STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034028	A. BUILDING: _____ B. WING _____	10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFORK	1345 JONESTOWN ROAD WINSTON SALEM, NC 27103

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 10/02/19 to 10/03/19.	D 000		
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 observations, record reviews, and interviews, the facility failed to assure physician notification for 1 of 5 sampled residents (#3) regarding fingerstick blood sugar (FSBS) readings outside of parameters. The findings are: Review of Resident #3's current FL2 dated 04/26/19 revealed: -Diagnoses included diabetic insulin dependent and vascular dementia. -There was a physician's order to check Resident #3's FSBS after each meal and at bedtime and to notify the physician when FSBS were less than 70 or greater than 300. Review of Resident #3's July 2019 electronic Medication Administration Record (eMAR) revealed:	D 273		

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D 273	Continued From page 1 -There was a computer-generated entry to monitor FSBS four times daily and to notify the Primary Care Provider (PCP) for FSBS less than 70 or greater than 300. -FSBS readings greater than 300 were documented as 335 at 4:00pm on 07/18/19, 321 at 4:00pm on 07/30/19 and 301 at 8:00pm. -There was no documentation on the eMAR related to contact with the physician. Review of Resident #3's record revealed there was no documentation the PCP was notified regarding elevated FSBS in July 2019. Review of Resident #3's August 2019 eMAR revealed: -There was a computer-generated entry to monitor FSBS four times daily and to notify the PCP for FSBS less than 70 or greater than 300. -FSBS readings greater than 300 were documented as 353 at 8:00am on 08/10/19, 301 at 8:00pm, 439 on 8/15/19, 305 at 8:00pm on 8/16/19, 321 at 11:00am on 08/18/19, 342 at 8:00pm on 08/30/19 and 328 at 7:00am on 08/31/19. -There was no documentation on the eMAR related to contact with the physician. Review of Resident #3's record revealed there was no documentation the PCP was notified regarding elevated FSBS in August 2019. Review of Resident #3's September 2019 eMAR revealed: -There was a computer-generated entry to monitor FSBS four times daily and to notify the PCP for FSBS less than 70 or greater than 300. -FSBS readings greater than 300 were documented as 318 at 4:00pm on 09/15/19 and 308 at 8:00pm on 09/24/19.	D 273		

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D 273	Continued From page 2	D 273		

-There was no documentation on the eMAR related to contact with the physician.

Review of Resident #3's record revealed there was no documentation the PCP was notified regarding elevated FSBS in September 2019.

Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.

Interview with a medication aide (MA) on 10/03/19 at 3:22pm revealed:
-She worked first and second shifts.
-The MAs were responsible to contact Resident #3's PCP for FSBS outside of parameters.
-She was aware Resident #3 had an order to contact the PCP when the resident's FSBS were less than 70 or greater than 300.
-When she checked Resident #3's FSBS sometimes the FSBS were greater than 300 and she notified the PCP.
-There were times when she did not notify the PCP because she got busy and forgot to notify the PCP.

Telephone interview with Resident #3's PCP on 10/03/19 at 11:45am revealed:
-There was documentation the PCP had received some notifications the resident's FSBS were greater than 300.
-The PCP wanted to be notified each time the resident's FSBS was greater than 300.

Interview with the Special Care Unit Coordinator (SCUC) on 10/02/19 at 5:00pm revealed:
-She checked Resident #3's eMARs to ensure the physician was notified for FSBS greater than 300.
-In August 2019, her office was moved, and she

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D 273	Continued From page 3 think the notifications were lost. -She was unable to verify she identified Resident #3's FSBS greater than 300 and reported them to the PCP. Interview with the Administrator on 10/03/19 at 2:45am revealed: -The MAs were responsible for contacting Resident #3's PCP for FSBS outside of parameters. -The SCUC was supposed to check Resident #3's FSBS to verify the PCP was notified of FSBS outside of parameters. -In June 2019, the SCUC had a meeting with the MAs to remind them to contact the PCP for FSBS greater than 300.	D 273		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 8 ounces of milk was served twice daily to residents in the Special Care Unit (SCU).	D 299		

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D 299	Continued From page 4 The findings are: Review of the Sping/Summer 2019 breakfast menu for 10/02/19 revealed juice of choice, 8 ounces of milk, coffee or tea were to be served to residents in the SCU. Observation of the SCU breakfast meal service on 10/02/19 from 08:25 am to 8:30 am revealed: -There were 20 residents present for the breakfast meal service. -Milk was not served or offered to 20 residents in the SCU. Interview with the Dietary Manager on 10/02/19 at 9:45 revealed: -Milk was offered to residents three times a day. -Milk was always served at breakfast. -Residents would need to request milk at lunch and dinner. -The kitchen was located in the Assisted Living Unit (ALU) side and the kitchen was used to prepare food for both the ALU and SCU residents. Observation of the walk-in-refridgerator in the ALU kitchen on 10/02/19 at 09:29 am revealed ten gallons of 2% milk were available to be served. Review of the Spring/Summer 2019 lunch menu for 10/02/19 revealed 8 ounces of milk and beverage of choice were to be served to residents in the SCU Observation of the SCU lunch meal service on 10/02/19 from 12:05 pm to 12:55 pm revealed: -There were 20 residents present for the lunch meal service. -Milk was not available in the SCU.	D 299		

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D 299	Continued From page 5 -Staff did not serve or offer milk to the SCU residents. Interview with the Dietary Manager on 10/02/19 at 1:00 pm revealed: -A gallon of milk in ice water should be delivered from the ALU kitchen daily to the SCU dining room for breakfast, lunch, and dinner -She did not know the SCU residents did not get milk for lunch on 10/02/19. -She expected dietary staff to deliver milk for the SCU to serve with meals. Review of the Spring/Summer 2019 dinner menu for 10/02/19 revealed a beverage of choice was to be served to residents in the SCU. Observation of the SCU dinner meal service on 10/02/19 from 05:35 pm to 06:20 pm revealed: -There were 20 residents present for the dinner meal service. -Milk was not available in the SCU. -Staff did not serve or offer milk to the SCU residents. Interview with a personal care aide (PCA) on 10/02/19 at 6:25 pm revealed: -He worked second shift and assisted SCU residents at dinner. -The SCU residents could have requested milk and he had only seen SCU residents request milk one to two times since he started working at the facility. Interview with the Special Care Unit Coordinator (SCUC) on 10/02/19 at 1:00 pm revealed: -She observed meals in the SCU every day. -A gallon of milk in ice water was usually delivered to the SCU for breakfast and lunch. -She did not know the SCU residents did not	D 299		

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D 299	Continued From page 6	D 299		

receive milk for lunch on 10/02/19.
-She did not know why the milk was not delivered to the SCU for lunch on 10/02/19.
-The SCU staff knew the residents who drank milk and staff would generally offer those residents milk with their meals.
-The kitchen staff would send prepoured cups of tea and water for every meal.
-The kitchen staff did not send individually poured cups of milk to the SCU.

Interview with a second PCA on 10/03/19 at 09:45 am revealed:
-She assisted with setting the tables, setting out beverages, serving meals, and provided meal assistance to SCU residents.
-She worked on 10/02/19 and she did not know why the SCU residents were not served milk.
-She knew milk should be served to SCU residents two times a day.
-Some SCU residents did not drink milk when it was served, and milk was being wasted.
-The SCU residents were usually served milk for breakfast and lunch, but the residents were not served milk every day of the week.
-Milk was not served to residents two times a week.
-Milk was delivered to the SCU in individual cups and a gallon of milk on ice was available for cereal.

Interview with a third PCA on 10/03/19 at 09:52 am revealed:
-She assisted with serving meals, setting the tables, and setting out beverages for SCU residents.
-The SCU residents were served milk every day for breakfast and lunch.
-The SCU staff sometimes had to remind the kitchen staff to send milk for lunch.

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D 299	Continued From page 7 -She knew milk should be served to SCU residents two times a day. -Individual cups of milk were delivered from the kitchen, and occasionally SCU staff poured milk from the gallon of milk into individual cups for SCU residents. Interview with the Administrator on 10/03/19 at 2:30 pm revealed: -She knew milk was to be served to residents twice daily. -Milk was delivered to the SCU by the gallon in ice water for breakfast and lunch. -She did not know milk was not served to SCU residents on 10/02/19. -She expected dietary staff to serve milk twice daily. -She expected the SCUC to observe meals and ensure milk was served to the SCU residents twice daily.	D 299		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each	D 468		

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D 468	Continued From page 8 employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff E) in the Special Care Unit (SCU) had completed 20 hours of training within the first six months of hire. The findings are: Review of Staff E's, medication aide (MA) personnel record revealed: -Staff E was hired on 03/19/19. -There was documentation Staff E had completed 6 hours of special care unit (SCU) orientation on 03/20/19. -There was no documentation Staff E completed the additional required 20 hours of SCU training during her first six months of employment at the facility. Attempted telephone interview with Staff E on	D 468		

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D 468	Continued From page 9 10/03/19 was unsuccessful. Interview with the Administrator on 10/03/19 at 11:50am revealed: -She was responsible to ensure staff completed trainings. -She was aware Staff E did not complete 20 hours of SCU training within the first six months of employment at the facility. -Staff E previously worked at a sister facility in 2017 and had completed 20 hours of SCU training at that facility. -Although Staff E left employment with the company in 2017, she thought 20 hours of SCU training would transfer.	D 468		