STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002007	A. BUILDING: _____ B. WING _____	03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A NEW OUTLOOK OF TAYLORSVILLE	360 WOOD ROAD TAYLORSVILLE, NC 28681

(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 Alexander County Department of Social Services conducted an annual survey on March 15 and 16, 2018.	D 000		
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 and interviews the facility failed to assure the facility was maintained in an clean and orderly manner, free of all obstructions and hazards related to the improper storage of oxygen tanks creating a potential mechanical hazard, an electrical cord laying across the floor in a resident room and plugged into an outlet under a hand sink creating a potential trip hazard and an electrical hazard (Room #9). The findings are: 1. Observations on 3/15/18 at 11:00am in the medication room revealed: -There were six oxygen tanks being stored behind the door inside the medication room. -Two of the tanks were in 2-wheeled oxygen tank carriers.	D 079	Rule 10A ncac 13F .0306(a)(5) met as evidenced by all hazards will be removed by 3/15/18. All staff will be trained on potential hazards and to correct them immediately. To prevent further occurences staff will check all areas in the facility daily for potential hazards. Supervisor will monitor weekly, RCC will monitor weekly and Administrator or designee will monitor monthly.	3/15/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa Matos | TITLE: Administrator | (X6) DATE: 4/11/18

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D 079	Continued From page 1 -A nasal cannula tubing was attached to a regulator on each of these tanks and the tubing was laying on the floor. -The remaining four tanks were sitting directly on the floor and were not physically supported in an oxygen stand or rack. (This requirement is intended to prevent mechanical hazards caused by a sudden release of gas if a tank falls over.) -Two of the tanks sitting directly on the floor had white plastic seals indicating they had not been used and were full tanks. Interview on 3/15/18 at 11:00am with the medication Aide (MA) revealed: -The oxygen tanks were for Resident #4 in Room #9. -The resident had a concentrator in her room that she used on a regular basis. -She did not know why the tanks were sitting directly on the floor and not physically supported in a stand or rack. -She did not know of the danger associated with improperly stored oxygen tanks. Interview on 3/15/18 at 11:30am with the Assistant Administrator revealed: -Resident #4 had an oxygen concentrator and also had several oxygen tanks on hand for when she needed them. -She did not know why the empty tanks had not been picked-up by the oxygen company when they were at the facility. -She did not know why the tanks were sitting directly on the floor in the medication room and not in a rack. -She did not know of the danger associated with improperly stored oxygen tanks. Interview on 3/16/18 at 10:30am with the Administrator revealed:	D 079		

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D 079	Continued From page 2 -When Resident #4 came to the facility, the resident communicated with the oxygen company and ordered what she needed. -The resident calls the company and orders supplies when she needs them. -The company that supplied the resident's oxygen also provided the tubing and other supplies on a regular basis. -The oxygen company checked to make sure there were several full tanks for her to use if she needed them. -She did not know why the oxygen company had not removed the empty tanks. -The oxygen tanks had been in a rack but she did not know where the rack had gone. -She did not know of the danger associated with improperly stored oxygen tanks. Interview on 3/16/18 at 12:15pm with Resident #4 revealed: -The resident had been on oxygen prior to being admitted to the facility. -She had called and arranged for her oxygen company to come to the facility. -The oxygen company came out monthly to bring her supplies and to check the compressor in the concentrator. -She had an oxygen concentrator in her room but no oxygen tanks. -The MA kept her oxygen tanks in the medication room. Interview on 3/16/18 at 1:30pm with the Administrator revealed she had located the oxygen rack in a resident's closet, returned it to the medication room and the oxygen tanks were properly stored in the rack. 2. Observation of Room #9 on 3/15/17 at	D 079		

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D 079	Continued From page 3 10:00am revealed: -There were two residents in the room. -An oxygen concentrator was on the floor beside the head of the bed on the left wall with the electrical cord extended from the oxygen concentrator across the floor to an outlet under the hand sink. -The electrical cord was approximately 8 feet in length. Interview with Resident #4 who resided in Room #9 on 3/15/17 at 10:00am revealed: -She used the oxygen concentrator. -She did not know who plugged in the concentrator and did not know how long it had been plugged into the outlet under the sink. -She had not tripped on the electrical cord and did not know of anyone who had tripped on the cord. Interview with the Assistant Administrator on 3/15/17 at 11:40am revealed: -She did not know who plugged in the oxygen concentrator and did not know how long it had been plugged into the outlet under the sink. -She said it was currently a trip hazard but she would move it to another outlet.	D 079		
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:	D 273		

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D 273	Continued From page 4 TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to follow-up with the physician when 1 of 3 sampled residents (Resident #3), with an order to notify the physician if a cough persisted longer than 48 hours, developed a cough that became more severe over a 5 day period resulting in hospitalization of the resident. The findings are: Review of Resident #3's current FL2 dated 2/16/18 revealed: -Diagnoses included pylonephritis (kidney infection) with sepsis (a life threatening complication of infection); resolving delirium and acute renal injury (the kidneys suddenly can not filter waste from the blood). -Medications ordered included Ceftin (an antibiotic) 250mg, twice a day for 7 days; and Robafen CF liquid 10ml every 4 hours as needed (for nasal congestion, cough and chest congestion). Observations on 3/15/18 during the initial tour of the facility revealed Resident #3 was in her room and constantly coughing and could be heard throughout the facility. Interview on 3/15/18 at 9:45am with Resident #3 revealed: -She had difficulty speaking due to the cough. -"I have a bad cough and I'm sick". -"I feel so bad I want to die." Review of a Physician's Order sheet in Resident #3's record revealed: -There was an order for "Robafen (cough syrup)	D 273	Rule 10A NCAC 13F .0902(b) met as evidenced by facility will evaluate and send requests for all healthcare referrals. Facility will notify residents primary MD of all changes of health status. To prevent further occurrence, Med techs and direct care staffwill monitor daily, RCC or designee will monitor weekly, Administrator or designee will monitor quarterly and as needed.	4/15/18

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D 273	Continued From page 5 100mg/5ml by mouth every 4 hours as needed for cough/congestion. Notify MD if cough persists longer than 48 hours". -The Nurse Practitioner (NP) had signed the orders on 2/19/18. Review of Resident #3's Medication Administration Record (MAR) for March 2018 revealed: -There was an entry for Robafen 100mg/5ml by mouth every 4 hours as needed for cough/congestion. Notify MD if cough persists longer than 48 hours". -The Robafen had been documented as administered on 3/10/18 at 7:58am with results "slightly effective", on 3/11/18 at 3:11am with results "effective", on 3/12/18 at 7:20am with results "effective", on 3/13/18 at 2:00am with results "not effective" and on 3/15/18 at 9:55am with results "slightly effective". Review of the staff notes in Resident #3's record revealed there had been no staff documentation of Resident #4's feeling sick her worsening and persistent cough. Interview on 3/15/18 at 9:45am with the medication aide (MA) revealed: -Resident #3 had been coughing for several days and "the cough seemed to be getting worse". -The resident had been "coughing quite a bit this morning". -The resident had an order for cough syrup and she would administer this to the resident. -She did not know why the cough syrup had not been administered more frequently. -The NP had been at the facility on Monday (3/12/18) and was scheduled to see the resident that day. -The NP had left the facility before seeing the	D 273		

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D 273	Continued From page 6 resident because it started to snow and she would see Resident #3 the following Monday (3/19/18). -She had not notified the NP on 3/12/18 of Resident #3 worsening cough. Interview on 3/15/18 at 11:00am with the Assistant Administrator revealed: -Resident #3 had been coughing "for several days". -The MA's had been giving her cough syrup. -The NP had been to the facility on Monday (3/12/18) and was scheduled to see Resident #3 for a routine visit. -The NP did not see the resident because it started snowing and she left the facility. -The NP would be back at the facility on Monday (3/19/18) and would see Resident #3 at that time. -She had not notified the NP on 3/12/18 of Resident #3 worsening cough. Observations on 3/16/18 at 7:30am of Resident #3 revealed her coughing was frequent and intense. Interview on 3/16/18 at 7:35am with the Administrator revealed: -She was a MA and had worked from 6:00pm until 6:00am "several nights before". -Resident #3 had been coughing, "but her cough is worse than the other night when I worked". -The resident had an order for cough syrup and the staff had been administering it but it "didn't seem to be helping". -"There is a NP who comes to the facility on Mondays and sees each resident at least monthly, more often if necessary." -"Resident #3 was scheduled to be seen by the NP this past Monday (3/12/18) but it started to snow and she had to leave."	D 273		

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D 273	Continued From page 7 -The NP would see Resident #3 the following Monday (3/19/18). -The Administrator did not know the cough syrup ordered on 2/19/18 specifically stated "Notify MD if cough persists longer than 48 hours". -She had not notified the NP Resident #3 had a worsening cough unrelieved by the cough syrup. Interview on 3/16/18 at 2:00pm with the Administrator revealed: -"Around 10:00am this morning, I had tried to get Resident #3 to go to the hospital but she refused." -The Administrator had notified the NP and she ordered a mobile chest xray for Resident #3. -The facility had faxed the chest xray request marked "Urgent" to the mobile xray company on 3/16/18 at 10:30am. Attempted telephone interview on 3/16/18 at 11:05am with the NP caring for Resident #3 was not successful. Review of Resident #3's chest xray report dated 3/16/18 revealed: -The results of the mobile xray taken at the facility: "Small bilateral lower lobe infiltrates. The heart is enlarged." -The primary care provider had written "Hospital" at the bottom of the report. The facility's failure to assure referral and follow-up to meet the acute health care needs of Resident #3 with a worsening cough unrelieved by cough syrup resulted with the resident feeling so badly she stated she wanted "to die" before a mobile chest xray was ordered and the resident was diagnosed with small bilateral lower lobe infiltrates (bilateral pneumonia) and an enlarged heart and was hospitalized. This failure resulted	D 273		

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D 273	Continued From page 8 in substantial risk that death or serious physical harm will occur to the resident and constitutes a Type A2 violation. _____ A Plan of Protection was provided by the facility on 3/19/18 and included the following. -The facility will immediately evaluate and send requests for all health care referrals. -The facility will notify any resident's physician of changes in the resident's health status. -Supervisors and medication aides will ensure all referrals for patient care needs are completed and sent to the appropriate places daily. -The RCC / Management will check weekly to ensure all referrals were followed up on promptly. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 15, 2018.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure for 2 of 2 sampled resident's (Resident #4 and #5) had written orders for oxygen administration in the	D 276	Rule 10A NCAC 13F .0902(c)(3-4) met as evidenced by RCC or designee will oversee, documenting, transcription, faxing, calling, and follow up of all orders daily. SIC will receive oversight of transcription process, faxing, calling and follow up of all orders weekly. Administrator will monitor quarterly and as needed.	4/15/18

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D 276	Continued From page 9 resident's records. The findings are: 1. Observation on 3/15/18 at 11:30am of the oxygen equipment in Resident #5's room revealed: -There was an oxygen concentrator beside the resident's bed. -Attached to the top of the concentrator was a "Home Oxygen Refill System" (a system which refills high-pressure oxygen tanks from a concentrator). -There was a small ambulatory tank attached to the refill system (Ambulatory tanks weigh less than 10 pounds, are designed to be carried by the resident and will last 4-6 hours at a setting of 2 liters per minute.) -There were several additional ambulatory tanks in shoulder carriers on the floor in front of the concentrator. -The concentrator was set at 3 liters per minute. Review of Resident #5's current FL2 dated 11/13/17 revealed: -Diagnoses included heart "diagnosis" (disease) and hypertension. -Physician's orders did not include oxygen. Review of Resident #5's Care Plan dated 7/31/17 revealed: -The resident had been admitted to the facility on 7/31/17. -The resident "uses O2"(oxygen). -There was no other documentation regarding the oxygen. -The care plan had been completed by the Assistant Administrator. Review of Resident #5's Licensed Health	D 276		

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D 276	Continued From page 10 Professional Support (LHPS) review and evaluation dated 10/18/17 revealed: -The resident had a personal care task of "Oxygen administration and monitoring". -There was no documentation of why the oxygen had been prescribed, when the oxygen was to be used or the oxygen flow rate (liters per minute). Review of the Nurse Practitioner (NP) notes in Resident #5's record dated 11/27/17 revealed: -He had been seen on a routine visit but had "a continued cough and wheeze" and had been treated for bronchitis. -There was no documentation regarding the resident's oxygen. Review of the Nurse Practitioner (NP) notes in Resident #5's record dated 2/5/18 revealed: -He had been seen for "complaints of deep congestion for 4-5 days". -He had told the NP he was "unable to stay off his O2 for long". -He had been treated for sinusitis and bronchitis. -There was no further documentation regarding the resident's oxygen. Review of the physician's/NP orders in Resident #5's record revealed there was no written order for oxygen. Interview on 3/15/18 at 11:35am with Resident #5 revealed: -"When I came here, the oxygen company from my old place set up my oxygen for me." -"I am on oxygen because my lungs are bad and I can't do much without it". -"I could walk to the end of my bed and maybe over to the sink without it, but I'd be out of breath and would need to put it right back on." -"This (the concentrator) is set on 3. I use the little	D 276		

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D 276	Continued From page 11 tanks when I go to the dining room for meals." Interview on 3/15/18 at 12:30pm with the Assistant Administrator revealed: -She thought there was an oxygen order in Resident #5's record but did not find one. -She did not know why there was no order for Resident #5's oxygen. -She thought the resident was on "2 or 3 liters". -She did not monitor the resident's concentrator or the liters per minute. -The staff did not monitor the amount of oxygen the resident received. Interview on 3/16/18 at 10:30am with the Administrator revealed: -When Resident #5 was discharged for the last facility, the orders that came with him were "incomplete". -There was no oxygen order on the FL2 and she did not know the resident needed oxygen. -The company that had provided oxygen to the resident at his old facility, set up his oxygen at this facility. -She thought there was an order for the oxygen somewhere in his record but none was found. -She thought the resident was on 3 liters of oxygen. -"We (the facility staff) have not had much experience with oxygen." -She would call the physician and get an oxygen order for Resident #5. Interview on 3/16/18 at 10:07am with a technician with Resident #5's oxygen provider revealed: -The resident had been discharged from the one facility and admitted to the current facility on 6/14/17. -The oxygen had been set up the day the resident was admitted according to how it was when he	D 276		

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D 276	Continued From page 12 left the previous facility. -They had not received order changes for Resident #5's oxygen. -A technician goes to the facility once a month to take supplies and check on the equipment. -There was no documentation the facility had ever called the company. -The staff had never requested training or services from the company. 2. Review of Resident #4's current FL2 dated 10/30/17 revealed: -Diagnoses included community acquired pneumonia and COPD (chronic obstructive pulmonary disease). -Physician's orders did not include oxygen. Review of Resident #4's Care Plan dated 10/30/17 revealed: -The resident had been admitted to the facility on 10/30/17. -The resident "uses O2 "(oxygen). -There was no further documentation regarding the resident's oxygen. -The care plan had been completed by the Assistant Administrator. Review of Resident #5's Licensed Health Professional Support (LHPS) review and evaluation dated 1/18/18 revealed: -The resident had a personal care task of "Oxygen administration and monitoring". -There was no further documentation regarding the resident's oxygen. Review of physician's orders in Resident #5's record revealed there was no written order for oxygen. Interview on 3/15/ at 12:30pm with the Assistant	D 276		

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D 276	Continued From page 13 Administrator revealed: -She knew who was providing oxygen and supplies for Resident #4 but she had never contacted the company. -Resident #4 had made all of the arrangements with the oxygen company. Observations on 3/15/18 of Resident #4's room (Room #9) revealed there was an oxygen concentrator, set at 3 liters per minute, beside the resident's bed which was up against the left wall of the room. Interview on 3/16/18 at 12:10pm with Resident #4 revealed: -She had used oxygen at home and the company providing that service was the one she was using at the facility. -She had called the company when she came to the facility and had "set everything up" herself. -She used the concentrator when she laid down during the day and when she slept at night. -"My lungs collapse when I lay down and the oxygen helps keep them open so I can breathe." -"The facility staff calls orders of the things I need to the company like tubing and stuff." -A technician came out every couple of weeks to bring humidifying bottles, hoses and the oxygen tanks. -A technician came out monthly to check the compressor pressure in the concentrator. Telephone interview on 3/15/18 at 4:05pm with a staff person at Resident #5's physician's office stated the resident should be on 3 liters of oxygen per minute and the office would fax over and order to the facility. Interview on 3/16/18 at 2:25pm with the Administrator revealed:	D 276		

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D 276	Continued From page 14 -When Resident #4 was admitted there was no oxygen order on the FL2. -She did not know the resident needed oxygen. -The resident had oxygen at home and she had called the company and they set it up at the facility. -The resident called the company and ordered her own supplies. She thought there was an order for the oxygen somewhere in her record but none was found. -She thought the resident was on 3 liters of oxygen. -In the past, resident's with oxygen were on Hospice and they (Hospice) got the orders, ordered supplies and cleaned the machines. -She would call the physician and get an oxygen order for Resident #4.	D 276		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure there was a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus. The findings are: Observation of the food supply on 3/15/18 at	D 285	Rule 10ANCAC 13F .0904(a)(4) Nutrition and Food Service met as evidenced by the facility will continue to supply at least a five day supply of non perishable food and a three day supply of perishable food in the facility for both regular and therapeutic diets. To ensure continued compliance dietary staff will check food supply daily, RCC or designee will monitor weekly and Administrator will oversee monthly and as needed.	4/15/18

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D 285	Continued From page 15 10:30am compared to the facility's menus for Week 3 Regular menu revealed the facility did not have the following perishable and non-perishable food items for the census of 24 residents to match the facility's regular menus for the day of the survey and the next three days: -Lunch on 3/15/18: squash blend and potato wedges -Dinner on 3/15/18: spinach, -Lunch on 3/16/18: mandarin oranges -Dinner on 3/16/18: split pea soup, lettuce and tomato, fresh fruit for salad, and milk -Breakfast on 3/16/18: English muffins, grits, and milk. -Lunch on 3/17/18: Swiss steak, cabbage, and wheat roll, -Dinner on 3/17/18: turkey, canned tomatoes, wheat bread, and milk -Breakfast on 3/18/18: french toast and milk. Lunch on 3/19/18: corn pudding, cake for pineapple upside down cake -Dinner on 3/18/18: corned beef and sauerkraut for Reuben sandwiches and fresh fruit for dessert. Observation on 3/15/17 at 10:30am revealed: -Three gallons of milk available. -No fresh fruits avaiable for serving. Review of the week-at-a glance menus revealed milk was listed on the menu twice daily. Three gallons of milk was a sufficient supply only to serve 24 residents 1 cup milk for two meals. Review of the food supply on 3/15/18 at 3:00pm revealed there were no sugar free foods or beverages and no caloric free sweetener available for the staff to serve the 7 residents on a No Concentrated Sweets diet or diabetic diet.	D 285		

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D 285	Continued From page 16 Interview with the cook on 3/15/18 at 10:30am revealed: -She started work there in November 2017 but the Administrator and Assistant Administrator ordered the food. -She was not aware of the licensure rule that the facility should always have a three day supply of perishable food and a five day supply of non-perishable foods. -The food truck always came on Thursday and would come "today," since it was Thursday. Interview with the Administrator on 3/16/18 at 3:50pm revealed: -The food truck delivered food today. -The walk-in freezer was temporarily out of order and the owner had been working with a repair man to find the correct parts to repair the freezer. -She had ordered less food recently because of storage issues with the freezer. -It was her policy to have a 3 day supply of perishable food and a five day supply of non-perishable food on hand. Observation of the kitchen on 3/15/18 at 10:30am revealed an upright freezer which was approximately 1/3 full of food.	D 285		
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	Rule 10A NCAC 13F .0904(e)(4) met as evidenced by all therapeutic diets, including nutiritional supplements and thickened liquids, shall be served as ordered by the residents physician. To prevent further occurrence, all nutritional orders will be clarified by physician by med tech, RCC or designee, upon receipt. Med techs will monitor therapeutic diets daily, RCC or designee weekly, and Administrator will oversee quarterly and PRN.	4/15/18

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D 310	Continued From page 17 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 2 of 2 sampled residents (#1, and #2) sampled were served therapeutic diets, Resident #1 a renal diet and renal supplements, and Resident #2 a No Concentrated Sweets diet, as ordered by their prescribing physicians. The findings are: 1. Review of Resident #1's current FL2 dated 9/25/17 revealed: -Diagnosis included end stage renal disease (ESRD). -An order for dialysis 3 times weekly. a. Review of Resident #1's record revealed: -An order from the dialysis center dated 12/29/17 to discontinue Mighty Shakes (a nutritional supplement). -Patient may have one can of Nepro or Novasource (nutritional supplements designed for renal patients) daily. Further review of the resident's record revealed: -An order from the facility provider dated 1/22/18 to discontinue current shake supplement-Mighty Shakes to replace three times daily. -An order from the facility provider to discontinue Nepro liquid. b. Continued review of Resident #1's record revealed: -A diet order dated 12/31/17 from the dialysis center for a 'low potassium diet'. -An order from the facility provider dated 2/19/18	D 310		

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D 310	Continued From page 18 for a regular diet. Interview on 3/15/18 at 2:30pm with the facility's medical care provider revealed: -She had been contacted by the facility for a regular diet order for Resident #1. -She had been contacted by the facility for an order for Mighty Shakes because the resident was not eating well. -The facility told her that Resident #1 did not have a diet order and needed a regular diet order in his record. -The facility did not tell her that Resident #1 had been previously ordered a low potassium diet. -If she had known that Resident #1 was supposed to be on a low potassium diet, she would have not changed his diet. Interview on 3/15/18 at 10:45am with the Assistant Administrator revealed: -The resident's insurance company would not pay for the Nepro or Novasource and that is why the order was changed. -She did not know that Resident #1 should not have Mighty Shakes. -She did not know why the facility physician was contacted about changing Resident #1's low potassium diet. -She was not sure Resident #1 had received a low potassium diet. Interview on 3/16/18 at 10:45am with the dietitian from the dialysis center revealed: -Resident #1 should have been on a potassium restricted diet. -Resident #1 should not have been getting Mighty Shakes. -The resident not getting a low potassium diet and getting Mighty Shakes would explain his elevated potassium levels.	D 310		

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D 310	Continued From page 19 Further review of Resident #1's record revealed: -A lab dated December 2017 with a potassium value of 5.9 (Range 3.5 - 5.2). -A lab dated February 2018 with a potassium value of 6.3 with a notation "'Your potassium is high. THIS IS VERY SERIOUS. Your Dietitian will review your food choices with you." Additional review of Resident #1's record revealed: -The January 2018 medication administration record documented Mighty Shakes 3 times per day as being administered from 4:00pm on the 23 through 4:30pm on the 31st. -The February 2018 medication administration record documented Mighty Shakes 3 times per day as being administered the entire month. -The March 2018 medication administration record documented Mighty Shakes 3 times per day as being administered from 8:00am on the 1st through 8:00am on the 15th. Interview on 3/16/18 at 9:40am with Resident #1 revealed: -"I am not supposed to be eating oranges, lots of potatoes, I can have milk with my cereal." -"I normally get orange juice every morning at breakfast." -"I was told this morning at breakfast that I could not have orange juice anymore". -The resident did not know that he should not be drinking Mighty Shakes. -He drinks Mighty Shakes 3 times every day with his meals. Review of the undated facility modified diet list revealed Resident #1 was not listed on the modified diet list but did have an order for "supplemental shakes."	D 310		

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D 310	Continued From page 20 Observation of the lunch meal on 3/15/18 at 11:45am revealed: -Resident #1 was served fried chicken livers, tater tots, green beans, apple cobbler, tea, and water. -Resident #1 ate all his food. Interview with the cook on 3/15/18 at 12:30pm revealed: -The only menus were the week-at-a-glance menus and she had not seen any modified menus since she started working there. -She started working there November 2017. -The previous cook trained her. -All the residents received the same foods except sometimes the diabetics were served canned fruit in place of dessert. -She did not know when but she had asked the Administrator if they had therapeutic menus but had not received a response. -She made the apple cobbler served at lunch with a "little bit" of calorie free sweetener but ran out and put sugar in the cobbler. -The iced tea that was served to Resident #1 also had sugar in it. -She substituted green beans for the squash blend on the lunch menu. Interview with the Assistant Administrator on 3/15/18 at 2:10pm revealed: -She looked for therapeutic menus "today" and had not found any in the facility. -She and the Administrator had trained the cook to serve the diabetics canned fruit in place of dessert. -She and the Administrator were in charge of food service. Review of the modified menus presented to surveyor on 3/15/18 at 3:30pm revealed:	D 310		

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D 310	Continued From page 21 -There was not a low potassium menu. -There was a Renal Menu. -The Renal lunch menu for 3/15/18 listed beef mini steak, renal starch, and 1/2 cup lemonade for beverage to be served in addition to squash blend, and garlic bread. -There were no explanations in the menu related to what type starchy foods and beverages were appropriate for the Renal diet. Review of the 3/15/18 renal lunch menu compared to what was served to Resident #1 revealed: -A renal starch should have been served in place of potatoes. -Lemonade should have been served in place of tea. -Beef mini steak should have been served in place of fried chicken livers. Observation of the breakfast meal on 3/16/18 at 8:00am revealed Resident #1 was served scrambled eggs, toast, reduced calorie jelly, cornflakes with milk, coffee, but no juice was served. Review of the breakfast Renal Menu for 3/16/18 compared to what was served to Resident #1 revealed: -Oatmeal, egg of choice, toast, renal juice of choice, renal beverage of choice were listed to be served with egg, toast, milk, and jelly. -There was no explanations related to the definitions of renal juices and beverages. -Oatmeal should have been served in place of the cornflakes. -No juice was served but a renal juice should have been served. Interview with the cook on 3/16/18 at 9:40am	D 310		

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D 310	Continued From page 22 revealed: -He did not serve Resident #1 any juice because there was a note posted in the kitchen for Resident #1 not to have any orange juice. -He did not know what juices and beverages were appropriate for residents on a Renal diet. -He did not know Resident #1 was supposed to get oatmeal in place of cornflakes. -He had only been working there as a cook for 2 weeks. -He had worked at another facility as a cook for several years. Interview with the Administrator on 3/16/18 at 1:50pm revealed: -She had just talked to the dietitian at the dialysis center about Resident #1's diet. -Since the facility did not have a Low Potassium diet the dialysis center would fax them an order to give Resident #1 a Renal diet. Review of personnel records revealed the Administrator, the Assistant Administrator, and the cooks had completed the food service orientation training and test. 2. Review of Resident #2's current FL2 dated 2/19/18 revealed: -Diagnoses included diabetes, hypertension, and schizophrenia. -A physician order for a No Concentrated Sweets diet. -Physician orders for fingerstick blood sugars (FSBSs) before meals and at bedtime with sliding scale Novolin R insulin. -Physician orders for Levemir Flextouch 100 units/ml 50 units twice daily and Metformin HCL 1,000 mg twice daily with meals (medications to lower blood sugar).	D 310		

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D 310	Continued From page 23 Review of the undated facility modified diet list revealed: - Resident #2 was not on any therapeutic diet and the list did not include residents on a Regular diet. -The only residents on a modified diet were 6 residents listed as "diabetic diet." Observation of the noon meal on 3/15/18 at 11:45am revealed: -Resident #2 was served fried chicken livers, tater tots, green beans, apple cobbler, tea, and water. -Resident #2 ate all his food and was served seconds on chicken livers and tater tots. Interview with the cook on 3/15/18 at 12:30pm revealed: -The only menus were the week-at-a-glance menus and she had not seen any No Concentrated Sweets menus or any modified menus since she started working there. -She started working there November 2017. -The previous cook trained her. -She had asked the Administrator if they had therapeutic menus but had not received a response. -She knew Resident #2 was a diabetic but currently they did not have sugar free foods available to serve diabetics. -She had made the apple cobbler served at lunch with a "little bit" of calorie free sweetener, but ran out and put sugar in the cobbler. -The iced tea that was served to Resident #2 was also sweetened with sugar. -She substituted green beans on the menu for squash blend and substituted tater tots for potato wedges. Interview with the Assistant Administrator on 3/15/18 at 2:10pm revealed -She looked for therapeutic menus "'today" and	D 310		

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D 310	Continued From page 24 had not found any in the facility. -She and the Administrator had trained the cooks to serve the diabetics canned fruit in place of dessert. -The Administrator would be in the facility on 3/16/18 and maybe she would know where the menus were. -She and the Administrator were in charge of food service. Preview of the modified menus presented to surveyor on 3/15/18 at 3:30pm revealed: -There was a Reduced Concentrated Sweets (RCS) menu but not a No Concentrated Sweets menu . -The RCS menu had sugar free beverage and apple cobbler listed to be served for lunch in addition to fried chicken livers, fried potato wedges, squash blend, and garlic bread. Interview with the Administrator on 3/16/18 at 1:50pm revealed: -The cooks had been trained on how to serve the diabetics and all modified diets. -She did not know the cooks did not have any modified menus to used as guidance. -She ordered the food. Telephone interview with Resident #2's primary care physician on 3/16/18 at 1:00pm revealed the failure to serve Resident #2 a No Concentrated Sweets diet could "adversely affect his glucose levels." Interview with Resident #2 on 3/16/18 at 1:30 pm revealed he had not been on a diabetic diet in "25 years," and that he was not a diabetic. Observation of the morning snacks served to Resident #2 on 3/16/18 at 11:00am revealed he	D 310		

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D 310	Continued From page 25 received 2 regular chocolate chip cookies and milk. Observation of the breakfast meal on 3/16/18 at 8:00am revealed Resident #2 was served scrambled eggs, toast, reduced calorie jelly, cornflakes with milk, and orange juice. Without a No Concentrated Sweets menu available for guidance, the breakfast meal served to Resident #2 could not be determined to be appropriate. Review of the March 2018 Medication Administration Record revealed: -The blood sugars documented at 7:30am were in the range of 99 to 240. -The blood sugars documented at 11:30am were in the range of 90 to 176. -The blood sugars documented at 4:30pm were in the range of 112 to 220. -The blood sugars documented at 8:00pm were in the range of 131 to 222. Review of personnel records revealed the Administrator, the Assistant Administrator, and the cooks had completed the food service orientation training and test. _____ The facility failed to ensure physician ordered therapeutic diets and a nutritional supplement were served as ordered related to a Renal diet and a Renal nutritional supplement for Resident #1 and a No Concentrated Sweets diet for Resident #2. Failure to serve Resident #1 a Renal diet and the incorrect nutritional supplement placed him at risk for less than optimum potassium, phosphorus, protein, sodium, and blood glucose levels. Failure to	D 310		

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D 310	Continued From page 26 serve Resident #2 a No Concentrated Sweets diet placed him at risk for increased blood glucose levels. The failure of the facility to serve therapeutic diets and a nutritional supplement as ordered was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The Plan of Protection provided by the facility on 3/15/18 revealed: -Facility staff will contact the dietitian to make sure the diet menus are in-house. -The dietary staff will be trained to assure diabetics receive the proper nutrition. -The staff will assure sugar free foods are in the facility for the No Concentrated Sweets diet while waiting on the menus. -The supervisor will oversee daily to make sure diets are served appropriately. -Management will oversee weekly and the Administrator will oversee monthly to assure modified diets are served according to physician orders. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 30, 2018.	D 310		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912	Rule G.S. 131D-21(2) Declaration of Residents Rights Refer to corrected tags D273 and D310	4/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002007	A. BUILDING: _____ B. WING _____	03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D912	Continued From page 27 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations in the areas of Health Care and Nutrition and Food Service. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to follow-up with the physician when 1 of 3 sampled residents (Resident # 3), with an order to notify the physician if a cough persisted longer than 48 hours, developed a cough that became more severe over a 5 day period resulting in hospitalization of the resident. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation.)] 2. Based on observations, interviews, and record reviews, the facility failed to assure 2 of 2 sampled residents (#1, and #2) sampled were served therapeutic diets, Resident #1 a renal diet and renal supplements, and Resident #2 a No Concentrated Sweets diet, as ordered by their prescribing physicians. [Refer to Tag 310, 10A NCAC 13F .0904(e)(4)) Nutrition and Food Service (Type B Violation.)]	D912		

Reviewed and Acknowledged by Joseph Cline on 4/23/18 Joseph Cline