Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041073	A. BUILDING: _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER HARBOUR	630 WHITTIER AVENUE HIGH POINT, NC 27262

(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 Licesnure Section conducted an annual survey on 09/22/21 and 09/23/21.	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, facility failed to ensure physician notification for 3 of 5 sampled residents (#2, #4 and #5) with orders to monitor a facial lesion and a referral to a dermatologist (#2), a resident with an order for TED (thrombo-embolus deterrent) hose (#5), and a resident with an order for Vitamin B12 laboratory work (#4). The findings are: 1. Review of Resident #2's current FL2 dated 02/22/21 revealed diagnoses included hypertension, iron anemia, chronic kidney disease, dementia, chronic pain syndrome, and chronic diastolic-systolic congestive heart failure. Review of Resident #2's primary care physician's (PCP) progress note dated 03/16/21 revealed: - A diagnosis of dermatitis. -An order for hydrocortisone 1% twice daily to right side of face for 1 week and monitor for changes. Review of Resident #2's physician's order dated 08/18/21 revealed an order for hydrocortisone cream 1% apply small amount to facial lesion twice daily for 14 days.	D 273	TAG D 273 – Health Care 1. Measures put in place to correct the deficient practice: • A checklist will be completed when a referral has been ordered, to ensure adequate follow through for the health care need identified. (see attached form) • A book with information regarding ordered labs will be used to ensure adequate follow through for ordered lab work and any subsequent orders attached to the results. (see attached form for book) • An EMR printout will be used to monitor for omissions of any ordered medications or treatments with the physician being informed if more than 3 omissions occur. 2. Measures put in place to prevent the problem from occurring again: • New orders for referrals will be given to The Nursing Coordinator by the staff receiving the order. • The Nursing Coordinator will create the referral checklist.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 10/11/21

Received and acknowledged 10/13/21

[signature]

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D 273	Continued From page 1 Review of Resident #2's PCP's physician visit and progress note dated 08/18/21 revealed: -Will do a trial of hydrocortisone cream to right side of face for longer duration. Monitor for changes. -If no change talk with family regarding dermatology consult. Review of Resident #2's August 2021 electronic medication administration record (eMAR) revealed: -There was an entry for hydrocortisone 1% topical cream to facial lesion twice daily for 14 days scheduled at 8:00am and 8:00pm. -Hydrocortisone cream was documented as applied from 08/19/21 to 08/31/21. Observation of Resident #2 in her room on 09/22/21 at 10:00am revealed: -There was a lesion noted on the resident 's right side of her face located between her cheek and jaw line. -The lesion was flat, 4 centimeters (cm) in size with a pink outline around the edges of the lesion with white crusty areas in the center of the lesion. Interview with Resident #2 on 09/22/21 at 10:05am revealed: -She had a wound on the right side of her face and it was painful to touch and it itched. -The wound on the right side of her face had been there for a couple of months. -She asked staff multiple times to do something about the wound and staff had done nothing. -Nobody had applied cream to her face in a long time. Interview with Resident #2's PCP on 09/22/21 at 4:25pm revealed:	D 273	• The Nursing Coordinator will review the referral checklists weekly for follow-up and ensure that the resident, resident RP and medical provider are all kept informed of the progress of the referral including any new orders or appointments. • Staff will use established Lab Book/tracker to check off that adequate steps are taken for lab orders received, labs scheduled for collection and results are received and given to the medical provider for review • The RCD/MCC/designee will review the lab book/tracker weekly (x4), then monthly (x5) to ensure that all steps are completed per protocol. • The Nursing Coordinator will run a weekly EMR report of documented medication/treatment omissions and will notify the RCD/MCC if any have been omitted 3 or more times. • The RCD/MCC will notify the medical provider of omissions. • EMR audit information will be kept in a binder. Information will be reviewed and verified bi-weekly (x 4) and then monthly (x 5) by the RCD/MCC. • Staff will be trained on protocols for handling referrals/consults, new orders, lab protocols and medication/treatment omissions. • Staff will be trained on importance of frequent monitoring and reporting during changes in condition.	

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D 273	Continued From page 2 -She last saw the resident at the end of July 2021 and she was not evaluated for the lesion on her face at that time. -She had ordered the hydrocortisone cream in August 2021 for 14 days and for staff to evaluate the lesion at the end of the hydrocortisone treatment and if no improvement she would have either ordered a stronger steroid cream, extended the course of treatment, or dermatology consult. -Staff had not contacted her about the lesion on Resident #2's face. -Since she had not been notified by staff about Resident #2's lesion and response to treatment, she assumed the lesion improved. -She expected staff to contact her if the lesion on Resident #2's face had not improved, and she was not aware the lesion had not improved. Interview with the Resident Care Director (RCD) on 09/23/21 at 8:45am revealed: -Resident #2 had not complained about the lesion on her face. -When she saw the lesion on Resident #2's face on 08/18/21 the skin in the lesion was raised. -She had not looked at the lesion since 08/18/21 until 09/22/21. -She had not contacted Resident #2's PCP about the lesion on the right side of Resident #2's face. -She expected staff to notify her if the lesion did not improve with the course of hydrocortisone cream. -Staff did not notify her of any changes to the lesion on Resident #2's right side of face. Interview with an MA on 09/23/21 at 9:05am revealed Resident #2 had not complained about the lesion on her face. Interview with a personal care aide (PCA) on 09/23/21 at 9:35am revealed:	D 273	• The RCD/MCC will present a report to the Quality Assurance Committee for at least six months or until problems are determined to be resolved. 3. Who will monitor the situation to ensure it will not occur again: • Referrals/Omissions: The Nursing Coordinator • Labs/EMR Audits: Resident Care Director (RCD), Memory Care Coordinator (MCC) or designee • The QA Committee 4. How often the monitoring will take place: • Referrals: Weekly by Nursing Coordinator • Labs: Weekly x 4, then Monthly x 5 by RCD/MCC • EMR Audits: Bi-weekly x 4, then Monthly x 5 by RCD/MCC • Referrals/Labs: Quarterly by • QA Committee	11/5/21

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D 273	Continued From page 3	D 273		

-The lesion on Resident #2's right side of her face began as a pea-sized area about a month ago.
-The PCAs were supposed to notify the medication aide (MA) and the MA was then supposed to notify the Resident Care Director (RCD) with any changes to the lesion.
-She had notified the previous MA about the lesion one month prior when she had first noticed it. She had not notified any other staff about the lesion on Resident #2's face.

Interview with Administrator on 09/23/21 at 1:00pm revealed:
-He was not aware of the lesion on Resident #2's face.
-The RCD was responsible for follow up and referral to physicians and he was not sure if one was made for Resident #2.

2. Review of Resident #5's current FL2 dated 06/02/21 revealed diagnoses included hypertension, diabetes mellitus type 2, and hyperlipidemia.

Review of Resident #5's primary care provider's (PCP) progress note dated 06/16/21 revealed:
-The chief complaint/nature of the presenting problem for the visit was bilateral lower extremity edema.
-There was an order for TED hose on every day and off every evening.

Review of Resident #5's electronic Treatment Administration Record (eTAR) for July 2021 revealed:
-There was an entry for TED hose apply to bilateral lower extremities every morning between 5:00am and 7:00am and off every day at bedtime between 8:00pm and 11:00pm.
-There was documentation TED hose were

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D 273	Continued From page 4 applied 9 of 31 opportunities and removed 16 of 31 opportunities in from 07/01/21 through 07/31/21. -There was documentation TED hose were not applied due to "refused and did not administer." -There was documentation TED were not removed due to "not applied in the a.m., was not on, did not administer, not wearing, and refused. Review of Resident #5's eTAR for August 2021 revealed: -There was an entry for TED hose apply to bilateral lower extremities every morning between 5:00am and 7:00am and off every day at bedtime between 8:00pm and 11:00pm. -There was documentation TED hose were applied 16 of 31 opportunities and removed 20 of 31 opportunities in from 08/01/21 through 08/31/21. -There was documentation TED hose were not applied due to "refused, not applied, missing, and need a new pair." -There was documentation TED were not removed due to "not applied in the a.m., refused, and TED hose were not on. Review of Resident #5's eTAR for September 2021 revealed: -There was an entry for TED hose apply to bilateral lower extremities every morning between 5:00am and 7:00am and off every day at bedtime between 8:00pm and 11:00pm. -There was documentation TED hose were applied 12 of 23 opportunities and removed 12 of 22 opportunities in from 09/01/21 through 09/23/21. -There was documentation TED hose were not applied due to "refused, other, need replacement, and missing." -There was documentation TED were not	D 273		

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D 273	Continued From page 5 removed due to "TED hose were not on, refused, and not applied." Observation of Resident #5 on 09/22/21 at 9:44am and 12:50pm revealed she did not have TED hose on. Observation of Resident #5 on 09/23/21 at 10:07am revealed: -Resident #5 was seated in her wheelchair in her room. -She had on soft slipper socks that came up above her ankles. -A medication aide (MA) pulled the soft slipper socks down below Resident #5's ankles. -Resident #5's ankles were swollen and there was an indenture around both of her lower legs where the top of her socks were placed. -The MA looked for Resident #5's TED hose in her bathroom, drawers, and in her closet, but she could not find them. Interview with Resident #5 on 09/23/21 at 10:06am revealed: -She had worn TED hose due to swelling in her legs. -Staff had not applied TED hose to her legs for a month or longer. -Staff did not ask her to put the TED hose on. -She had not refused to wear TED hose. Interview with a MA on 09/23/21 at 12:07pm revealed: -He worked third shift as a MA. -Resident #5 sometimes refused to get out of bed prior to the end of third shift and when that happened, he told first shift staff to apply her TED hose. -He documented Resident #5's TED hose were applied on 09/23/21, but they were not applied	D 273		

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D 273	Continued From page 6 during his shift. -He told first shift staff to apply Resident 5's TED hose on 09/23/21 because she was still in bed when he ended his shift. -He noticed Resident #5 had swelling in her legs about one month ago, and he told the Resident Care Director (RCD). -He had not looked at Resident #5's legs lately. -He had seen Resident #5 with her TED hose on, but he did not remember the last time he saw the TED hose. -No one reported to him Resident #5's TED hose were missing. -TED hose were supposed to be washed by hand and hung in the bathroom daily, but sometimes TED hosed were misplaced in the laundry. Interview with a MA on 09/23/21 at 12:18pm revealed: -She usually worked first shift. -TED hose were scheduled to be applied on third shift, but Resident #5 did not get out of bed until first shift. -Personal care aides (PCA) were responsible for applying TED hose and informing MAs they had been applied. -The MA was responsible for documenting the TED hose had been applied. -She documented on 09/14/21 and 09/15/21 TED hose had been applied, but she did not remember if Resident #5 had the TED hose on. -No PCAs reported to her when Resident #5 refused to have the TED hose applied or that Resident #5's TED hose were missing. -TED hose were washed daily and kept hanging in the bathroom to dry overnight. Interview with a PCA on 09/23/21 at 2:43pm revealed: -She had never applied TED hose to Resident #5	D 273		

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D 273	Continued From page 7 and did not know she was supposed to wear TED hose. -She had never seen Resident #5 with TED hose on. -Resident #5 had swelling in the lower part of her legs and ankles. -Resident #5 had on a pair of socks this morning that left a ring around her ankles. -She thought the socks were too small, so she changed her socks to a bigger pair. -She did not tell anyone on 09/23/21 resident had swelling in her ankles, but she did report the swelling to a MA about 3 weeks ago. Interview with a second PCA on 09/23/21 at 2:55pm revealed: -PCAs were responsible for applying and removing TED hose. -She did not know Resident #5 was supposed to have TED hose applied. -She had assisted Resident #5 with bathing and getting dressed and no one ever told her Resident #5 was supposed to have on TED hose. -She had never seen Resident #5 wearing TED hose and had not seen them in her room. Interview with the RCD on 09/23/21 at 3:04pm revealed: -A MA told her today that Resident #5 threw her TED hose in the trash. -She did not know MAs had documented Resident #5's eTAR that her TED hose were missing and she had refused to have them applied. -After three consecutive refusals to have TED hose applied, the MA should have notified Resident #5's PCP to inform of the refusals or to get a new order for TED hose. -The MAs also could have notified her, and she would have notified Resident #5's PCP.	D 273		

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D 273	Continued From page 8 -Staff had not reported to her any issues with Resident #5 wearing TED hose and she had not been informed of any swelling in Resident #5's legs since she was assessed by her PCP in June 2021. Interview with Resident #5's PCP on 09/23/21 at 12:40pm revealed: -She wrote an order for TED hose for Resident #5 because she was having edema in her legs. -Staff had not reported to her Resident #5's TED hose were missing or that Resident #5 had refused to wear TED hose. -She expected Resident #5 to wear the TED hose, and she expected the facility staff to call to let her know if Resident #5 refused to wear the TED hose or if she did not have any TED hose available. Interview with the Administrator on 09/23/21 at 4:17pm revealed: -He did not know TED hose were not being applied to Resident #5 daily as ordered by her PCP. -He expected staff to contact Resident #5's PCP to inform Resident #5's TED hose were not being applied. 3. Review of Resident #4's current FL2 dated 10/28/20 revealed diagnoses included dementia in other diseases classified with behavioral disturbances, essential hypertension, and generalized anxiety disorder. Review of Resident #4's physician's progress notes dated 06/30/21 revealed: -Resident #4 had a hospital visit from 05/11/21 to 05/19/21 for rectal bleeding and a fall. -Resident #4 was noted to have Vitamin B12 deficiency and started on Vitamin B12 (a vitamin	D 273		

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D 273	Continued From page 9 supplement) 1000mcg daily. -Vitamin B 1000mcg daily was included on the verified medications signed electronically by the primary care provider (PCP) on 06/30/21. Review of Resident #4's physician's order dated 08/13/21 revealed orders to continue Vitamin B12 (1000mcg) daily and obtain Vitamin B12 level laboratory test. Review of Resident #4's laboratory test results revealed there were no Vitamin B12 level laboratory test results available for review. Interview with the Administrator on 09/23/21 at 1:05pm revealed the Resident Care Director (RCD) was responsible to ensure provider's order for laboratory test were obtained by the contracted laboratory. Telephone interview with Resident #4's PCP on 09/23/21 at 2:45pm revealed: -Resident #4 was in a local hospital from 05/11/21 to 05/19/21. -Resident #4's Vitamin B12 was low and the resident was started on a Vitamin B12 supplement (1,1000mcg) daily. -The PCP continued the Vitamin B12 1000mcg daily therapy on 08/12/21. -The PCP ordered a laboratory test of Resident #4's Vitamin B12 level in order to determine if the supplemental dose was appropriate or if the dose should be modified or discontinued. -She expected the facility to obtain the Vitamin B12 laboratory test within one or 2 weeks of the order since the order did not to specify to delay the laboratory test until the next laboratory test routinely preformed on the resident. -The PCP had no documentation for notification by the facility that Resident #4's Vitamin B12 level	D 273		

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D 273	Continued From page 10 had not been obtained as ordered. Interview with the RCD on 09/23/21 at 3:45pm revealed: -She was responsible to enter prescriber's orders into the facility's electronic laboratory request section of the residents' electronic record. -She entered the request for Resident #4's Vitamin B12 level laboratory test to be completed on 08/17/21. -The lead night shift medication aide (MA) was responsible to review laboratory request input by the RCD during the night shift (third shift) on the night before the contracted laboratory service came one the routine weekly visit to the facility. -The MA should process the laboratory requests stored in the electronic records to generate a laboratory request ticket for the residents who needed laboratory test for the current laboratory staff visit. -When the RCD entered the request a color coded screen appeared for the MA to use to process the laboratory request. -The completed request changed the color of the laboratory request screen to indicate the order had been processed. -Resident #4's Vitamin B12 level test had not been processed. -She was responsible to ensure laboratory test were completed as ordered or to notify the PCP if a resident's requested laboratory test was not completed as ordered. -She had not notified Resident #4's PCP that the Vitamin B12 level had not been obtained because she did not know until she was questioned on 09/22/21 if the test had been completed. -There was no system in place currently to routinely audit the laboratory request screens for completeness.	D 273		

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D 358	Continued From page 11	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, facility failed to ensure medications were administered as ordered by a licensed practicing practitioner for 1 of 5 sampled residents (#2). The findings are: Review of Resident #2's current FL2 dated 02/22/21 revealed: -Diagnoses included hypertension, iron anemia, chronic kidney disease, dementia, chronic pain syndrome, and chronic diastolic-systolic congestive heart failure. -A physician's order for Lasix 20mg daily. Review of Resident #2's laboratory result dated 06/22/21 revealed a creatinine value (a test to measure renal function to indicate renal damage) of 1.74 (high)(normal reference range is 0.60-0.88mg/dL). Review of Resident #2's laboratory result dated 07/22/21 revealed a creatinine value (a test to measure renal function to indicate renal damage)	D 358	TAG D 358 – Medication Administration 1. Measures put in place to correct the deficient practice: • A tracking system will be created to ensure that medications are administered as ordered. 2. Measures put in place to prevent the problem from occurring again: • The Order Tracking Process Sheet will be completed when a new order is received. (see attached form) • The Med Tech (first Med Tech) receiving the order will transcribe the order into the EMR system and provide a copy of the order for the RCD/MCC. • A second Med Tech will verify that the order transcribed in the EMR matches the order given by the medical provider. • The Order Tracking Process Sheet will be completed by both the First Med Tech and the Second Med Tech to ensure that all steps have been completed in processing the order. • The RCD/MCC will conduct a verification audit within 48 hours of the date the order was received as further evidence that medications are administered as ordered.	

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	HAL041073	A. BUILDING: _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER HARBOUR	630 WHITTIER AVENUE HIGH POINT, NC 27262

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 12 of 1.60 (high)(normal reference range is 0.60-0.88mg/dL). Review of Resident #2's physician progress notes dated 06/30/21 revealed a history of congestive heart failure (CHF) and hypertension with lower leg edema. Review of Resident #2's physician's orders dated 06/23/21 revealed an order to decrease dose of Lasix to 10mg daily (one half of a 20mg tablet). Review of Resident #2's June 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Lasix 20mg give one tablet daily at 8:00am. -There was documentation Lasix 20mg was administered from 06/01/21 through 06/23/21. -There was documentation Lasix 20mg was discontinued on 06/24/21. -There was no entry for Lasix 20mg take one half tablet (10mg total) daily on the June 2021 eMAR. Review of Resident #2's July, August and September 2021's eMARs revealed: -There was no entry for Lasix 20mg tablet daily at 8:00am. -There was no entry for Lasix 20mg tablet, take one half tablet (10mg) daily at 8:00am. Observation of medications on hand on 09/22/21 at 4:30pm revealed there was no Lasix 20mg available for administration. Interview with Resident Care Director (RCD) on 09/22/21 at 3:07pm revealed: -She was responsible for entering medication orders on the eMAR. -The order for Lasix was received the day	D 358	• Staff training will be provided on protocol for obtaining orders, follow through on orders and completion of orders. Initial training on updated protocol then, training will be provided during orientation prior to working a medication cart and at intervals as deemed necessary by the RCD/MCC. • The RCD/MCC will present a report to the Quality Assurance Committee for at least six months or until problems are determined to be resolved. 3. Who will monitor the situation to ensure it will not occur again: • The Resident Care Director (RCD) and Memory Care Coordinator (MCC) • The Quality Assurance Committee (QA) 4. How often the monitoring will take place: • Initial audit (within 48 hours of order received): RCD/MCC	11/05/2021

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D 358	Continued From page 13 Resident #2's primary care physician (PCP) was in the facility on 06/23/21. -Lasix was ordered for Resident #2 by the PCP due to the resident having congestive heart failure (CHF) and Resident #2's creatinine level was elevated. -She discontinued Lasix 20mg daily from the eMAR but did not go back and enter the Lasix 20mg half tablet (10mg daily) order into the eMAR. -She was responsible for the medication error. Interview with a representative from the contracted pharmacy on 09/22/21 at 3:22pm revealed: -The pharmacy received the Lasix 20mg half tablet (10mg total) daily order on 06/23/21 and was dispensed on the same day (06/23/21) for a quantity of 15 tablets. -The facility was responsible for entering medication orders on the eMAR and approving the entries. Interview with a medication aide (MA) on 09/22/21 at 3:50pm revealed: -He had not administered Lasix to Resident #2. -The Lasix 20mg order was discontinued on the eMAR in June 2021. Interview with Resident #2's primary care provider (PCP) on 09/22/21 at 4:25pm revealed: -She had ordered the Lasix dose to be decreased from 20mg daily to 20mg half tab (10mg) daily due to decrease in kidney function and elevated creatinine levels. -She was not aware Resident #2 had not received Lasix 20mg one half tablet daily as ordered. -She was not aware that Lasix had been discontinued. -She had not been told until today (09/22/21) that	D 358		

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D 358	Continued From page 14 Lasix had been discontinued. Observation of Resident #2 in her room on 09/22/21 at 4:40pm revealed there was no edema noted to both lower legs. Interview with Resident #2 on 09/22/21 at 4:45pm revealed: -She denied ever taking a "water pill" or "fluid pill." -She had never had any swelling in her legs. Interview with a second MA on 09/23/21 at 9:05am revealed: -She administered medication to Resident #2. -Resident #2 was getting Lasix at one time and she did not know what happened to the Lasix order. Interview with RCC on 09/23/21 at 10:25am revealed: -She was not aware that Lasix 20mg one half tablet daily was dispensed from the pharmacy. -There was no record of the Lasix having been sent back to the pharmacy. -She contacted the pharmacy and they did not have record of the Lasix being sent back to them. -She did not know what happened to the Lasix. -The pharmacy only contacted the facility if they had a question or needed an order clarified. -Medication orders were faxed to the pharmacy but she was responsible for entering the orders into the eMAR. Interview with Administrator on 09/23/21 at 1:00pm revealed: -RCC was responsible for all orders and entering medication orders into the eMAR. -He was not aware of Resident #2 not receiving Lasix as ordered.	D 358		

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D911	Continued From page 15	D911		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure all residents were treated with respect, consideration, and dignity related to the resident having poor vision and not being assisted with meals when she chose to eat in her room. The findings are: Review of Resident #5's current FL2 dated 06/02/21 revealed diagnoses included macular degeneration. Review of Resident #5's primary care provider (PCP) progress note dated 08/25/21 revealed: -Staff reported Resident #5 had difficulty with swallowing some pills. -Medications had been crushed, but there were a few capsules that could not be crushed. -Resident #5 denied any issues with swallowing medications or food at the current texture or coughing after drinking or eating. -Resident #5 reported her main issue was eating and not swallowing. -She reported having difficulty with feeding herself due to poor vision. -She was feeling for her food and eating with her hands and not the utensils. -She usually ate her meals in her room and not in	D911	TAG D 911 – Declaration of Resident's Rights 1. Measures put in place to correct the deficient practice: • An updated dining system will be created to ensure that residents are treated with respect, dignity and consideration during meals. 2. Measures put in place to prevent the problem from occurring again: • The protocols for eating in both the dining room and the resident's room will be updated to include: ▪ assigned staff for each area during meals ▪ an updated list of residents who eat in their rooms, and ▪ a staggered meal-tray delivery system to accommodate staff ability to provide meal assistance in the resident rooms when needed • The Med Tech/Team Leader for each care area will ensure that residents who are eating in their rooms will have adequate assistance (as needed) during the entire meal.	

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D911	Continued From page 16 the dining room. -There was an order for occupational therapy (OT) to evaluate and treat due to poor vision. Review of Resident #5's OT notes dated 08/27/21 revealed: -Resident #5 was admitted to home health services following a referral from the PCP due to recent decline in vision and feeding skills. -She was not able to use silverware and was spilling most food. -An assessment on 08/27/21 revealed Resident #5 could bring food to her mouth, but she needed assistant with scooping all food onto the utensil. -Resident #5 was unable to feed herself and must be assisted or supervised throughout the meal/snack. -She required maximum assistance in feeding skills due to increase in macular degeneration and her inability to see food on the plate. -Resident #5 and caregiver were educated on macular degeneration and loss of vision and adaptation skills and the caregiver verbalized understanding. Observation of Resident #5 during the lunch meal on 09/22/21 between 12:50pm and 1:10pm revealed: -Resident #5 was seated in her wheelchair in her room and a television tray table was placed in front of her wheelchair with her lunch meal on it. -Resident #5 had been served chicken tenders and lyonnaise potatoes in a foam container placed to the right of the tray table, butterscotch pudding in a plastic container placed to the left of the tray table, and iced tea in a paper cup placed behind the container of pudding on the top left hand side of the tray. -The lids of the foam plate and the plastic container had been opened and the lid from the	D911	• The RCD/MCC will assess each resident that requests to eat meals in their room for the need of staff assistance and make assignments accordingly. • Staff training will be provided on dining room/meal protocols. • The RCD/MCC will observe residents taking meals in their rooms as well as those eating in the dining room. Adherence to resident rights and to safety will be the main focus. • The RCD/MCC will present a report to the Quality Assurance Committee for at least six months or until problems are determined to be resolved. 3. Who will monitor the situation to ensure it will not occur again: • The Med Tech (Team Leader) • The Resident Care Director (RCD) and Memory Care Coordinator (MCC) • The Quality Assurance Committee (QA) 4. How often the monitoring will take place: • Meal observation: Bi-weekly x 4 weeks, then Monthly x 5 months	11/05/2021

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D911	Continued From page 17	D911		

paper cup had been removed.
-There were plastic utensils in plastic packaging that had been opened, but the utensils had not been removed from the packaging.
-Resident #5 felt around on tray table from 12:55pm until 12:58pm until she found the cup of tea.
-She lifted the cup with her left hand, but she had difficulty placing the cup to her mouth to drink.
-She placed the cup at her nose several times and spilled some of the tea on her pants.
-She felt around on her plate until she found her chicken tenders and dropped her last bite of chicken tenders on the floor.
-She felt the lyonnaise potatoes, but she did not eat the potatoes or the pudding.

Interview with Resident #5 on 09/22/21 at 12:51pm revealed:
-She could not see her food, so it was difficult for her to eat.
-The staff wanted her to go to the dining room to eat because staff told her they did not have enough staff to assist her in her room.
-Staff did not assist her with eating when she ate in her room.
-She went to the dining room sometimes, but she did not want to go to the dining room all the time.
-She had knocked food and cups off her tray table when she ate in her room unassisted.
-When the staff brought her lunch meal to her today, the staff did not tell her what was on her plate.
-She had to eat with her hands, and she did not like that.
-Her biggest problem when she ate her meals in her room was with drinking.

Interview with Resident #5 on 09/23/21 at 10:19pm revealed:

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D911	Continued From page 18 -She did not know she was going to the dining room for the breakfast meal on 09/23/21. -She was told she was going to the dining room as she was being pushed down the hallway. -She told the staff she did not want to go, and she was told by the staff that the only way she could get some assistance with eating was if she went to the dining room. -She did not like going to the dining hall because before staff started assisting her in the dining hall, she had to eat with her hands around other residents. -A staff once told her, "you can see," and it really hurt her feelings. Interview with the home health provider on 09/23/21 at 9:08am revealed: -Resident #5 was admitted to OT services due to the need for feeding assistance. -Therapists were looking into possible adaptive equipment and exercises to help bring Resident #5's hand to her mouth to assist with feeding. -Resident #5 had not been following through with the exercises because she did not think the exercises were helping. -Resident #5 required assistance with feeding with all meals and snacks. -She informed a medication aide (MA) at the facility Resident #5 needed help with feeding and that OT was looking into adaptive equipment. Interview with a personal care aide (PCA) on 09/23/21 at 2:43pm revealed: -Sometimes Resident #5 was adamant about not going to the dining room. -She liked to eat in her room, but the policy was you had to be able to feed yourself to eat in your room. -If Resident #5 refused to go to the dining hall, she did not take her.	D911		

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D911	Continued From page 19 -If she delivered Resident #5's meal to her room, she opened her foam container, told her what was on her plate and where the food items were, placed utensils in her hand, and assisted her with the first bite of the meal to get her started. -When Resident #5 ate in her room, she normally ate whatever she could see, but she did not drink her beverages. -"She probably needs to go to the dining room more often so she can get assistance with feeding." Interview with a second PCA on 09/23/21 at 2:55pm revealed: -Resident #5 sometimes wanted to eat in her room -She did not want to go to the dining hall for the lunch meal on 09/23/21, but she told Resident #5 that if she came to the dining room, she could help her better. -If she delivered Resident #5's meal to her room, she told the resident where all her food was and checked on her after the PCA was done passing out meals to other residents who ate in their rooms. -She did not assist Resident #5 with eating her whole meal when she ate in her room, but she stopped by her room to check on her. -Resident #5 usually ate most of her meal when she ate in her room and was able to drink by herself if she had a straw and lid on her cup. Interview with the Resident Care Director (RCD) on 09/23/21 at 3:04pm revealed: -Resident #5 had macular degeneration and had trouble seeing. -Resident #5 liked to eat in her room. -There were other residents who ate in their room, but they did not require assistance. -When Resident #5 ate in her room, staff opened	D911		

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D911	Continued From page 20	D911		

her package of utensils and made sure she had a straw in her cup.
-Some days she was able to eat by herself and other days she could not because her vision was blurry.
-Staff did not sit down to assist Resident#5 with eating when she chose to eat her meals in her room because the staff would have either been pulled from the dining room or from the floor and it could affect the staffing numbers.
-Staff would stop by to assist if Resident #5 asked for assistance.
-She did not know Resident #5's OT provider assessed her as needing assistance with eating at all meals.

Interview with Resident #5's PCP on 09/23/21 at 12:40pm revealed:
-Resident #5 had difficulty with eating because she could not see her food and that was why she ordered OT.
-Resident #5 did not like to go to the dining room and staff could not make her go.
-She expected staff to assist Resident #5 with all meals if that was the recommendation of OT.

Interview with the Administrator on 09/23/21 at 4:02pm revealed he did not know OT recommended Resident #5 receive assistance with all meals.