STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RESIDENTIAL SERVICES, INC. RETIREMENT CENTER	6310 MOUNT HERMAN CHURCH ROAD DURHAM, NC 27705

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W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations and record reviews, the facility failed to assure all staff were competently trained to monitor when a client self-medicates by verifying she does so with accuracy. This affected 1 of 5 audit clients (#9). The finding is: Staff did not ensure the accuracy of client #9's dry eye drops when she administered them. During observations on 7/8/19 and 7/9/19, client #9 administered her own eye drops. A. During observations on 7/8/19 at 12:10pm, client #9 received artificial tears. She administered the drops independently herself and missed her left eye completely. B. During observations on 7/9/19 during the 8am medication pass, client #9 administered her own medications and dropped numerous (more than 4) drops in each eye. Interview of Staff A and Staff B on 7/9/`9 revealed neither staff realized she had not administered the correct number of drops in her eye. Review on 7/9/19 of the physician orders dated 6/26/19 revealed client #9 should receive "artificial tears solution 1.4%...one drop in each eye 4 times a day....8am, 12pm, 4pm, and 8pm."	W 189		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 189	Continued From page 1 Further review on 7/9/19 of client #9's assessment confirmed she is completely independent at administering eye drops. Interview with the Clinical Coordinator Registered Nurse (CCRN) #1 and the CCRN #2 on 7/9/19 confirmed that based on the observations, staff were not utilizing their training and were not competently verifying the self-medication administration of client #9's drop	W 189		
W 361	PHARMACY SERVICES CFR(s): 483.460(i) The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that their stock supply of medication was available for as needed (PRN) drug administration for 1 of 5 audit clients (#14). The finding is: The facility failed to re-order saline spray once the last bottle was used. During observation of medication administration on 7/8/19 at 5:03 pm, client #14 had just finished taking his scheduled medication, when he started sniffling. The nurse, passed client #14 two tissues and he began to blow and wipe his nose. The nurse asked client #14 if she could examine his	W 361		

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W 361	Continued From page 2 nose and he consented. The nurse put on gloves, grabbed a small flashlight, then looked up both nostrils of client #14. Afterwards, the nurse searched the medication cart and could not find the medication. The nurse then used a step ladder to open the medication cabinet and look in client #14's medication basket and still could not find the saline spray that she was looking for. The nurse asked client #14 how long had his nose been stuffy and he responded that it just started today. Review on 7/8/19 of client #14's current physician orders revealed an order that originated on 9/20/16 prescribed the use of saline spray for nasal congestion, prn. Interview on 7/9/19 at 8:15 am with the clinical coordinator registered nurse #1 (CCRN#1) revealed that she was unaware that client #14 did not have saline spray available for prn use. CCRN#1 shared that she was on call last night and their procedure required the nurse on duty to contact her regarding any emergency drugs that needed to be ordered with pharmacy, after 5:00 pm. She did not get any call. CCRN#1 suggested that the medication might not have been pursued by the nurse because the nurse might have determined that the spray was not necessary, if she re-assessed client #14 later. CCRN#1 went to double check the med cart and shared that the last bottle of saline spray was used on another client, on unknown date. CCRN#1 was not certain why the nurse did not re-order then.	W 361		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment	W 454		

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W 454	Continued From page 3	W 454		

to avoid sources and transmission of infections.

This STANDARD is not met as evidenced by:
Based on observation, record review and interviews, the facility failed to prevent cross contamination during mealtime for 1 of 5 audited clients (#3). The findings are:

Staff failed to remove all touched stir fry chicken that client #2's hand came into contact with, while serving herself at the kitchen steam table.

During observations of dinner on 7/8/19 at 5:55 pm, client #4 stood in line with other clients, to enter the kitchen to self serve food on plate. Two staff stood at the steam table, as each client approached the prepared food. Client #2 was handed a large serving spoon to scoop rice on her plate. Client #4 was then verbally prompted to scoop a serving of stir fry on her plate. After client #2 placed the stir fry on her plate, she then reached with her left hand and placed her fingers into the container of cooked stir fry. Staff A immediately blocked client #2's hands from grabbing the food. Client #2 was given the spoon again, and scooped a 2nd serving, and a piece of chicken fell off the spoon and client #2 went to grab it. Staff A picked up the chicken so that it would not fall back into the container of cooked food. Food that had fallen off of the spoon was scooped out of the pan, however, food that client #2 had touched in the opposite corner of the pan, was not removed by staff. Three clients, which included client #3 were still waiting to eat. After client #2 blended her food, plates were made for the remaining three clients, from the same stir fry container.

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W 454	Continued From page 4 Review on 7/8/19 of client #2's individual personal plan (IPP) dated 4/15/19 revealed that she had difficulty waiting for meal time. In additional a behavior assessment, dated 4/30/19 indicated that client #2 became agitated on a predictable basis prior to meals and snacks. Interview on 7/9/19 at 8:40 am with the clinical coordinator RN (CCRN#1) revealed that client #2 needed to be supervised while in the kitchen because she will overeat. CCRN#1 shared that client #2 does very well while scooping her food when at the steam table. CCRN#1 was not aware that client #2 had touched the stir fry mix left in the container last night at dinner. CCRN#1 shared that when food became contaminated staff should try to remove the food that was touched, if possible or prepare more food if other clients still needed to eat.	W 454		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to follow dietary guidelines for 1 of 5 clients (#2) on a mechanically altered diet. The finding is: Client #2 did not receive a pureed diet at dinner. During meal observations on 7/8/19 at 5:55 pm, client #2 had stir fry for dinner which contained rice, peas, carrots and chicken. Client #2	W 460		

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Continued From page 5

scooped the contents of the food on her dinner plate, then was accompanied by staff A to the blender in the kitchen. Client #2 pushed the button on the appliance twice to blend food before staff A added a few ounces of chicken broth to the mixture and continued to blend. The food was transferred from the blender into a bowl. Client #2 returned to the dining table and began to eat the food quickly, with a large spoon. The texture of the food was observed. There were small pieces of carrots, grains of rice and coarse texture to the mixture. Client #2 ate all of her food, without observed difficulty.

Review on 7/9/19 of client #2's meal and snack guidelines, which were updated June 2019, revealed that client #2 had a history of eating large bites very quickly. Client #2 was on a pureed diet, which was defined as "blend until pureed or smooth, with no lumps."

Interview on 7/8/19 at 6:00 pm with staff A revealed that when asked by surveyor to describe the texture of client #2's food, staff A responded, "I'm not sure", then continued saying that the food "just had to be softened, depending on what it is." Staff A commented that she has been cooking at the facility since September 2017 and had never been told that she needed to prepare a pureed smooth texture for client #2. Staff A claimed the nutritionist told her that client #2 needed her food broken into small, bite size pieces due to client #2 not having teeth and eating rapidly. Tonight, she added broth to the food to help break down the chunky pieces of chicken and vegetables.

Interview on 7/9/19 at 8:00 am with the clinical coordinator registered nurse (CCRN#1) confirmed that client #2 was on a pureed diet.

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W 460	Continued From page 6 The dentist and primary care physician of client #2 had recommended a pureed diet because client #2 did not have any teeth. Foods that included oatmeal, mashed potatoes, or chicken noodle soup that had a soft texture did not have to be pureed. Otherwise, client #2's food was expected to have a smooth, lump free texture, when served.	W 460		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to serve food at appropriate hot temperature for 1 of 5 audited clients (#2). The finding is: The facility did not reheat oatmeal for client #2, after extensive standing time at room temperature. During an observation at breakfast on 7/9/19 at 6:40 am, staff C had prepared oatmeal, toast, sliced oranges and coffee for the resident's breakfast. At a table was a plate of covered food for client #14 who had not entered the dining room yet. Client #14 entered the dining room at 6:50 am, his plate was reheated before he ate, by staff C. Client #2's bowl of oatmeal was left covered for her on the table at 6:55 am, by staff C. At 7:39 am, client #2 independently entered the dining room and immediately began to eat the oatmeal. Staff B entered the dining room at 7:41 am, sitting next to client #2. There were no offers to reheat the oatmeal and client #2 finished all	W 473		

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W 473	Continued From page 7 food in her bowl. Interview with the clinical coordinator registered nurse (CCRN#1) on 7/9/19 at 8:10 am, revealed that it was sufficient for oatmeal to be eaten by clients, if left out for 20 minutes, but then the hot food should be reheated.	W 473		