ounce cups and 8 ounce cups were ordered and recieved in order to have ample supplies to serve beverages at meals.	3/20/24 3/26/24

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D 306	Continued From page 8 served. Observation of the breakfast meal service on 03/20/24 between 8:00am and 8:45am revealed: -There were 25 residents in the dining room. -There were 8 residents who were not served water. -There were 6 place settings prepared for residents who had not entered the dining room and none of the prepared place settings included water. Observation of the kitchen on 03/20/24 at 8:59am revealed: -There were 82 clean cups in crates that were washed after the breakfast meal. -There were 3 dirty cups that had been brought into the kitchen to be washed. -There were 3 residents still eating in the dining room with an unknown number of cups. -In order to serve a census of 45 residents water, milk, and another beverage at any meal setting, there needed to be at least 135 cups available. Interview with a personal care aide (PCA) on 03/20/24 at 8:24am revealed all 25 residents in the dining room during the breakfast meal service on 03/20/24 were not served water because they ran out of cups. Interview with a second PCA on 03/20/24 at 8:35am revealed: -The cups were already on the table when she entered the dining room for the breakfast meal service on 03/20/24. -She guessed some residents were not served water because they ran out of cups. Interview with a third PCA on 03/20/24 at 1:19pm revealed:	D 306	D 306 - continued Re-education was completed by the Corporate Dining Director with the Executive Director and Dietary Manager regarding the supply that should always be on hand for use and also when to re-order supplies to ensure that a supply of each size cup is available for meals. In order to prevent recurrence, QA/QI will occur related to supply inventory weekly for 4 weeks, then monthly for 3 months. Audit results will be reviewd in the AQ/QI meetings to ensure sustained compliance.	4/4/24 4/15/24

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D 306	Continued From page 9 -She knew all residents should have been served water with each meal. -All residents were not served water for the breakfast meal service on 03/20/24 because there were not enough cups. -She told the Dietary Manager (DM) a few days ago there were not enough cups for all residents to have water, milk, and another beverage. Interview with the DM on 03/20/24 at 8:59am revealed: -Residents were to be served water with each meal. -Water was not served to all the residents for the breakfast meal service on 03/20/24 because there were not enough cups available. -Residents put cups in their pockets, took them to their rooms, and sometimes cups were not brought back to the kitchen when residents were served meals in their rooms. -He ordered at least 48 cups every 2 weeks and the cups kept ending up missing. -He brought the last box of cups out of storage on yesterday, 03/19/24, and they were still short on cups. -He told the Regional Nurse and the Executive Director (ED) this morning that he needed more cups. Interview with the ED on 03/20/24 at 2:36pm revealed: -He was not aware there were not enough cups for all residents to be served water in addition to other beverages with the breakfast meal until this morning on 03/20/24. -He expected for water to be served to all residents with each meal.	D 306		

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D 310	Continued From page 10	D 310		
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 therapeutic diets as ordered by the physician for 2 of 5 sampled residents (#1 and #4) who had an order for a regular pureed diet (#2) and a regular finger food diet (#4). The findings are: 1. Review of Resident #1's current FL2 dated 02/14/24 revealed: -Diagnoses included dementia, type 2 diabetes mellitus, hyperlipidemia, muscle weakness and hypertension. -There was no diet documented. Review of Resident #1's diet order form dated 02/21/24 revealed an order for a regular pureed diet. Review of the facility's undated therapeutic diet list revealed Resident #1 was to be served a pureed diet. Review of the therapeutic menu spreadsheet for the breakfast meal service on 03/20/24 revealed Resident #1 was to be served pureed cereal of choice, pureed eggs of choice, and pureed biscuit and gravy.	D 310	At time of discovery, Resident #1's oatmeal was pureed with additional water to eliminate the visible chunks. Resident #4's finger food serving of boiled eggs at the breakfast meal could not be corrected. An audit of menus for additional residents who are on pureed diets and finger food diets, and no additional descrepancies related to the food that was being served were noted. Re-education was completed by the Corporate Dining Director with the Executive Director and Dietary Manager regarding the consistancy of pureed foods and serving finger foods that are easier to grasp. Included in the re-education was having food on hand to fulfill the diet listed on the daily menu or changing the menu to reflect the resident preference. In order to prevent recurrence, QA/QI will occur related to diets being served weekly for 4 weeks, then monthly for 3 months. Audit results will be reviewed in the QA/QI meetings to ensure sustained compliance	3/20/24 4/15/24 4/4/24 4/15/24

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D 310	Continued From page 11 Observation of the breakfast meal service on 03/20/24 revealed: -Resident #1 was served a pureed brown food item, a pureed tan food item, and regular oatmeal. -The oatmeal had visible chunks and looked the same as the oatmeal served to the other residents. -Resident #1's plate was taken to the kitchen and the Dietary Manager (DM) pureed the oatmeal. -Resident #1's plate was returned to him with his oatmeal pureed along with his other two pureed food items. -Resident #1 consumed 100% of the meal. Based on observations, record reviews, and interviews, it was determined Resident #2 was not interviewable. Interview with a personal care aide (PCA) on 03/0/24 at 8:35am revealed: -Resident #1 was to be served a pureed diet. -She did not know the consistency of a pureed food item, but she knew it should not be runny. Interview with a third PCA on 03/20/24 at 1:19pm revealed: -Resident #1 was to be served a pureed diet. -She noticed resident #1 received regular oatmeal for the breakfast meal this morning, 03/20/24. -The oatmeal was not pureed and was chunky, but she thought it was okay. Interview with the Dietary Manager (DM) on 03/20/24 at 9:07am revealed: -Resident #1 had orders for a pureed diet. -He pureed all of Resident #1's food items for each meal. -Pureed food items should be a smooth, creamy	D 310		

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D 310	Continued From page 12 texture and should not have clumps of food in it. -He pureed Resident #1's oatmeal this morning, but he did not put enough water in it. -He added more water to the oatmeal in the processor when he pureed Resident #1's oatmeal the second time. Interview with Resident #1's Primary Care Provider (PCP) on 03/20/24 at 12:17pm revealed: -She expected for Resident #1 to be served a pureed diet according to the pureed menu. -Resident #1's family requested there be a change to his diet order, but until speech therapy assessed him for a diet change, he was to be served a pureed diet. Interview with Executive Director (ED) on 03/20/24 at 2:36pm revealed he expected Resident #1 to be served according to his pureed diet order and according to the menu for a pureed diet. 2. Review of Resident #4's current FL2 dated 03/15/23 revealed: -Diagnoses included Alzheimer's disease, hyperlipidemia, hypothyroidism, chronic kidney disease stage 3, and osteoporosis. -There was an order for a regular diet. Review of Resident #4's diet order sheet revealed an order for finger foods. Review of the therapeutic menu spreadsheet for a finger foods diet for the breakfast meal service on 03/20/24 revealed Resident #4 was to be served a pop tart, a hard-boiled egg, and a biscuit with sausage gravy on the side. Observation of the breakfast meal service on 03/20/24 between 8:00am and 8:45am revealed:	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041089	A. BUILDING: _____ B. WING _____	R 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND SQUARE	3823 LAWNDALE DRIVE GREENSBORO, NC 27455

(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 13 -Resident #4 was served toast, sausage cut into quarters, and omelet style eggs in 3 to 4-inch-long pieces. -Resident #4 tried breaking a piece of the egg off with one hand, but she was unable to. -Resident #4 picked up a piece of the eggs with her thumb and first finger and the egg was hanging over her thumb. -Resident #4 took bites from the egg that hung over her thumb. -Resident #4 consumed 90% of the meal. Observation of the walk in and reach in coolers on 03/20/24 at 8:59am revealed there were no regular eggs available. Based on observations, record reviews, and interviews, it was determined Resident #2 was not interviewable. Interview with the Dietary Manager (DM) on 03/20/24 at 9:07am revealed: -He used the therapeutic diet menu for a finger foods diet to prepare Resident #4's breakfast meal. -He knew Resident #4 was to be served a hard-boiled egg for the breakfast meal, but he cooked it omelet style because she enjoyed it that way. -He used liquid eggs and did not have regular eggs available to boil. -He last ordered regular eggs in January 2024. -He ordered meal items according to the regular menu. Interview with Resident #1's Primary Care Provider (PCP) on 03/20/24 at 12:17pm revealed she expected Resident #4 to be served finger foods as ordered and according to the finger foods menu.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041089	A. BUILDING: _____ B. WING _____	R 03/20/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 14 Interview with Executive Director (ED) on 03/20/24 at 2:36pm revealed he expected Resident #1 to be served according to her finger foods diet order and according to the menu for a finger foods diet.	D 310		