STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from November 19, 2024 to November 20, 2024.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (#3) related to failing to ensure the resident was referred to a general surgeon after an emergency department visit for nausea and vomiting. The findings are: Review of Resident #3's current FL-2 dated 08/01/24 revealed: -Diagnoses included type 2 diabetes, hypertension, hypothyroidism, mixed hyperlipidemia, memory impairment, insomnia and vitamin D deficiency. -The resident's level of care was assisted living (AL). -The resident was ambulatory and intermittently disoriented. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 12/18/23. Review of Resident #3's progress note dated 10/15/24 at 11:35pm revealed:	D 273	D273 - 10NCAC 13F .0902(b) Health Care The Bridges of Hendricks Creek shall ensure referral and follow-up to meet the routine and acute health care needs of Residents. RCC will review the electronic facility documentation daily for any needed follow-up. This documentation will be reviewed with the ED during management meeting daily. ED/RCC will be sure to review the discharge summaries when Residents return from hospital visits to ensure all new orders, and/or order changes, are processed accurately and promptly. This will also be reviewed during management meeting daily. Clinical Nurse Consultant (CNC) in-serviced ED, RCC, and Med Techs on Health Care Referral and Follow-Up, as well as, the Order Processing System.	11/25/2024 11/25/2024 11/25/2024 12/16/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joshua B Lanier | TITLE: Executive Director | (X6) DATE: 12/27/2024

Reviewed and Acknowledged SJS 12/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R 11/20/2024

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D 273	Continued From page 1 -The resident complained of nausea. -She was sent to the local emergency department (ED) via emergency medical services (EMS) at 6:35pm on 10/15/24. -Resident #3's primary care provider (PCP) was notified via telemediq. -The resident's responsible party (RP) was notified. -The progress note was documented by the medication aide (MA). Review of Resident #3's hospital ED notes dated 10/15/24 revealed: -The resident arrived at the ED via EMS on 10/15/24 at 7:08pm. -Her chief complaint was vomiting. -A computerized tomography (CT) scan of the abdomen and pelvis with contrast performed revealed large fat, small bowel and colon containing anterior abdominal wall hernia without obvious findings of obstruction, no obvious findings of bowel obstruction on the current exam, small hiatal hernia, distended gallbladder without obvious findings of acute cholecystitis, and moderate atherosclerosis of the aorta and its main branches. -The resident was discharged back to the facility with orders for ondansetron 4mg to take one tablet every 8 hours as needed for nausea and vomiting for up to 5 days and to follow-up with general surgery (name, address and phone number were provided) as soon as possible. Review of Resident #3's ED after visit summary (AVS) dated 10/15/24 revealed: -Instructions: take medication as prescribed, follow-up with general surgeon as soon as possible for further evaluation of your symptoms and CT findings. -Ondansetron (a medication used to treat nausea	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 2	D 273		

and vomiting) was ordered.
-The reason for the visit was vomiting.
-The diagnosis for the visit was nausea and vomiting, unspecified vomiting type.
-Schedule an appointment with a general surgeon (name, phone number, and address were provided) as soon as possible.
-Lab work and a CT of the abdomen and pelvis with contrast were performed.

Review of Resident #3's progress note dated 10/16/24 at 8:36am revealed:
-Resident #3 returned from the ED visit via community vehicle.
-Medications were clarified and faxed to the pharmacy.
-Readmission skin assessment was completed.
-Any follow-up appointments added to the calendar were marked as N/A.
-There were no dietary changes.
-There were no labs ordered.
-The progress note was documented by the Resident Care Coordinator (RCC).

Review of Resident #3's Incident/Accident (I/A) report dated 10/15/24 revealed:
-The resident was sitting in her recliner in her room.
-The resident complained of nausea and requested to be sent to the ED.
-The resident was transported via EMS to the local ED at 6:32pm.
-The resident was not hospitalized.
-Her PCP and RP were notified.
-In the referral and follow-up section of the I/A report, record status of Resident after ED/hospital (discharge diagnosis, new medication and follow-up with PCP), nausea, vomiting and Zofran (Zofran is a brand name for ondansetron) as needed were documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R 11/20/2024

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D 273	Continued From page 3	D 273		

-Evaluation notes were to follow up with the PCP.
-Under follow-up initiated, N/A was documented,
-The I/A event date and time were recorded as 10/15/24 at 6:27pm.
-The I/A report was recorded by the MA on 10/15/24 at 11:18pm and closed by the RCC on 10/17/24 at 12:47pm.
-There was no documentation of need to follow-up with a general surgeon.

Review of Resident #3's PCP visit note dated 10/24/24 revealed:
-The resident reported experiencing nausea consistently after eating meals.
-She denied a history of gastrointestinal reflux disease (GERD) or acid reflux.
-Her blood sugar was measured at 125 this morning with a previous reading of 120.
-She was recently hospitalized and informed that she had a viral illness, but it was not COVID-19.
-She denied pain, bleeding, constipation or diarrhea.
-She reported feeling too full after eating and had not experienced heartburn in a long time.
-Ondansetron was available upon request and she agreed to try omeprazole (a medication used to treat heartburn and GERD).
-Orders were placed for omeprazole 20mg delayed release, take one 1 tablet once a day, as well as lab work.

Review of Resident #3's record on 11/20/24 revealed there were no notes from the general surgeon.

Interview with Resident #3 on 11/20/24 at 10:02am revealed:
-She occasionally had nausea depending on what she ate.
-She went to the ED in October 2024 and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

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D 273	Continued From page 4	D 273		

told she had "a bacteria".
-She did not recall having a CT scan at the October 2024 ED visit.
-She had not seen a general surgeon.
-She was not told that she needed to see a general surgeon at the October 2024 ED visit.
-She saw the PCP when she came to the facility.
-She was unsure if she took medication for nausea.

Interview with the RCC on 10/20/24 at 8:16am revealed:
-She reviewed Resident #3's ED AVS summary for 10/15/24.
-She placed Resident #3's 10/15/24 ED AVS in a folder for her PCP to review.
-She verbally told the PCP that Resident #3 needed a general surgery referral when she saw the resident on her 10/24/24 visit.
-She said the PCP asked her why Resident #3 needed a general surgery referral, and she told her due to a hernia and the PCP did not respond.
-The PCP reviewed and signed Resident #3's 10/15/24 ED AVS on 10/17/24.
-If a referral was needed, the PCP placed the order and gave it to her care coordinator.
-The PCP's care coordinator was responsible for sending the referral and would send her an email once the referral was sent notifying her where the referral was sent.
-She had not received an email or notification from the PCP's care coordinator regarding the general surgery referral for Resident #3.
-She had not followed up with the PCP's care coordinator regarding the general surgery referral for Resident #3.

Interview with an MA on 11/20/24 at 12:57pm revealed:
-The MAs or the RCC could process new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

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D 273	Continued From page 5	D 273		

medication orders.
-The RCC usually handled referrals, but the MAs could fax referrals.

Interview with a second MA on 11/20/24 at 2:31pm revealed the RCC handled referrals for the residents.

Telephone interview with a representative from the named general surgeon's office on 11/20/24 at 8:40am revealed:
-There was no documentation of a referral being received for Resident #3.
-There were no past or future appointments scheduled for Resident #3.

Telephone interview with Resident #3's PCP's care coordinator on 11/20/24 at 8:55am revealed:
-If the PCP ordered a referral, the referral was given to her, and she researched to see where the resident could go and sent the referral.
-Once she sent the referral, she notified the facility's RCC by phone, telemediq or email, where the referral was sent so the facility could follow up to obtain the appointment date and time.
-She had not received an order for a general surgery referral for Resident #3.
-She was not aware that Resident #3 needed a general surgery referral.

Second interview with the RCC on 11/20/24 at 3:18pm revealed:
-When a resident returned from an ER visit, she reviewed the AVS for new orders.
-If there were medication orders or changes, she faxed the information to the pharmacy.
-The PCP had a care coordinator that handled all referrals.
-If a referral was indicated on an ED AVS, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R 11/20/2024

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D 273	Continued From page 6	D 273		

placed the AVS in a folder for the PCP to review and place an order.
-The PCP's care coordinator sent the referrals and notified her where the referrals were sent.
-She did not have a process to follow up on referrals since these were handled by the PCP's care coordinator and could take several days or weeks.
-The facility had difficulty contacting the PCP's care coordinator by phone.
-She assumed Resident #3's PCP did not feel Resident #3 needed a general surgery referral since a referral was not made.

Interview with the Administrator on 11/20/24 at 4:14pm revealed:
-The RCC was the first point of contact for new orders from a hospital or ED AVS.
-New orders were also communicated at daily stand-up meetings.
-The RCC placed all ED AVSs in a folder for the PCP to review.
-He did not consider the general surgery referral noted on Resident #3's 10/15/24 ED AVS to be an order and the general surgery referral had to be ordered by Resident #3's PCP.
-Resident #3's PCP had been provided with a copy of Resident #3's 10/15/24 ED AVS and signed it on 10/17/24.
-He understood it was the facility's responsibility to ensure that referrals were made for the residents, but did not feel this was fair because the PCP had to place an order for the referral, and they could not force the PCP to place the referral order.
-It was assumed that the PCP did not feel a general surgery referral was needed for Resident #3, but this was not documented or clarified.

Interview with Resident #3's PCP on 11/20/24 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

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D 273	Continued From page 7 1:44pm revealed: -She last saw Resident #3 on 10/24/24. -She was told the resident had to go to the ED in October 2024 for nausea and vomiting. -She started omeprazole daily and continued ondansetron as needed for Resident #3 at her 10/24/24 visit. -She was not aware that Resident #3 needed to see a general surgeon. -She did not recall being told by the facility that Resident #3 needed a general surgery referral. -She was not aware of Resident #3's CT of the abdomen and pelvis results from the 10/15/24 ED visit. -If the resident had a hernia, it could possibly cause worsening nausea and vomiting or an obstruction or blockage. -If the resident had a distended gallbladder, it could cause worsening nausea and vomiting and possibly require surgery. -If a resident required a referral, she had a care coordinator that could make the referral, or the facility could make the referral. -She did receive a copy of Resident #3's 10/15/24 ED AVS. Attempted telephone interview with Resident #3's RP on 11/20/24 at 3:20pm was unsuccessful.	D 273	D310 - 10A NCAC 13F.0904(e)(4) Nutrition and Food Service The Bridges of Hendricks Creek will ensure all therapeutic diet orders are prepared and served as per the PCP's Diet Order. The Executive Director (ED) in-serviced dietary staff on Therapeutic Diet Orders. All staff will ensure that a resident's Diet Order is confirmed before serving a food plate to a Resident. The Resident Care Coordinator (RCC) and Executive Director (ED) will ensure Diet Orders are delivered to Dietary Manager (DM) weekly, as well as, immediately upon admission or changes.	11/25/2024 12/19/2024 11/25/2024 11/25/2024
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

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D 310	Continued From page 8 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to serve a therapeutic diet as ordered by the primary care provider (PCP) for 1 of 3 sampled residents (#4) with a mechanical soft entire meal with chopped meats diet. The findings are: Review of Resident #4's current FL-2 dated 10/17/24 revealed diagnoses included Gerd, acquired hyperthyroidism, mixed hyperlipidemia, venous stasis dermatitis and non-traumatic rhabdomyolysis. Review of Resident #4's diet order dated 10/17/24 revealed an order mechanical soft entire meal with chopped meats diet. Review of the facility's posted menu for breakfast on 11/20/24 revealed it included French toast bake, egg of choice, apple rings, 100% juice and milk. Review of the facility's diet chart on 11/20/24 revealed Resident #4 should have been served a mechanical soft, entire meal diet. Review of the therapeutic diet list on the bulletin board in the facility's kitchen revealed Resident #4 should have been served a mechanical soft, entire meal diet. Review of the facility's diet extensions therapeutic diet menu for breakfast dated 11/20/24 revealed: -There was a listing for a mechanical soft chopped diet which included: French toast bake soft and bite-sized/moistened, egg of choice soft and bite-sized/scrambled, and apple rings	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 310	Continued From page 9	D 310		

mechanical soft.
-There was a listing for a mechanical soft diet which included: French toast bake bite-sized/moistened, egg of choice bite-sized/scrambled, and apple rings mechanical soft.

Review of the facility's diet extensions therapeutic diet menu for breakfast dated 11/12/24, used for breakfast meal on 11/20/24 revealed:
-There was a listing for a mechanical soft chopped diet which included sausage link diced/gravy.
-There was a listing for a mechanical soft diet which included sausage link ground meat/gravy.

Observation of Resident #4 during meal service on 11/20/24 from 8:14am-10:15am revealed:
-Resident #4 was served a whole piece of French toast, 2 whole sausage links, scrambled eggs, and diced peaches.
-The French toast was not bite-sized/moistened.
-The sausage links were not diced/gravy or ground meat/gravy.
-Resident #4 did not have any issues eating her meal and ate 100% of the meal.

Interview with Resident #4 on 11/20/24 at 4:45 PM revealed:
-She had no issues eating or swallowing.
-She had been taken off the "baby food diet".
-She did not like her food mashed or chopped and preferred regular food.
-She had no throat or swallowing issues.
-She thought the diet change happened when she went to the hospital but could not explain further.
-She did not remember what she had for breakfast.

Interview with the dietary manager (DM) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

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D 310	Continued From page 10 11/19/24 at 10:56am revealed: -The Resident Care Coordinator (RCC) updated him when a new resident came in or a diet changed by bringing him the diet order. -He kept the diet orders in a book in his office. Second interview with the DM on 11/20/24 at 8:48am revealed: -Resident #4's sausage was supposed to be ground, and the French toast was supposed to be bite sized/chopped. -He was not aware Resident #4 was served a plate with 2 whole sausage links and a whole piece of French toast. -He did not know why Resident #4 was served a regular diet plate. -His concern with Resident #4 being served a regular diet plate was the risk of choking. -He did an in-service with all the dietary staff, so they were aware Resident #4 was not supposed to be served a regular diet plate. -There were new personal care aides (PCA) assisting today and they were not aware of the diet orders. -He usually prepared the regular diet plates first and the therapeutic diet plates last. -He was not made aware when Resident #4's plate was served. Interview with the RCC on 11/20/24 at 9:49am revealed: -They primary care provider (PCP) determined the diet orders. -Every Monday she printed a report on diet orders and gave it to the DM. -The DM prepared the plates. -Dietary Aides (DA) and care staff assisted in serving resident plates. -DAs and care staff should have been aware of the diet orders for each resident.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 11 -Resident #4 was on a regular diet and that diet was changed during her last hospitalization to puree due to swallowing issues while in the hospital. -Resident #4's PCP changed her diet from puree to mechanical soft entire meal with chopped meats because Resident #4 did not want the puree diet. -She was not aware Resident #4 was served a regular plate until the DM told her today. -Resident #4 had been getting a mechanical soft entire meal, chopped meats diet. -She did not know why chopped meat was not selected on the diet order that was kept in the DM's office. -She did not know why Resident #4 was served a regular diet plate. -She had already notified the PCP that Resident #4 was served a regular diet plate. Interview with the Administrator on 11/20/24 at 10:21 AM revealed: -The PCP did the diet orders. -The RCC received diet orders from the PCP upon admission or when there was a change. -Diet order changes were immediately communicated to the DM when received and every Monday. -The DM and cook prepared the plates and were to ensure the plates went to the correct residents. -DAs served plates and care staff assisted. -When Resident #4 went to the hospital, she returned with a diet order that had become mechanical soft, chopped. -The concern with Resident #4 receiving a regular diet plate was the risk of choking. -The expectation was that the diet order be communicated to the DM. -The RCC was responsible for communicating the diet order to the DM.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033006	A. BUILDING: _____ B. WING _____	R 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES OF HENDRICKS CREEK	3210 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 12 -He was not aware Resident #4 was served a regular diet plate until the DM told him. -He did not know why Resident #4 was served a regular diet plate. -The PCP had been notified that Resident #4 was served a regular diet plate. Interview with Resident #4's primary care provider (PCP) on 11/20/24 at 1:45 PM revealed: -She believed Resident #4's diet was mechanical soft. -She was not sure if Resident #4 was to be served chopped meats. -The diet order may have been an order from the hospital. -Residents usually came into the facility with a diet order upon admission. -Her first time seeing Resident #4 was October 2024. -She did not recall signing the diet order for mechanical soft entire meal with chopped meats on 10/17/24. -She was informed today that Resident #4 was served a regular diet plate at breakfast. -She was informed by the RCC today that Resident #4 wanted a regular diet. -The concern with Resident #4 receiving a regular diet plate, while on a mechanical soft diet, would be the risk of aspiration because Resident #4 was put on the mechanical soft diet for a reason. -She was informed by the RCC that Resident #4 would not eat the puree diet and that was why the diet was changed to mechanical soft.	D 310		