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
	HAL018038	A. BUILDING: ____ B. WING ____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PLACE II	**807 4TH STREET SW CONOVER, NC 28613**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Catawba County DSS conducted a complaint investigation and annual survey on 04/02/24 to 04/04/24.	D 000		
D 022	10A NCAC 13G .0214 Suspension Of Admission 10A NCAC 13G .0214 Suspension Of Admission (a) Either the Secretary or his designee shall notify the domiciliary home by certified mail of the decision to suspend admissions. Such notice will include: (1) the period of the suspension, (2) factual allegations, (3) citation of statutes and rules alleged to be violated, (4) notice of the facility's right to contested case hearing or the suspension. (b) The suspension will be effective when the notice is served or on the date specified in the notice of suspension, whichever is later. The suspension will remain effective for the period specified in the notice or until the facility demonstrates to the Secretary or his designee that conditions are no longer detrimental to the health and safety of the residents. (c) The home shall not admit new residents during the effective date of the suspension. (d) Any action taken by the Division of Facility Services to revoke a home's license or to reduce the license to a provisional license shall be accompanied by a recommendation to the Secretary or his designee to suspend new admissions. A suspension may be ordered without the license being affected.	D 022		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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D 022	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to comply with the Suspension of Admissions (SOA) notification by the Adult Care Licensure Section by admitting a resident, (# 8), who was admitted after the notification date of March 5, 2024. The findings are: Review of the facility's Daily Census Report revealed Resident #8 admission date was 03/29/24. Review of Resident #8's current FL-2 dated -Diagnoses included adjustment disorder with mixed anxiety, depression and hypothyroidism. -His level of care was Assisted Living. Review of Resident #4's Resident Register revealed Resident #8 was admitted to the facility on 03/29/24. Interview with Resident #8 on 04/02/24 at 9:00am revealed: -He arrived at the facility on 03/29/24. -He was admitted to the facility from the hospital. Interview with a medication aide (MA) on 04/02/24 at 10:30am revealed: -Staff did not know Resident #8 was being admitted until he arrived. -Staff did not know the facility was under a SOA. Interview with Administrator on 04/02/24 at 9:45am revealed: -Resident #8 was admitted on 03/29/24. -She did not know the facility was issued a SOA. -She was aware that under a SOA there were to	D 022		

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D 022	Continued From page 2 be no new admissions until the SOA was lifted.	D 022		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain the facility free of hazards for 1 of 1 sampled residents (#9) related to oxygen tanks not properly stored by being secured in a storage crate or cart. The findings are: Review of Resident #9's current FL2 dated 10/11/23 revealed: -Diagnoses included hypertension, atherosclerotic cardiovascular disease, blind. -There was an order for oxygen at 3 liters (lt) per minute via a nasal cannula. Observation of Resident #9's room on 04/02/24 at 9:27am revealed there were 9 full oxygen tanks, from two different oxygen companies, standing up without being in an oxygen storage cart or stand. Interview with Resident #9 on 04/02/24 at 9:27am revealed: -She and her roommate were on oxygen from two different companies.	D 079		

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D 079	Continued From page 3 -All oxygen tanks were supposed to be secured in carts. -She was blind and did not know there were tanks out of their crates. -She did not know who moved the oxygen tanks out of their crate. Telephone interview with a representative from one of the facility's contracted medical supply companies on 04/04/24 at 11:00am revealed: -There were 6 oxygen tanks with a crate to secure the oxygen tanks when they were delivered to the facility on 03/28/24. -All oxygen tanks were to be maintained in some form of a crate to keep from tipping over. -An oxygen tank was compressed oxygen and was dangerous if the regulator stem was hit because the oxygen tank could become a missile and was capable of going through a concrete wall. Telephone interview with a representative from a second facility's contracted medical supply companies on 04/04/24 at 11:15am revealed: -There were 12 oxygen tanks with a create to secure the oxygen tanks in delivered to the facility on 02/01/24. -All oxygen tanks were to be maintained in some form of a crate to keep from tipping over. -An oxygen tank was compressed oxygen and was considered dangerous if the regulator stem was hit. -Damage to the regulator stem could cause the oxygen tank to become a missile and was capable of going through a concrete wall or causing harm to whomever was struck by it. Interview with the medication aide (MA) on 04/02/24 at 9:30am revealed: -She was also the Administrator.	D 079		

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D 079	Continued From page 4 -All oxygen tanks were to be stored securely in the crates. -Oxygen tanks were dangerous if they fell over and the regulator stem was hit that could cause the oxygen tank to become a torpedo and hurt someone. -The staff were responsible for making sure all oxygen tanks were secured in their crates at all times. -She did not know the oxygen tanks were not secured in the crates.	D 079		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the plumbing was in operating condition in 1 of 2 resident's private bathroom sinks and failed to ensure a floor vent had a cover leaving an approximate 3 X 12 inch opening in the floor in of 1 of 1 resident's room (#7) which proposed a safety hazard. Observation of the adjoining residents bathroom between rooms #7 and #9 on 04/02/24 at 11:25am revealed: -The right and left faucet handles did not produce the flow of water in the bathroom sink when turned on. -No water came out from the faucet when both handles were turned on.	D 105		

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Interview with a resident in room #7 on 04/02/24 at 4:09pm revealed:
-He thought the faucet had not worked in almost a year.
-He thought he told someone who cleaned his room but could not remember who it was.
-He had nowhere to wash his hands.
-He received hand sanitizer from the church on Easter of this year (2024) but prior to that had not had any.

Interview with a resident who resided in room #9 on 04/04/24 at 11:49am revealed:
-He thought the facility was going to fix the faucet in his bathroom.
-He used the bathroom sink down the hall to wash his hands.

Interview with a personal care aide (PCA) on 04/02/24 at 11:30am revealed:
-The faucet worked sometimes off and on.
-It had not worked at all now for well over a month.
-She had not told anyone about it.

Observation in room #7 on 04/02/24 at 4:13pm revealed:
-There was an opening in the floor located next to the wall by the room door.
-The opening was approximately 3 X 12-inch opening and appeared to be missing a floor vent.
-The residents bed post covered part of opening.

Interview with a resident who resided in room #7 on 04/03/24 at 2:45pm revealed:
-He would like it if the bathroom sink worked in his room.
-He would like to wash his hands and face.
-He had been at the facility a short time and was not sure why it was not working, it had been that

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way since he had moved in.
-He had not noticed the missing floor vent.

Interview with the Administrator on 04/03/24 at 11:48am revealed:
-She had turned off the water in December of 2023 because the resident in room #9 was putting food in the sink.
-It would clog the sink and cause a large mess.
-She asked the resident several times not to put food in the sink.
-The residents could walk down the hall to the other bathroom to wash their hands.
-The residents were probably not washing their hands, but they had put hand sanitizer in the bathroom for the residents to use.
-She was not aware of the floor vent without a cover in room #7.

D 167 — 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation — D 167

10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation
Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

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This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure there was at least one staff person was on the premises for each shift, who successfully completed a course in cardio-pulmonary resuscitation (CPR) within the last 24 months for 15 of 15 sampled days from 03/18/24 through 04/01/24.

The findings are:

Review of the facility's personnel files revealed:
-There were six staff who provided direct resident care.
-Six of the Six staff had no current documentation of completing a course in CPR within the last 24 months.

Review of the listing of employees with current CPR and the time punch detail report dated 03/18/24 revealed there were no CPR certified staff in the building for 24 hours.

Review of the listing of employees with current CPR and the time punch detail report dated 03/19/24 revealed there were no CPR certified staff in the building for 24 hours.

Review of the listing of employees with current CPR and the time punch detail report dated 03/20/24 revealed there were no CPR certified staff in the building for 24 hours.

Review of the listing of employees with current CPR and the time punch detail report dated 03/21/24 revealed there were no CPR certified staff in the building for 24 hours.

Review of the listing of employees with current

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D 167	Continued From page 8 CPR and the time punch detail report dated 03/22/24 revealed there were no CPR certified staff in the building for 24 hours. Review of the listing of employees with current CPR and the time punch detail report dated 03/22/24 revealed there were no CPR certified staff in the building for 24 hours. Review of the listing of employees with current CPR and the time punch detail report dated 03/23/24 revealed there were no CPR certified staff in the building for 24 hours. Review of the listing of employees with current CPR and the time punch detail report dated 03/24/24 revealed there were no CPR certified staff in the building for 24 hours. Review of the listing of employees with current CPR and the time punch detail report dated 03/25/24 revealed there were no CPR certified staff in the building for 24 hours. Review of the listing of employees with current CPR and the time punch detail report dated 03/26/24 revealed there were no CPR certified staff in the building for 24 hours. Review of the listing of employees with current CPR and the time punch detail report dated 03/27/24 revealed there were no CPR certified staff in the building for 24 hours. Review of the listing of employees with current CPR and the time punch detail report dated 03/28/24 revealed there were no CPR certified staff in the building for 24 hours. Review of the listing of employees with current	D 167		

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CPR and the time punch detail report dated 03/29/24 revealed there were no CPR certified staff in the building for 24 hours.

Review of the listing of employees with current CPR and the time punch detail report dated 03/30/24 revealed there were no CPR certified staff in the building for 24 hours.

Review of the listing of employees with current CPR and the time punch detail report dated 03/31/24 revealed there were no CPR certified staff in the building for 24 hours.

Review of the listing of employees with current CPR and the time punch detail report dated 04/01/24 revealed there were no CPR certified staff in the building for 24 hours.

Interview with a medication aide (MA) on 04/04/24 at 11:14am revealed:
-She was not aware her CPR ran out in June 2023.
-The Administrator was responsible for setting up the CPR classes.
-If she came up on a resident who was not breathing and had no pulse she would call out for someone to call 911 and begin chest compressions and stop only when local emergency personnel arrived and took over.
-If she came up on a resident who was choking and making no sound she would call out for someone to call 911 and attempt the Heimlich maneuver.

Telephone interview with a second MA on 04/04/24 at 11:28am revealed:
-She was not aware her CPR ran out in June 2023.
-The Administrator was responsible for setting up

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D 167	Continued From page 10 the CPR classes. -If she came up on a resident who was not breathing and had no pulse she would call out for someone to call 911 and begin chest compressions and stop only when local emergency personnel arrived and took over. -If she came up on a resident who was choking and making no sound she would call out for someone to call 911 and attempt the Heimlich maneuver. Telephone interview with a third MA on 04/04/24 at 11:34am revealed: -She was not aware her CPR ran out in June 2023. -The Administrator was responsible for setting up the CPR classes. -If she came up on a resident who was not breathing and had no pulse she would call out for someone to call 911 and begin chest compressions and stop only when local emergency personnel arrived and took over. -If she came up on a resident who was choking and making no sound she would call out for someone to call 911 and attempt the Heimlich maneuver. Telephone interview with a personal care aide (PCA) on 04/04/24 at 11:39am revealed: -She was not aware her CPR ran out in June 2023. -The Administrator was responsible for setting up the CPR classes. -If she came up on a resident who was not breathing and had no pulse she would call out for someone to call 911 and begin chest compressions and stop only when local emergency personnel arrived and took over. -If she came up on a resident who was choking and making no sound she would call out for	D 167		

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someone to call 911 and attempt the Heimlich maneuver.

Interview with the Administrator on 04/04/24 at 11:15am revealed:
-The last CPR class was 05/27/21 for all of the whole staff.
-There was to be another CPR class held in June of 2023 but she forgot to schedule one.
-There was to be at least one staff scheduled every shift who was CPR certified.
-She did not review any staff records since January 2023 because of all the issues with the facility that required her attention.
-There was an Assistant Administrator until January 2023 and all of the staff records were good to that point.
-That Assistant Administrator left the position to become a MA.
-She became responsible for auditing staff records after January 2023 when the Assistant Administrator left the position.
-There was no one in the facility who required CPR since she started as the Administrator in June 2021.
-If she came up on a resident who was not breathing and had no pulse she would call out for someone to call 911 and begin chest compressions and stop only when local emergency personnel arrived and took over.
-If she came up on a resident who was choking and making no sound she would call out for someone to call 911 and attempt the Heimlich maneuver.

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

10A NCAC 13F .0902 Health Care
(b) The facility shall assure referral and follow-up

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to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 3 sampled residents (Resident #1) related to a referral to an eye doctor and a diabetic diet served not as ordered.

The findings are:

Review of Resident #1's current FL2 dated 10/20/23 revealed:
-Diagnoses included below the knee amputation, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, diabetic peripheral neuropathy, morbid obesity, impaired mobility, and a history of deep vein thrombosis and pulmonary embolism.
-An order for a diabetic diet.

a. Observation of the kitchen on 04/02/24 revealed:
-There was a week-at-a glance menu from Spring Summer 2021 hanging on the wall, but no therapeutic diet menus.
-There was a handwritten menu hanging on the refrigerator which included lunch and dinner only and no therapeutic diet menus.
-There was no diet list of residents on physician ordered therapeutic diets.

Observation of Resident #1's breakfast on 04/03/24 at 8:25am revealed:
-He was served scrambled eggs, 1 sausage patty, toast, coffee and orange juice.
-He poured regular sugar into his coffee.
-He ate 100% of his breakfast.

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D 273	Continued From page 13 Observation of Resident #1's lunch on 04/03/24 at 12:18pm revealed he was served chicken thighs, mashed potatoes, bread, broccoli, strawberry cake and regular sweetened lemonade. Interview with a Dietician from the facility's contracted menu company on 04/02/24 at 5:25pm revealed: -A diabetic diet can be a no concentrated sweets diet or low concentrated sweet diet and the facility should ask the physician for clarification. -The facility should be working with a dietician to monitor the servings needed for each diet and monitor the protein, grains, vegetables (starchy and non-starchy), fruits and desserts. -There were spreadsheets that go with the regular diet menu that include all therapeutic diets for food service guidance. -Fruits that are canned should be packed in water or juice. -The facility had not used the menu company since 11/10/23. Telephone interview with Resident #1's Primary Care Provider (PCP) on 04/03/24 at 1:05pm revealed: -Resident #1 required a diabetic diet in order to decrease his finger stick blood sugars (FSBS). -With his FSBS ranging between 200-600 it put Resident #1 at risk for stroke, and heart disease due to insulin resistance contributing to hardening of the arteries and leading to hypertension. -The increased FSBS put Resident #1 at risk for blood clots due to the arterial disease. -Resident #1 sustained a below the knee amputation several years ago due to arterial disease. -The increased FSBS put Resident #1 at risk for	D 273		

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kidney failure due to a decrease in kidney function.
-Resident #1's kidney function was considered Stage 3 kidney disease (mild to moderate damage and was less able to filter waste and fluid out of the body).
-He was aware Resident #1 was non-compliant with junk food and extra sweet but was not aware Resident #1 was not provided a diabetic diet.

Interview with the Administrator on 04/03/24 at 9:07am revealed:
-All residents at the facility were served a regular diet.
-Resident #1 was always served a regular diet because he would not eat a diabetic diet.
-She did not supply diabetic diets because food was so expensive and the residents would not eat it.
-She did not have any unsweetened jelly for breakfast or fruit in fruit juice for the diabetic residents.
-She did not notify Resident #1's PCP that Resident #1 was not receiving a diabetic diet or ask if Resident #1 could have a regular diet.

b. Review of Resident #1's PCP visit notes dated 02/07/24 revealed an order for a referral to a local eye clinic due to visual disturbances in Resident #1's right eye, blood and issues with hyperglycemia.

Telephone interview with Resident #1's PCP on 04/03/24 at 1:05pm revealed:
-The increased FSBS put Resident #1 at risk for vision issues/blindness due to damaging blood vessels in the eye.
-On 02/07/24, Resident #1 had blood in his right eye with visual disturbances.
-On 02/07/24, because of Resident #1's visual

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disturbances, he ordered a referral to a eye doctor.
-He was not aware Resident #1 was not seen by an eye doctor yet and needed to be completed as soon as possible.
-There was no notification to him related to any more issues with Resident #1's right eye.
-Resident #1 was last seen at the facility on 03/13/24 and there was no issues with Resident #1's right eye at that time.
-He expected Resident #1 to be seen by the eye specialist.

Interview with a medication aide (MA) on 04/03/24 at 4:00pm revealed:
-On 02/07/24, Resident #1 received an order for a referral to an eye doctor due to visual disturbances in his right eye.
-On 02/07/24, she fax the referral over to the local eye doctor's office.
-She also called the eye doctor's office three times since 02/07/24 and left a voice mail about the referral.
-If the eye doctor's office called the facility back there was no way to check if a voice mail was left because the staff does not have the code to check the facility voice mail.
-She informed the Administrator about the referral and no response because of staff not being able to access the voice mail.
-The Administrator could not access the voice mail.
-She did not notify Resident #1's PCP about the referral not made as of 04/03/24.
-It was the MAs responsibility to notify the PCP about the difficulties with the referral.

Telephone interview with a representative from the local eye doctor's office on 04/03/24 at 4:10pm revealed:

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D 273	Continued From page 16 -There was an option on the recording to leave a voice mail or hold for the operator. -There was a option in the recording to use an email that was provided in the recording to make an appointment for easier service. -The office did not receive a request for an appointment or a referral order for Resident #1. Interview with the Administrator on 04/03/24 at 4:25pm revealed: -The eye doctor came to the facility and she was under the understanding Resident #1 received all of his eye appointments. -She was not aware Resident #1 did not have an appointment with the eye doctor. -It was the MAs responsibility to make the referrals. -If there was an issue with leaving voice mails and no return calls then it was the MAs responsibility to continue to call about the referral and notify the PCP about the issues. -She was aware that there was no way to check the facility voice mail so the staff were to continue to call the eye doctor's office.	D 273		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers.	D 286		

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This Rule is not met as evidenced by:
Based on observations and interviews the facility failed to ensure mealtime service consisted of non-disposable place settings for all residents.

The Findings are:

During the initial kitchen tour on 04/02/24 revealed boxes of styrofoam plates, cups and plastic silverware stored on the shelves.

Observation of the dining room on 04/02/24 at 09:25am revealed the tables were preset with a napkin and plastic cutlery.

Observation during the noon meal service on 04/02/24 at 12:13pm revealed all residents received their meal on a styrofoam plate and beverages in styrofoam cups.

Observation of the dining room on 04/03/24 at 7:56am revealed the tables were preset with a napkin and plastic cutlery.

Observation during the breakfast meal service on 04/03/24 at 08:25am revealed all residents received their meal on a styrofoam plate and beverages in styrofoam cups.

Interview with a resident on 04/02/24 during the initial tour at 9:10am revealed:
-She had eaten breakfast in her room.
-Staff always served her food on styrofoam plates and plastic cutlery.
-She would prefer to have non-disposable plates and real silverware.

Interview with two other residents on 04/03/24 at

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2:50pm revealed:
-They would prefer to have real plates and real silverware when eating their meals.
-They were always given disposable plates and cups and plastic silverware.
-It is hard to use plastic cutlery when trying to cut food as sometimes the forks will break.

Interview with the cook on 04/02/24 at 10:30am revealed:
-She started working at the facility in November 2023
-The facility always used disposable plates, cups and plastic cutlery since she started.
-She was unsure as to why.

Interview with a medication aide on 04/03/24 at 11:19am revealed:
-She had held many roles at the facility over the years.
-They had been using disposable dinnerware for the last three years when the new owner took over.

Interview with the Administrator on 04/03/24 at 11:48am revealed:
-The facility had been using disposable plates and silverware since Covid-19.
-She believed the use of disposable plates and silverware prevented the spread of germs and viruses.
-She believed it was easier for the residents and more sanitary.
-She was aware of the regulatory rule.
-She reported she asked the health department, and they did not say they could not use the disposable serve ware.

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D 292	Continued From page 19	D 292		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to document any substitutions made to the menu for 3 of 3 sampled residents (#1, #2, and #3). The findings are: Observation of the kitchen on 04/02/24 revealed: -There was no food substitution list available. -There was a handwritten menu hanging on the refrigerator which included lunch and dinner only and no breakfast or therapeutic diet menus. Observation of the breakfast meal on 4/03/24 at 8:25am revealed: -Residents were served scrambled eggs, grits, sausage patty and toast. -There was no menu for breakfast posted in the facility to determine what residents would be eating and if substitutions were made.	D 292		

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Review of the planned menu for the lunch service on Wednesday 04/03/24 revealed residents were to be served baked chicken, mashed potatoes, corn, bread and cake.

Observation of the lunch meal served on 04/03/24 at 12:18pm revealed:
-Residents were served baked chicken, mashed potatoes, broccoli, bread and cake.
-Corn was not served during the lunch meal service on 04/03/24.

Interview with the Cook on 04/02/24 at 9:55am and 04/03/24 at 8:15am revealed:
-She started working at the facility in November 2023
-She was told not to use the cycle menu, only the handwritten menu posted on the refrigerator which was completed by the Administrator.
-She had no therapeutic diets to reference for guidance.
-She only went by what the Administrator told her regarding menus.
-Breakfast was to be prepared with whatever she had on hand, and what residents liked.
-She did not have access to a food substitution list to determine if something was substituted on the menu that it was substituted with a food in the same food group or of equal nutritional value.

Interview with a medication aide (MA) on 04/03/24 at 11:19am and 12:24pm revealed:
-The facility used to order food from the food service company and had a dietician to consult with and that had stopped over a year ago.
-The menus were not planned by a dietician.
-She was familiar with the substitution book when she was in an administrative roll with the facility and used the book regularly.

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-She looked for the book in the filing cabinet in the kitchen and it was an empty binder with no substitution entries.

Observation of the substitution book in kitchen on 04/03/24 at 12:24pm revealed the book was an empty binder with no substitution entries in the book.

Interview with a Dietician from the facility's contracted menu company on 04/02/24 at 5:25pm revealed:
-The facility should be following a menu that is signed by a practicing dietician.
-The facility should be working with a dietician to monitor the servings needed for each diet and monitor the protein, grains, vegetables (starchy and non-starchy), fruits and desserts.
-For example if the menu called for 1 cup of fresh fruit, it could be substituted for 1/2 cup of canned or frozen fruit.
-There are diet extension spreadsheets that go with the regular menu to include all therapeutic diets for food service guidance.

Interview with the Administrator on 04/03/24 at 9:07am and 11:48am revealed:
-She was not utilizing a substitution book in the kitchen.
-The cooks would be responsible for making entries in the substitution book and that would include her as she also cooked in the kitchen.
-She was not consulting with a dietician and was creating menus based on residents' choice and did not have any therapeutic menus for the kitchen staff.

D 295

10A NCAC 13F .0904(c)(6) Nutrition And Food Service

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D 295	Continued From page 22 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (6) Menus for all therapeutic diets shall be planned or reviewed by a licensed dietitian/nutritionist. The facility shall maintain verification of the licensed dietitian/nutritionist's approval of the therapeutic diets. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure therapeutic diet menus were planned or reviewed by a license dietitian/nutritionist and failed to maintain verification of the licensed dietitian/nutritionist's approval of therapeutic diets for 2 of 2 sampled residents (#1 & #2) with physicians' orders for a diabetic diet (#1) and a diet for no concentrated sweets (NCS) diet (#2). The findings are: Observation of the kitchen on 04/02/24 revealed: -There was a week-at-a glance menu titled Spring Summer 2021 hanging on the wall, but no therapeutic diet menus. -There was a handwritten menu hanging on the refrigerator which included lunch and dinner only and no therapeutic diet menus. Review of the undated weekly handwritten planned menu revealed: -There was no breakfast planned for the days of the week.	D 295		

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D 295	Continued From page 23 -Tuesday lunch menu, residents were to be served spaghetti, tossed salad, fruit and bread. -Tuesday dinner menu, residents were to be served corn dogs, french fries, cole slaw, fruit or pudding. -There was no documentation or signature of a dietician or nutrionist who reviewed and approved the menu. 1. Review of Resident #1's current FL2 dated 10/20/23 revealed: -Diagnoses included below the knee amputation, hypertension, diabetes mellitus, diabetic peripheral neuropathy and morbid obesity. -An order for a diabetic diet. Refer to the interview with the cook on 04/02/24 at 9:55am and 04/03/24 at 8:15am. Refer to the interview with a medication aide (MA) 04/03/24 at 11:19am. Refer to the interview with a Dietician from the facility's contracted menu company on 04/02/24 at 5:25pm. Refer to the interview with Administrator on 04/03/24 at 9:07am and 11:48am. 2. Review of Resident #2's current FL2 dated 10/21/23 revealed: -Diagnoses included major depressive disorder, high blood pressure and vitamin D deficiency. - An order for a regular no concentrated sweet diet (NCS). Refer to the interview with the cook on 04/02/24 at 9:55am and 04/03/24 at 8:15am. Refer to the interview with a MA 04/03/24 at	D 295		

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11:19am.

Refer to the interview with a Dietician from the facility's contracted menu company on 04/02/24 at 5:25pm.

Refer to the interview with Administrator on 04/03/24 at 9:07am and 11:48am.

Interview with the Cook on 04/02/24 at 9:55am and 04/03/24 at 8:15am revealed:
-She started working at the facility in November 2023
-She was told not to use the cycle menu, only the handwritten menu posted on the refrigerator which was created by the Administrator.
-She had no therapeutic diet menus to reference for guidance.
-She was unaware if there was a dietician to consult with, she only went by what the Administrator told her regarding menus.
-She did not have any special recipes she needed to follow.
-Breakfast was to be prepared with whatever she had on hand, and what the residents liked.
-She knew some residents were diabetic and she "knew what to do", like give them sugar free items.

Interview with a MA on 04/03/24 at 11:19am revealed:
-The facility used to order food from the menu company and had a dietician to consult with and that had stopped over a year ago.
-The menus are not planned by a dietician now.
-She was not aware of anyone being on a therapeutic diet and thought all residents were on a regular diet.

Interview with a Dietician from the facility's

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D 295	Continued From page 25 contracted menu company on 04/02/24 at 5:25pm revealed: -The facility should be following a menu that is signed by a practicing dietician. -The facility should be working with a dietician to monitor the servings needed for each diet and monitor the protein, grains, vegetables (starchy and non-starchy), fruits and desserts. -There are spreadsheets that go with the regular menu to include all therapeutic diets for food service guidance that can be provided by a contracted food service company. -The facility had not used the food service company where she works since 11/10/23. Interview with the Administrator on 04/03/24 at 9:07am and 11:48am revealed: -She was not consulting with a dietician. -She used the food service company's menu that was provided for Spring/Summer 2020-2021. -She created menus based on residents' choice and did not have any therapeutic menus for the kitchen staff.	D 295		
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.	D 296		

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

Based on observations, interviews, and record reviews, the facility failed to ensure there were matching therapeutic diet menu for food service guidance for 2 of 2 sampled residents (#1 & #2) with physicians' orders for a diabetic diet (#1) and for a no concentrated sweets (NCS) diet (#2).

The findings are:

1. Review of Resident #1's current FL2 dated 10/20/23 revealed:
-Diagnoses included below the knee amputation, hypertension, diabetes mellitus, diabetic peripheral neuropathy, and morbid obesity.
-An order for a diabetic diet.

Review of Resident #1's record revealed:
- Resident #1's last hemoglobin (A1C) (a blood test that measures the average blood sugar levels over the past three months with target range <6.5% on 02/07/23 was 10%,
-The resident's finger stick blood sugars (FSBS) ranged from 182 to 600 over the last two months.

Observation of the kitchen on 04/02/24 revealed:
-There was a week-at-a glance regular diet menu labeled Spring/Summer 2021 hanging on the wall, but no therapeutic diet menus.
-There was a handwritten menu hanging on the refrigerator which included lunch and dinner only and no therapeutic diet menus.
-There was no diet list of residents on physician ordered therapeutic diets.

Review of the week at- a -glance Spring/Summer 2020-2021 regular diet menu for breakfast on Wednesday (day 25) revealed residents on a

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regular diet should be served stewed prunes, cereal, eggs, breakfast meat, toasted bread, margarine/jelly, vitamin C fortified juice and 2% milk.

Attempted review of the regular diet menu for breakfast on 04/03/24 revealed it was unavailable.

Observation of Resident #1's breakfast meal service on 04/03/24 at 8:25am revealed:
-He was served scrambled eggs, 1 sausage patty, toast, orange juice and coffee.
-He applied regular jelly on his toast.
-There was no sugar free jelly available.
-He poured regular sugar into his coffee.

Based on observation of the breakfast meal service on 04/03/24, it could not be determined if Resident #1 was served the correct therapeutic diet due to no diabetic diet breakfast menu available for staff guidance.

Review of the week at- a -glance Spring/Summer 2020-2021 regular diet menu for lunch on Wednesday (day 25) revealed:
-The cycle menu was labeled spring/summer 2021 and was for regular diets.
-Residents on a regular diet were to be served chef's choice entrée, starchy vegetable, chef's choice vegetable seasonal fresh fruit, white or wheat roll, margarine spread.

Review of the handwritten regular diet lunch menu for 04/03/24 posted on the refrigerator revealed residents were to be served baked chicken, mashed potatoes, corn, bread and cake.

Observation of resident #1's lunch meal service on 04/03/2024 12:18pm revealed he was served

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chicken, mashed potatoes, broccoli, bread, strawberry cake, and regular sweetened lemonade.

Based on observation of the lunch meal service on 04/03/24, it could not be determined if Resident #1 was served the correct therapeutic diet due to no diabetic diet lunch menu was available for staff guidance.

Based on observation of the lunch meal service on 04/03/24, it could not be determined if Resident #1 was served the correct therapeutic diet due to no diabetic diet menu was available for staff guidance.

Interview with Resident #1's primary care provider (PCP) on 04/03/24 at 1:05pm revealed:
-Resident #1 was ordered a diabetic diet in order to lower his finger stick blood sugars (FSBS) and A1C of 10%.
-He was not aware Resident #1 was not being served a diabetic diet as ordered.
-Resident had an A1C of 10% and FSBS ranging between 184-600 that put Resident #1 at risk for stroke, and heart disease due to insulin resistance contributing to hardening of the arteries and leading to hypertension.

Interview with a Dietician from the facility's contracted menu company on 04/02/24 at 5:25pm revealed:
-A diabetic diet can be a no concentrated sweets diet or low concentrated sweet diet and the facility should ask the physician for clarification.
-The facility should be following a menu that is signed by a practicing dietician.

Interview with the Administrator on 04/02/24 at 8:45am and 4:17pm revealed:

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-All residents were on regular diets
-She wrote out the menu based on the residents' choice and did not have therapeutic menus.
-She did not consult with a dietician.
-She did not write down a breakfast menu, it would be up to the cook to make what she had on hand.

Refer to the interview with a personal care aide (PCA) on 04/03/24 at 7:50am.

Refer to the interview with a second PCA on 04/03/24 at 8:30am.

Refer to the interview with the cook on 04/02/24 at 9:55am and 04/03/24 at 8:15am.

Refer to the interview with a medication aide (MA) 04/03/24 at 11:19am.

Refer to the interview with a Dietician from the facility's contracted menu company on 04/02/24 at 5:25pm.

Refer to the interview with the Administrator on 04/03/24 at 11:48am.

2. Review of Resident #2's current FL2 dated 10/21/23 revealed:
-Diagnoses included high blood pressure, vitamin D deficiency.
- An order for a regular no concentrated sweet diet.

Observation of the kitchen on 04/02/24 revealed:
-There was a week-at-a glance menu from Spring Summer 2021 hanging on the wall, but no therapeutic diet menus.
-There was a handwritten menu hanging on the refrigerator which included lunch and dinner only

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D 296	Continued From page 30 and no therapeutic diet menus. -There was no diet list of residents on physician ordered therapeutic diets. Review of the week at- a -glance regular diet menu for breakfast on Wednesday (day 25) revealed: -The cycle menu was labeled spring/summer 2021 and was for regular diets. -Residents on a regular diet should be served stewed prunes, cereal, eggs, breakfast meat, toasted bread, margarine/jelly, vitamin C fortified juice and 2% milk. Attempted review of the regular diet menu for breakfast on 04/03/24 revealed it was unavailable. Observation of Resident #2's breakfast on 04/03/24 at 8:25am revealed: -She was served scrambled eggs, 1 sausage patty, toast, orange juice, and milk. -She applied regular jelly on her toast. -There was no sugar free jelly available. -She did not like grits and was not being served grits. -She ate 100% of her breakfast Based on observation of the breakfast meal service on 04/03/24, it could not be determined if Resident #2 was served the correct therapeutic diet due to NCS diet menu available for staff guidance. Review of the week at- a -glance regular diet menu for lunch on Wednesday (day 25) revealed: -The cycle menu was labeled spring/summer 2021 and was for regular diets. -Residents on a regular diet were to be served chef's choice entrée, starchy vegetable, chef's	D 296		

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choice vegetable seasonal fresh fruit, white or wheat roll, margarine spread.

Review of the handwritten regular diet lunch menu for 04/03/24 posted on the refrigerator revealed residents were to be served baked chicken, mashed potatoes, corn, bread and cake.

Observation of resident #2's lunch meal service on 04/03/2024 12:18pm revealed she was served chicken, mashed potatoes, broccoli, bread, cake, and water.

Based on observation of the lunch meal service on 04/03/24, it could not be determined if Resident #2 was served the correct therapeutic diet due to no concentrated sweet diet menu available for staff guidance.

Interview with Resident #2 on 04/03/24 at 8:02am revealed:
-She had had diabetes for a long time and takes oral medications for her diabetes but did not know what the medications were.
-She did not require to have her blood sugar checked and thought maybe she was a borderline diabetic.
-She knew she should not drink sugared drinks due to her diabetes.
-No one ever told her she was on a physician ordered diet.
-Yesterday (04/02/24) she was served peaches for lunch, but she did not eat them because processed fruit had a lot of sugar.
-Sometimes the evening staff would bring her hamburger and shakes when she had the money.

Interview with the Administrator on 04/02/24 at 8:45am and 4:17pm revealed:
-All residents were on regular diets

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-She knew Resident #2 was on a no concentrated sweet diet.
-Resident #2 was non-compliant with her diet.
-She wrote out the menu based on residents' choice and did not have therapeutic menus.
-She did not consult with a dietician.
-She did not write down a breakfast menu, it would be up to the cook to make what she had on hand.

Interview with Resident #2's Primary Care Provider (PCP) on 04/03/24 at 1:15pm revealed:
-He was not aware Resident #2 was not served a no concentrated sweets diet as ordered.
-The risks of Resident #2 not getting a NCS diet increased her chances of having uncontrolled and elevated blood sugar levels.

Refer to the interview with a personal care aide (PCA) on 04/03/24 at 7:50am

Refer to the interview with a second PCA on 04/03/24 at 8:30am

Refer to the interview with the cook on 04/02/24 at 9:55am and 04/03/24 at 8:15am

Refer to the interview with a medication aide (MA) 04/03/24 at 11:19am

Refer to the interview with a Dietician from the facility's contracted menu company on 04/02/24 at 5:25pm

Refer to the interview with Administrator on 04/03/24 at 11:48am

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Interview with a personal care attendant (PCA) on 04/03/24 at 7:50am revealed:
-She was not aware of any of the residents on a

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special diet because she worked third shift and they had not told her about any special diets.
-She had gotten residents milkshakes at night if they request one and they had the money.
-Resident #1 and sometimes Resident #2 would get milkshakes.

Interview with a second PCA on 04/03/24 at 8:30am revealed:
-She was not aware of any resident being on a therapeutic diet.
-She assisted the kitchen staff with serving residents meals.

Interview with the Cook on 04/02/24 at 9:55am and 04/03/24 at 8:15am revealed:
-She started working at the facility in November 2023
-She was told not to use the cycle menu, but only the handwritten menu posted on the refrigerator.
-The menu was completed by the administrator.
-She had no therapeutic diets for guidance.
-She did not have any special recipes she needed to follow.
-Breakfast was to be prepared with whatever she had on hand, and what residents liked.
-She knew some residents were diabetic and she "knew what to do", like give them sugar free items.
-She served 8 oz of orange juice to all of the residents.

Interview with a medication aide (MA) on 04/03/24 at 11:19am revealed:
-She had held many roles at the facility over the years.
-The facility used to order food from the menu company and had a dietician to consult with and that had stopped over a year ago.
-The administrator buys the food from "big box

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stores".
-The menus are not planned by a dietician.
-She was not aware of anyone being on a therapeutic diet and thought all residents were on a regular diet.
-When the new FL-2's came in she would only look at the medications and not the diet orders.

Interview with a Dietician from the facility's contracted menu company on 04/02/24 at 5:25pm revealed:
-A diabetic diet can be a no concentrated sweets diet or low concentrated sweet diet and the facility should ask the physician for clarification.
-The facility should be following a menu that is signed by a practicing dietician.
-The facility should be working with a dietician to monitor the servings needed for each diet and monitor the protein, grains, vegetables (starchy and non-starchy), fruits and desserts.
-There are spreadsheets that go with the regular menu to include all therapeutic diets for food service guidance.
-Fruits that are canned should be packed in water or juice.
-The facility had not used the menu company since 11/10/23.

Interview with the Administrator on 04/03/24 at 9:07am and 11:48am revealed:
-She was responsible for ensuring the cooks had a list of residents on therapeutic diets.
-She was not consulting with a dietician and was creating menus based on residents' choice and did not have any therapeutic menus for the kitchen staff.
-She sent the FL-2 to the PCP to sign and make any necessary changes and was responsible for reviewing the FL-2 once signed.
-She was responsible for ensuring the physician

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D 296	Continued From page 35 ordered diets were being followed. -She missed the diet orders for Resident #1 and Resident #2. ______________________________ The facility failed to ensure there were matching therapeutic diets posted in the kitchen resulting in the staff serving regular diets to 2 residents requiring who had physician's orders for diabetic and NCS concentrated diets. This placed the residents at risks for ongoing elevated blood sugars and A1C results, along with risk for stroke, and heart disease due to insulin resistance contributing to hardening of the arteries and leading to hypertension. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. ______________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/03/24 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 19, 2024.	D 296		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.	D 309		

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This Rule is not met as evidenced by:
Based on observations, record review and interviews the facility failed to maintain an accurate and current listing of residents, for 2 of 2 residents (#1 & #2) with physicians' orders for a diabetic diet (#1) and no concentrated sweets (NCS) diet (#2).

The findings are:

Observation of the kitchen on 04/02/24 at 09:55am revealed there was not a list of physicians ordered therapeutic diets posted for staff to reference.

1. Review of Resident #1's current FL2 dated 10/20/23 revealed:
-Diagnoses included below the knee amputation, hypertension, diabetes mellitus, diabetic peripheral neuropathy, morbid obesity and, impaired mobility.
-An order for a diabetic diet.

Interview with Resident #1 on 04/03/24 at 8:57am revealed:
-He was not aware he was on a physician ordered diabetic diet.
-If he wanted to have sugar substitute, they would give it to him, but he would rather have sugar.

Interview with Resident #1's Primary Care Provider (PCP) on 04/03/24 at 1:05pm revealed:
-Resident #1 was ordered a diabetic diet in order to lower his finger stick blood sugars (FSBS) and A1C of 10%.
-He was not aware Resident #1 was not being served a diabetic diet as ordered.

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-Resident had an A1C of 10% and FSBS ranging between 184-600 that put Resident #1 at risk for stroke, and heart disease due to insulin resistance contributing to hardening of the arteries and leading to hypertension.

Refer to the interview with the cook on 04/02/24 at 9:55am and 04/03/24 at 8:15am.

Refer to the interview with the personal care attendant (PCA) on 04/03/24 at 7:50am.

Refer to the interview with a second PCA on 04/03/24 at 7:50am.

Refer to the interview with a medication aide (MA) on 04/03/24 at 11:19am.

Refer to the interview with Administrator on 04/03/24 at 9:07am and 11:48am.

2. Review of Resident #2's current FL2 dated 10/21/23 revealed:
-Diagnoses included major depressive disorder, high blood pressure, vitamin D deficiency.
- An order for a regular no concentrated sweet diet (NCS).

Interview with Resident #2 on 04/03/24 at 8:02am revealed:
-She had been diabetic for a long time and takes oral medications for her diabetes but did not know what the medications were.
-She did not require to have her blood sugar checked and thought maybe she was a borderline diabetic.
-She knew she should not drink sugared drinks due to her diabetes and not eat foods that would flare up her gout such as red meat and pork
-No one ever told her she was on a physician

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ordered no concentrated sweets diet.
-Yesterday (04/02/24) she was served peaches for lunch, but she did not eat them because processed fruit had a lot of sugar.
-Sometimes the evening staff would bring her hamburger and shakes when she had the money.

Interview with Resident #2's Primary Care Provider (PCP) on 04/03/24 at 1:15pm revealed:
-He was not aware Resident #2 was not served a NCS diet as ordered.
-The risks of Resident #2 not getting a NCS diet increased her chances of having uncontrolled and elevated blood sugar levels.

Refer to the interview with the cook on 04/02/24 at 9:55am and 04/03/24 at 8:15am.

Refer to the interview with the personal care attendant (PCA) on 04/03/24 at 7:50am.

Refer to the interview with a second PCA on 04/03/24 at 7:50am.

Refer to the interview with a MA 04/03/24 at 11:19am.

Refer to the interview with Administrator on 04/03/24 at 9:07am and 11:48am.

____

Interview with the cook on 04/02/24 at 9:55am and 04/03/24 at 8:15am revealed:
-There was no therapeutic diets list or therapeutic diets for her to follow.
-Everyone was on a regular diet.
-She knew some residents were diabetic and she "knew what to do", like give them sugar free

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items.
-The administrator would be responsible for providing her with a list of residents on therapeutic diets.

Interview with a PCA on 04/03/24 at 7:50am revealed:
-She was not aware of anyone on a special diet because she worked third shift and they had not told her about any special diets.
-She had gotten residents milkshakes at night if they request one and they have the money.

Interview with a second PCA on 04/03/24 at 8:30am revealed:
-She was not aware of any resident being on a therapeutic diet.
-She assisted the kitchen staff with serving residents meals and pouring beverages.

Interview with a Medication Aide (MA) on 04/03/24 at 11:19am revealed:
-She was not aware of anyone being on a therapeutic diet and thought all residents were on a regular diet.
-When the new FL-2's came in she would only look at the medication orders and not the diet orders.

Interview with the Administrator on 04/03/24 at 9:07am and 11:48am revealed:
-She was responsible for ensuring the cooks had a list of residents on therapeutic diets.
-She sent the FL-2 to the PCP to sign and make any necessary changes and was responsible for reviewing the FL-2 once signed for diet orders.
-She was responsible for ensuring the physician ordered diets were being followed.
-She overlooked the diet orders for Resident #1 and Resident #2.

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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:
TYPE B VIOLATION

Based on observations, interviews, and record reviews the facility failed to ensure 2 of 2 sampled residents (#1 & #2) were served therapeutic diets as ordered by the physician for a diabetic diet (#1) and no concentrated sweets (NCS) diet (#2).

The findings are:

1. Review of Resident #1's current FL2 dated 10/20/23 revealed:
-Diagnoses included below the knee amputation, hypertension, diabetes mellitus, diabetic peripheral neuropathy, morbid obesity, impaired mobility, and a history of deep vein thrombosis and pulmonary embolism.
-An order for a diabetic diet.

Attempted review of the therapeutic diet menus on 04/03/24 revealed they were not available.

Review of the week at- a -glance Spring/Summer 2020-2021 regular diet menu for breakfast on Wednesday (day 25) revealed residents on a regular diet should be served stewed prunes, cereal, eggs, breakfast meat, toasted bread, margarine/jelly, vitamin C fortified juice and 2% milk.

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D 310	Continued From page 41 Attempted review of the regular diet menu for breakfast on 04/03/24 revealed it was unavailable. Observation of Resident #1's breakfast meal service on 04/03/24 at 8:25am revealed: -He was served scrambled eggs, 1 sausage patty, toast, orange juice and coffee. -He applied regular jelly on his toast. -There was no sugar free jelly available. -He poured regular sugar into his coffee. Review of the week at- a -glance Spring/Summer 2020-2021 regular diet menu for lunch on Wednesday (day 25) revealed residents on a regular diet were to be served chef's choice entrée, starchy vegetable, chef's choice vegetable seasonal fresh fruit, white or wheat roll, margarine spread. Review of the handwritten regular diet lunch menu for 04/03/24 posted on the refrigerator revealed residents were to be served baked chicken, mashed potatoes, corn, bread and cake. Observation of resident #1's lunch meal service on 04/03/2024 12:18pm revealed he was served chicken, mashed potatoes, broccoli, bread, strawberry cake, and regular sweetened lemonade. Interview with Resident #1 on 04/03/24 at 8:57am revealed: -He was not aware he was on a physician ordered diabetic diet. -If he wanted to have sugar substitute, they would give it to him, but he would rather have sugar. Interview with Resident #1's Primary Care Provider (PCP) on 04/03/24 at 1:05pm revealed:	D 310		

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-Resident #1 was ordered a diabetic diet in order to lower his finger stick blood sugars (FSBS) and A1C of 10%.
-He was not aware Resident #1 was not being served a diabetic diet as ordered.
-Resident had an A1C of 10% and FSBS ranging between 184-600 that put Resident #1 at risk for stroke, and heart disease due to insulin resistance contributing to hardening of the arteries and leading to hypertension.

Interview with a Dietician from the facility's contracted menu company on 04/02/24 at 5:25pm revealed:
-A diabetic diet can be a no concentrated sweets diet or low concentrated sweet diet and the facility should ask the physician for clarification.
-The facility should be following a therapeutic diet menu that is signed by a practicing dietician.

Interview with the Administrator on 04/02/24 at 8:45am and 4:17pm revealed:
-All residents were on regular diets
-She wrote out the menu based on residents' choice, and she did not have therapeutic menus.
-She did not consult with a dietician.
-She did not write down a breakfast menu, it would be up to the cook to make what she had on hand.

Refer to the interview with a personal care aide (PCA) on 04/03/24 at 7:50am

Refer to the interview with a second PCA on 04/03/24 at 8:30am

Refer to the interview with the cook on 04/02/24 at 9:55am and 04/03/24 at 8:15am

Refer to the interview with a medication aide (MA)

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on 04/02/24 at 4:18pm

Refer to the interview with a Dietician from the facility's contracted menu company on 04/02/24 at 5:25pm

Refer to the interview with Administrator on 04/03/24 at 11:48am

2. Review of Resident #2's current FL2 dated 10/21/23 revealed:
-Diagnoses included vitamin D deficiency.
- An order for a regular no concentrated sweet diet (NCS).

Review of Resident #2's signed care plan dated 10/11/23 revealed a dietary restriction as NCS with a notation "resident non-compliant with diet"

Attempted review of the therapeutic diet menus on 04/03/24 revealed they were not available.

Review of the week at- a -glance Spring/Summer 2020-2021 regular diet menu for breakfast on Wednesday (day 25) revealed residents on a regular diet should be served stewed prunes, cereal, eggs, breakfast meat, toasted bread, margarine/jelly, vitamin C fortified juice and 2% milk.

Attempted review of the breakfast menu for 04/03/24 revealed it was unavailable.

Observation of Resident #2's breakfast on 04/03/24 at 8:25am revealed:
-She was served scrambled eggs, 1 sausage patty, toast, orange juice, and milk.
-She applied regular jelly on her toast.
-There was no sugar free jelly available.
-She did not like grits and was not being served

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grits.

Review of the week at- a -glance Spring/Summer 2020-2021 regular diet menu for lunch on Wednesday (day 25) revealed residents on a regular diet were to be served chef's choice entrée, starchy vegetable, chef's choice vegetable seasonal fresh fruit, white or wheat roll, margarine spread.

Review of the handwritten regular diet lunch menu for 04/03/24 posted on the refrigerator revealed residents were to be served baked chicken, mashed potatoes, corn, bread and cake.

Observation of resident #2's lunch meal service on 04/03/2024 12:18pm revealed she was served chicken, mashed potatoes, broccoli, bread, cake, and water.

Interview with Resident #2 on 04/03/24 at 8:02am revealed:
-She had been diabetic for a long time and takes oral medications for her diabetes but did not know what the medications were.
-She did not require to have her blood sugar checked and thought maybe she was a borderline diabetic.
-She knew she should not drink sugared drinks due to her diabetes and not eat foods that would flare up her gout such as red meat and pork
-No one ever told her she was on a physician ordered no concentrated sweets diet.
-Yesterday (04/02/24) she was served peaches for lunch, but she did not eat them because processed fruit had a lot of sugar.
-Sometimes the evening staff would bring her hamburger and shakes when she had the money.

Interview with the Administrator on 04/02/24 at

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8:45am and 4:17pm revealed:
-All residents were on regular diets
-She knew Resident #2 was on a NCS diet.
-Resident #2 was non-compliant with her diet.
-She wrote out the menu based on residents' choice and did not have therapeutic menus.
-She did not consult with a dietician.
-She did not write down a breakfast menu, it would be up to the cook to make what she had on hand.

Interview with Resident #2's Primary Care Provider (PCP) on 04/03/24 at 1:15pm revealed:
-He was not aware Resident #2 was not served a NCS diet as ordered.
-The risks of Resident #2 not getting a NCS diet increased her chances of having uncontrolled and elevated blood sugar levels.

Refer to the interview with a personal care aide (PCA) on 04/03/24 at 7:50am

Refer to the interview with a second PCA on 04/03/24 at 8:30am

Refer to the interview with the cook on 04/02/24 at 9:55am and 04/03/24 at 8:15am

Refer to the interview with a Medication Aide (MA) on 04/02/24 at 4:18pm

Refer to the interview with a Dietician from the facility's contracted menu company on 04/02/24 at 5:25pm

Refer to the interview with Administrator on 04/03/24 at 9:07am and 11:48am.

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Interview with a personal care aide (PCA) on

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04/03/24 at 7:50am revealed:
-She was not aware of anyone on a special diet because she worked third shift and they had not told her about any special diets.
-She had gotten residents milkshakes at night if they request one and they have the money.
-Resident #1 and sometimes Resident #2 will get milkshakes.

Interview with a second PCA on 04/03/24 at 8:30am revealed:
-She was not aware of any resident being on a therapeutic diet.
-She assisted the kitchen staff with serving residents meals.

Interview with the Cook on 04/02/24 at 9:55am and 04/03/24 at 8:15am revealed:
-All Residents were on a regular diet.
-There were no therapeutic diet menus available.
-She did not go by the cycle menu, just the handwritten menu posted on the refrigerator in which the Administrator wrote out.
-Breakfast consisted of whatever she had on hand and knew what residents liked.
-She knew some residents were diabetic and she "knew what to do", like give them sugar free items.
-She served 8 oz of orange juice to all the residents.

Interview with a medication aide (MA) on 04/02/24 at 4:18pm revealed a staff member who worked evenings would get residents milkshakes almost every night at 8:00pm if they would like one.

Interview with a Dietician from the facility's contracted menu company on 04/02/24 at 5:25pm revealed:

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D 310	Continued From page 47 -A diabetic diet can be a no concentrated sweets diet or low concentrated sweet diet and the facility should ask the physician for clarification. -The facility should be following a menu that was signed by a practicing dietician. -The facility should be working with a dietician to monitor the servings needed for each diet and monitor the protein, grains, vegetables (starchy and non-starchy), fruits and desserts. -Fruits that are canned should be packed in water or juice. -The facility had not used the company since 11-10-23. Interview with the Administrator on 04/03/24 at 9:07am and 11:48am revealed: -She did not have sugar free jelly or fruit packed in juice or water because the residents did not like the diabetic food and they would not eat it. -She spent so much money on food that it would just go to waste. -She was not consulting with a dietician and went by the menu from 2021. -She was responsible for ensuring the physician ordered diets were being followed. -She overlooked the diet orders for Resident #1 and Resident #2. -She would be getting Resident #1 and Resident #2 diets changed to a regular diet because both residents are non-compliant. -She did not inform the physician that Resident #1 and Resident #2 were non-compliant with their diets and that the facility was not giving them a physician ordered therapeutic diet. ______________________________ The facility failed to ensure therapeutic diets were served as ordered to 2 residents requiring a physician's ordered diabetic diet (Resident #1) and NCS diet (Resident #2). This placed the	D 310		

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D 310	Continued From page 48 residents as risks for ongoing elevated blood sugars and A1C results along with risk for stroke, and heart disease due to insulin resistance contributing to hardening of the arteries and leading to hypertension. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. ______________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/03/24 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 19, 2024.	D 310		
D 316	10A NCAC 13F .0905 (c) Activities Program 10A NCAC 13F .0905 Activities Program (c) The activity director shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to	D 316		

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determine what have been the most valued activities and to elicit suggestions of ways to enhance the program;
(5) encourage residents to participate in activities; and
(6) assure there are, supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities.

This Rule is not met as evidenced by:
Based upon observations and interviews, the facility failed to post a current, monthly activity calendar on the first day of the month for the 14 residents residing in the facility.

The findings are:

Observation of the facility on 04/02/24 at 9:30am revealed there was no activity calendar posted in the facility.

Observations of the facility during various hours on 04/02/24 from 9:00am to 5:00pm, on 04/03/24 from 8:00am to 5:00pm and 04/03/24 from 8:00am to 5:00pm revealed no organized activities as residents primarily remained in bedrooms, or smoked outdoors.

Interview with a resident, on 04/03/24, at 8:40am revealed:
-There was no activity calendar posted in the facility.
-Residents just walk the halls, or smoke.
-Activities only occur once monthly, when a church group visits.
-He would like more options for activities, such as

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D 316	Continued From page 50 card games. Interview with a second resident, on 04/03/24, at 8:15am, revealed: -There was no activity calendar posted in the facility. -The only activity offered was bingo, and it was not available often, maybe once per week. -She would like more activities, such as board games, drawing, and painting. Interview with a third resident, on 04/03/24, at 8:30am, revealed: -There was no activity calendar posted in the facility. -The only activity available was smoking. -There were no activities offered to the residents. -She would like to see more activities, such as arts and crafts, and board games, such as scrabble. Interview with Administrator on 04/03/24 at 8:50am, revealed: -There was no activity calendar created for the month of April. -There wasn't time to create an activity calendar for the month of April due to other duties because of staff calling out and filling in for them.	D 316		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills.	D 317		

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This Rule is not met as evidenced by:
Based upon observations and interviews, the facility failed to ensure least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills.

The findings are:

Observation of the facility on 04/02/24, at 9:30am, revealed there was no activity calendar posted in the facility.

Observations of the facility during various hours on 04/02/24 from 9:00am to 5:00pm, on 04/03/24 from 8:00am to 5:00pm and 04/03/24 from 8:00am to 5:00pm revealed:
-There were no organized activities as residents primarily remained in bedrooms, or smoked outdoors.
-There were no activity supplies located in the facility.
-There was a TV in the dining room and two recliners.

Interview with a resident, on 04/03/24, at 8:40am, revealed:
-There was no activity calendar posted in the facility.
-There were no activities offered to the residents.
-Residents just walk the halls, or smoke.
-Activities only occur once monthly, when a church group visits.
-He would like more options for activities, such as card games.

Interview with a second resident, on 04/03/24, at 8:15am, revealed:

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D 317	Continued From page 52 -There was no activity calendar posted in the facility. -The only activity offered was bingo, and it was not available often, maybe once per week. -She would like more activities, such as board games, drawing, and painting. Interview with a third resident, on 04/03/24, at 8:30am, revealed: -There was no activity calendar posted in the facility. -The only activity available was smoking. -There were no activities offered to the residents. -She would like to see more activities, such as arts and crafts, and board games, such as scrabble. Interview with Administrator on 4/3/2024 at 8:50 am, revealed: -There was no Activity Director at the facility at this time. -There was no activity calendar created for the month of April. -There wasn't time to create an activity calendar for the month of April because she was busy completing other projects due to staff calling out o work.	D 317		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies	D 358		

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and procedures.

This Rule is not met as evidenced by:
Based on observation, interviews, and record reviews the facility failed to ensure medications were administered as order for 2 of 2 residents (#2 & #9) sampled during the medication pass related to medication to treat high blood pressure, high cholesterol, and depression (#2) and a medication used to treat erosion and ulceration of the esophagus, and to reduce the risk of a heart attack (#9).

The findings are:

Review of the facility's undated Medication Administration policy revealed medications were to be administered in accordance with the prescribing practioner's orders.

1. Review of Resident #2's current FL2 dated 10/21/23 revealed:
-Diagnoses included frontal and parietal Infarct, major depressive disorder, radial artery laceration (status post), high blood pressure, vitamin D deficiency.
-There was an order for amlodipine (a medication used to treat high blood pressure) 10mg every day.
-There was an order for atorvastatin (a medication used to treat high cholesterol) 80mg at bedtime.
-There was an order for esclitalopram (a medication used to treat depression) 20mg every day.

Observation during the medication pass on 04/02/24 from 8:00am to 9:15am revealed:
-The medication aide (MA) pulled all of Resident #2's medications out of the medication cart.

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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 358	Continued From page 54 -She began popping pills out of each bubble pack. -She did not verify the labels on the medication bubble packs with the Medication Administration Record (MAR) to check to see if they matched. -The amlodipine 10mg in the medication cup was to be administered at 8:00pm. -The atorvastatin 80mg in the medication cup was to be administered at 8:00pm. -There were two esclitalopram 20mg tablets in the medication cup instead of one. Review of Resident #2's April 2024 MAR -There was an entry for amlodipine 10mg daily at 8:00pm. -There was an entry for atorvastatin 80mg daily at 8:00pm. -There was an entry for esclatopram 20mg daily at 8:00am. Interview with the MA on 04/02/24 at 10:30am revealed: -She was the Administrator and was administering medications on 04/02/24. -She was responsible for administering medications as ordered by the physician. -All MAs were responsible for matching the medication in the bubble packs with the MAR before the medications were placed in the medication cup. -She did not verify the medication in the bubble pack with the MAR. -She used a time written on the medication bubble pack that was written by another MA and did not pay attention to the MAR as she should have. 2. Review of Resident #9's current FL2 dated 10/11/23 revealed: -Diagnoses included hypertension,	D 358		

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D 358	Continued From page 55 atherosclerotic cardiovascular disease, blind, and retinitis pigmentosa (an eye disease that causes severe vision impairment) in the right eye. -There was an order for aspirin (a medication used to treat cardiovascular disease) 81mg every day. -There was an order for pantoprazole (a medication used to treat high gastric acid levels) 40mg every morning before breakfast. Observation during the medication pass on 04/02/23 from 9:15am to 9:40am revealed: -The MA pulled all of Resident #9's medications out of the medication cart. -She began popping pills out of each bubble pack. -She did not verify the labels on the medication bubble packs with the MAR to check to see if they matched. -The pantoprazole 40mg in the medication cup was to be administered at 7:30am before breakfast not after breakfast. -There was no aspirin 81mg in the medication cup to be administered or in the medication cart. Review of Resident #9's April 2024 MAR revealed: -There was an entry for aspirin 81mg every day and documented as administered on 04/02/24 at 8:00am. -There was an entry for pantoprazole 40mg every morning before breakfast documented as administered on 04/02/24 at 7:30am. Interview with the MA on 04/02/24 at 10:30am revealed: -She was the Administrator and was administering medications on 04/02/24. -She was responsible for administering medications as ordered by the physician.	D 358		

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D 358	Continued From page 56 -All MAs were responsible for matching the medication in the bubble packs with the MAR before the medications were placed in the medication cup. -Resident #9's pantoprazole was supposed to be administered before breakfast this morning but she missed it on the earlier medication pass so she administered it during the medication pass from 9:15am to 9:40am when Resident #9 finished breakfast. -She thought she administered the aspirin but it was not located with Resident #9's medications. -She did not verify the medication in the bubble pack with the MAR. -She used a time written on the medication bubble pack that was written by another MA and did not pay attention to the MAR as she should have. -The MAs were responsible for reordering the aspirin when there was 7 days left in the bubble pack. -She was not aware the aspirin was not reordered.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by:	D 366		

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Based on observations, record reviews, and interviews, the facility failed to ensure staff documented on the administration medication record immediately after administering medication for 1 of 3 sampled residents (#3).

The findings are:

Review of the facility's undated medication administration policy revealed the documentation of the administration of the medication shall be by the staff person who administered the medication following administration of the medication to the resident before

Review of Resident #3's current FL-2 dated 02/29/24 revealed:
-Diagnoses included major depressive disorder and chronic pain due to trauma.
-There was an order for Protonix (a medication used to treat high levels of stomach acid) 40mg at 6:00am
-There was an order for Lipitor (a medication used to treat high cholesterol) 40mg every day.
-There was an order for Vitamin D3 (a medication used to treat low vitamin D) 2000u every day.
-There was an order for K-Dur (a medication used to treat low potassium) 10mEq every day.
-There was an order for Tapazole (a medication used to treat excessive thyroid hormone levels) 5mg two times a day.
-There was an order for Robaxin (a medication used to treat muscle spasms and pain) 500mg twice a day.
-There was an order for Sucrafate (a medication used to treat and prevent ulcers) 1gm four times a day/before meals and at night.
-There was an order for Lidocaine patch (a medication used to treat pain) topically every day.

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Review of Resident #3's April 2024 Medication Administration Record (MAR) on 04/02/24 revealed:
-There was an entry for Protonix 40mg at 6:00am not documented as administered on 04/01/24 at 6:00am.
-There was an entry for Lipitor 40mg every day not documented as administered on 04/01/24 at 8:00am.
-There was an entry for Vitamin D3 2000u every day not documented as administered on 04/01/24 at 8:00am.
-There was an entry for K-Dur 10mEq every day not documented as administered on 04/01/24 at 8:00am.
-There was an entry for Tapazole 5mg two times a day not documented as administered on 04/01/24 at 8:00am.
-There was an entry for Robaxin 500mg twice a day not documented as administered on 04/01/24 at 8:00am.
-There was an entry for Sucrafate 1gm four times a day/before meals and at night not documented as administered on 04/01/24 at 8:00am and 1:00pm.
-There was an entry for Lidocaine patch topically every day not documented as administered on 04/01/24 at 8:00am.

Review of Resident #3's medications available for administration on 04/03/24 revealed:
-There was a bubble pack containing 28 Protonix 40mg tablets.
-There was a bubble pack containing 28 Lipitor 40mg tablets.
-There was an bubble pack containing 28 Vitamin D3 2000u tablets.
-There was a bubble pack containing 28 K-Dur 10mEq tablets.
-There was a bubble pack containing 56 Tapazole

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D 366	Continued From page 59 5mg tablets. -There was a bubble pack containing 56 Robaxin 500mg tablets. -There was an almost full medication bottle containing Sucrafate 1gm liquid. -There was a box containing 28 Lidocaine patches. Interview with the medication aide (MA) on 04/03/24 at 8:00am revealed: -She was supposed to identify the resident, pull out that residents medications and dispense the medication after she confirmed the medication and the MAR matched and it was the correct administration time. -After the resident, medication, and time was correct, she was to administer the medication and document before administering medications to another resident. -She knew the resident's medications very well and at times administered medications without verifying the medication with the MAR. -She did not realize she forgot to go back and check all of the MARs to make sure she signed off on administration of all medications for each resident. Observation of the MA on 04/03/24 at 1:30pm revealed: -A resident came to the medication room door and asked for her afternoon medications. -The MA opened the medication cart and removed a bottle and poured some into a medication cup and gave it to the resident. -The resident drank the fluid in the medication cup and left the medication room. -The MA went back to the medication cart and began dispensing medications for another resident without looking at the resident's MAR.	D 366		

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D 366	Continued From page 60 Interview with a second MA on 04/03/24 at 1:30pm revealed: -She was trained by a nurse to identify the resident, compare the MAR to the medication and administer the medication if the medication matched the MAR. --She was also trained to document after she administered the medication before she started with another resident. -She could not be 100% sure she administered the correct medications to the correct resident at the correct time every time she administered medications because she did not compare the MAR to the resident's medications. -She did not document some of the time after she administered medications to a resident before she started with the next resident. -She would document after her medication pass was complete some of the time. -She knew the residents so well she could just administer the medications without looking at the MAR. Interview with the Administrator on 04/02/24 at 10:30am revealed: -The MAs were responsible for administering the correct medications to the correct resident at the correct time and document the medications administered before starting on the next resident. -She did not know the MA who worked on 04/01/24 did not document medications after she administered them.	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the	D 367		

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following:
(1) resident's name;
(2) name of the medication or treatment order;
(3) strength and dosage or quantity of medication administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observation, record review, and interviews, the facility failed to ensure the accuracy of medication administration records during the medication pass for 2 of 2 sampled residents related to a medication used for seasonal allergies (#2) and heart disease (#9).

The findings are:

Review of the facility's undated Medication Administration policy revealed documentation will be provided for each dose of medication by the staff who prepares the medication for administration.

1. Review of Resident #2's current FL2 dated 10/21/23 revealed:
-Diagnoses included frontal and parietal Infarct, major depressive disorder, radial artery laceration

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D 367	Continued From page 62 (status post), high blood pressure, vitamin D deficiency. -An order for fluticasone 50mcg/ACT, spray one spray in each nostril every day. Review Resident #2's April 2023 Medication Administration Record (MAR) revealed an entry for fluticasone 50mcg/ACT, spray one spray in each nostril every day documented as administered on 04/01/24 at 8:00am. Observation of Resident #2's medications available for administration on 04/03/24 revealed there was no fluticasone available for administration. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 04/02/24 at 15:15pm revealed: -An order for fluticasone 50mcg/ACT, spray one spray in each nostril every day, dated 01/22/24 on profile and it was never dispensed. -Fluticasone nasal spray was used to treat seasonal allergy symptoms such as, itchy and runny nose,watery eyes, blocked nose and sneezing. -Not using fluticasone could result in an increase of the seasonal allergy symptoms. Refer to interview with the Administrator on 04/02/24 at 2:00pm. 2. Review of Resident #9's current FL2 dated 10/11/23 revealed: -Diagnoses included hypertension, atherosclerotic cardiovascular disease, blind, and retinitis pigmentosa (an eye disease that causes severe vision impairment) in the right eye. -An order for aspirin 81mg every day.	D 367		

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D 367	Continued From page 63 Review of Resident #2's April 2024 MAR revealed there was an entry for aspirin 81mg every day documented as administered on 04/01/24 at 8:00am. Observation of Resident #9's medications available for administration on 04/03/24 revealed there was no aspirin available for administration. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 04/02/24 at 15:15pm revealed: -An order for aspirin 81mg every day, dated 08/10/23 and on profile and never dispensed. -Aspirin was used to treat cardiovascular disease by reducing the risk of blood clot formation. -Not using aspirin could increase the risk of a stroke or heart attack. Refer to interview with the Administrator on 04/02/24 at 2:00pm. ______________________________ Interview with the Administrator on 04/02/24 at 2:00pm revealed: -She did not initial the MAR after each medication was placed in the medication cup. -She would initial after the resident took the medication. -She did not realize she initialed a medication that was not administered or in the building. -She did not realize she was not able to determine what medications were administered by placing all medication in the medication cup, administering them to the resident and then initialing each medication on the MAR.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications	D 375		

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10A NCAC 13F .1005 Self -Administration Of Medications
(a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:
(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and
(2) specific instructions for administration of prescription medications are printed on the medication label.

This Rule is not met as evidenced by:
Based on observation, record review, and interviews, the facility failed to ensure 1 of 1 sampled resident (#9) had a physician's order to self-administer medications and a completed assessment related to Symbicort (a medication used to treat breathing problems).

The findings are:

Review of the facility's undated policy on Resident Self-Administration of Medication revealed:
-There physician would write an order for self-administration of medications.
-The resident would be competent and physically able to self-administer medications.

Review of Resident #9's current FL2 dated 10/11/23 revealed:
-Diagnoses included hypertension, atherosclerotic cardiovascular disease, blind, and retinitis pigmentosa (an eye disease that causes

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D 375	Continued From page 65 severe vision impairment) in the right eye. -There was an order for Symbicort 80/4.5mcg, 2 puff twice a day. Review of Resident #9's Resident Register revealed an admission date of 06/16/23. Review of Resident #9's Care Plan dated 06/21/23 revealed: -Resident #9 was independent with eating. -Resident #9 required extensive assistance with toileting, ambulating, bathing, dressing, grooming and transfers. -Resident #7 was not independent with self-administration of medications. -Resident #7 required staff to assist/administer medications up to 3 times per day or more than 4 medications per medication pass. -The care plan was signed by the physician. Review of Resident #9's record on 04/04/23 revealed: -There was no self-administration order signed by Resident #9's primary care physician. -There was no self-administration of medications assessment to reveal Resident #9's competency with self-administration of medications. Interview with a medication aide (MA) on 04/03/24 at 8am revealed: -Resident #9 had 2 Symbicort inhalers in her room this morning when she delivered medications for administration. -Resident #9 was not a resident who could self-administer her medications due to her blindness. -There was no order from the physician that allowed Resident #9 to self-administer medications or an assessment completed to make sure Resident #9 was capable to	D 375		

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self-administer medications.

Interview with a second MA on 04/04/24 at 8:38am revealed:
-Resident #9 required assistance with administering her medications due to the fact she was blind.
-Resident #9 count not read to medication labels and depended the MAs to give her the correct medications.
-She walked into Resident #9's room before to administer medications and found her Symbicort inhaler in her room.
-She would take the inhaler out of her room because Resident #9 did not have an order to self-administer or an assessment in her record.

Interview with the Administrator on 04/03/24 at 4:25pm revealed:
-Resident #9 was not supposed to have medications in her room.
-She did not know Resident #9 kept Symbicort in her room to use.
-Resident #9 was unable to safely administer her own medications because Resident #9 was blind.
-In order for a resident to self-administer medications, they needed a physicians order for self-administration and an assessment to prove competency.
-Staff were not allowed to leave medications in residents rooms and were responsible for removing medications from the resident's room if some were found and the order and assessment were not in the resident's record.