Received via email 01/28/22.

PRINTED: 01/07/2022
FORM APPROVED

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
	HAL019021	A. BUILDING: _____ B. WING _____	12/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 000	Initial Comments The Adult Care Licensure Section and the Chatham County Department of Social Services conducted an annual and follow-up survey and complaint investigation from 12/15/21-12/17/21 with an exit conference via telephone on 12/20/21. The complaint investigation was initiated by the Chatham County Department of Social Services on 11/19/21.	D 000	The following is the Plan of Correction for Chatham Ridge Assisted Living and Memory Care. The Plan of Correction is a result of an Annual and Follow-up Survey and Complaint Survey completed 12/20/2021. The Plan of Correction is not to be construed as an admission of our agreement with findings and conclusions in the statement. Rather, it is submitted to confirmation of our ongoing efforts to comply with statutory and regulatory requirements.	
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 interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents (Resident #4) related to fingerstick blood sugar (FSBS) checks. The findings are: Review of Resident #4's current FL2 dated 09/03/21 revealed diagnoses included type 2 diabetes. Review of Resident #4's subsequent primary care provider's (PCP) orders revealed: -There was an order dated 09/03/21 for FSBS checks once a day. -There was an order dated 09/29/21 to stop the	D 276	Resident #4's Physician Orders and Medication Administration Record (MAR) have been updated with current FSBS orders. The Director of Clinical Services (DCS) will ensure the New Order Tracking Form is implemented and utilized by all persons who receive and process new orders so that all content of new orders is transcribed and carried out as prescribed. A documented in-service will occur demonstrating training regarding this new process. The DCS or Executive Director (ED) will review new orders daily x 30 days, then weekly x4, to assure documentation of orders from a physician or other licensed professional and implementation of orders are processed correctly.	~~12/18/21~~ dN 12/21/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Executive Director

TITLE

(X6) DATE: 01/21/2022

Reviewed and acknowledged. 01/31/22 SM

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D 276	Continued From page 1 current FSBS checks and start weekly FSBS checks. Review of Resident #4's charting note dated 09/29/21 revealed: -The note was entered by a medication aide (MA) at 10:18pm. -Resident #4 had a new order to stop current FSBS checks and to start weekly FSBS checks. Review of Resident #4's Licensed Health Professional Support evaluation dated 12/14/21 indicated the resident received FSBS checks daily. Review of Resident #4's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for weekly FSBS checks scheduled at 6:30am. -There was documentation FSBS checks had been performed 4 of 5 opportunities weekly on Friday at 6:30am. -There was documentation Resident #4 refused the weekly FSBS check for 1 of 5 opportunities. -There was an entry for daily FSBS checks (listed under the brand name of a blood sugar meter) scheduled at 7:30am. -There was documentation daily FSBS checks were performed 20 of 31 opportunities. -There was documentation Resident #4 refused daily FSBS checks for 10 of 31 opportunities. -There was no documentation for 1 of 31 opportunities. Review of Resident #4's November 2021 eMAR revealed: -There was an entry for weekly FSBS checks scheduled at 6:30am. -There was documentation FSBS checks had	D 276	The new order tracking process will be reviewed in the weekly at risk meeting x4, then at the quarterly Quality Improvement meeting.	

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been performed 3 of 4 opportunities weekly on Friday at 6:30am.
-There was documentation Resident #4 refused the weekly FSBS check for 1 of 4 opportunities.
-There was an entry for daily FSBS checks (listed under the brand name of a blood sugar meter) scheduled at 7:30am.
-There was documentation daily FSBS checks were performed 22 of 30 opportunities.
-There was documentation Resident #4 refused daily FSBS checks for 8 of 30 opportunities.

Review of Resident #4's December 2021 eMAR revealed:
-There was an entry for weekly FSBS checks scheduled at 6:30am.
-There was documentation a FSBS check had been performed for 1 of 2 opportunities weekly on Friday at 6:30am.
-There was documentation Resident #4 refused the weekly FSBS check for 1 of 2 opportunities.
-There was an entry for daily FSBS checks (listed under the brand name of a blood sugar meter) scheduled at 7:30am.
-There was documentation daily FSBS checks were performed 9 of 16 opportunities.
-There was documentation Resident #4 refused daily FSBS checks for 7 of 16 opportunities.

Telephone interview with Resident #4's family member on 12/17/21 at 8:41am revealed:
-The resident's previous order was for daily FSBS checks.
-The resident "rebelled" and did not want the FSBS checks performed daily, so the PCP changed the order to weekly.

Interview with a first shift MA on 12/17/21 at 2:21pm revealed:
-The MA was responsible for faxing orders to the

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pharmacy if the Memory Care Wellness Director (MCWD) was not present.
-Whoever approved the order in the eMAR system after the pharmacy entered the order was responsible for checking the order for accuracy.
-The order for daily FSBS checks had been approved by the previous MCWD.
-Another MA had approved the order for weekly FSBS checks.
-Resident #4 had FSBS checks performed at 6:30am and 7:30am on 12/17/21.
-She did not know which order for FSBS checks was the current order.
-She performed the FSBS check for Resident #4 whenever it showed up on the eMAR screen during her shift.

Interview with the MCWD on 12/17/21 at 3:00pm revealed:
-She routinely met with the PCP to review orders and then faxed the orders to the pharmacy.
-A copy of the order would be placed in the new order binder.
-After the order was entered on the eMAR by the pharmacy, she or the MA would approve the order in the eMAR system.
-She last reviewed Resident #4's eMAR on 12/13/21.
-She had not reviewed any eMARs before this week.
-She did not know there were two different entries for FSBS checks on Resident #4's eMAR.
-She attributed the conflicting order entries to human error.

Interview with the MA who entered Resident #4's charting note dated 09/29/21 revealed:
-Resident #4's FSBS checks were to be performed weekly at 6:30am during third shift.
-She did not know why Resident #4's FSBS

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D 276	Continued From page 4 checks were changed from daily to weekly. -She approved both orders for Resident #4's FSBS checks. -She routinely did not approve an order without seeing a copy of the order. -If she approved the order for FSBS checks without seeing it, she may have done so under the instruction of the facility's Registered Nurse (RN) or the MCWD. -The order for weekly FSBS checks was written when the facility was in the process of changing pharmacies. -The use of the brand name of the blood sugar meter in the entry on the eMAR "threw" her. -The RN or MCWD should have removed the order for daily FSBS checks from the eMAR. -It was a mistake. Interview with the RN on 12/17/21 at 5:05pm revealed: -New orders were sent to the pharmacy to enter into the eMAR system. -She, the Wellness Directors (WD), or the MAs reviewed the eMARs for accuracy after the orders were entered by the pharmacy. -She and the WDs were responsible for checking the eMAR against the hard copy of the order. -The eMAR was reviewed whenever new orders came in. -The PCP reviewed orders every six months. -The MAs should have been looking for duplicate or conflicting orders listed on the eMARs whenever they administered medications. -The conflicting orders should have been caught when the order was changed in September 2021. -The MCWD was ultimately responsible for this situation. Interview with the Administrator on 12/17/21 at 5:16pm revealed:	D 276		

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D 276	Continued From page 5 -New orders were faxed to the pharmacy to be updated on the eMAR. -The WD or MA could witness or approve orders in the eMAR system. -She expected the MCWD to review the eMARs twice weekly for accuracy. -The MCWD was expected to review the eMAR when the PCP was at the facility. -The conflicting entries for FSBS checks on Resident #4's eMAR should have been caught when the new order was reviewed or during the medication cart audit. -A printed copy of the eMAR was used for completing the medication cart audit. -The MCWD was expected to perform medication cart audits at least monthly. -The MCWD should have noticed the conflicting orders for FSBS checks on the printed eMAR when the cart audit was performed. -The MCWD was ultimately responsible for the accuracy of orders. -The MCWD had changed since the orders were written. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/20/21 at 11:15am revealed: -The pharmacy started providing services to the facility on 10/01/21. -The facility was responsible for completing an eMAR reconciliation when switching to the new pharmacy. -The facility may not have completed the eMAR reconciliation and that explained why there were conflicting entries for FSBS checks on Resident #4's eMAR. Attempted telephone interview with Resident #4's PCP on 12/17/21 at 8:34am was unsuccessful.	D 276		

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D 276	Continued From page 6 Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.	D 276		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a therapeutic diet menu for 1 of 4 sampled residents (#7) with a diet order for a fermentable, oligosaccharides, disaccharides, monosaccharides and polyols (FODMAP) diet (#7). The findings are: Observation of the kitchen on 12/16/21 at 9:37am revealed the Food Service Manager and the cook could not locate the therapeutic diet menu. Review of Resident #7's current FL2 dated 10/27/21 revealed: -Diagnoses included irritable bowel with diarrhea and constipation. -There was no diet listed. Review of Resident #7's signed physician's orders dated 11/15/21 revealed an order for a FODMAP diet.	D 296	Resident #7's FODMAP diet has been discontinued. She is currently on a regular puree diet. Resident #7's care plan has been updated to reflect the current diet order. All diet orders have been reviewed for each resident and a current copy of the order given to the Dining Services Director (DSD) to update the Master Diet Order Sheet that is maintained in the kitchen and used to serve the correct diet to the correct resident. The DSD will ensure the diet cards used in Memory Care are also updated to reflect all current diet orders and diet instructions, including items such as "family requests to cut meats" A documented in-service has been conducted on 01/12/22-01/19/22 including the DSD who ensures the most current and up to date diet order at all times, and that the DSD subsequently updates the Master Diet Order Sheet and Memory Care diet cards as warranted for and and all diet order changes. Diet orders will be discussed at the weekly at risk meeting x4 then quarterly x1 at the Quality Improvement meeting.	

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D 296	Continued From page 7 Review of Resident #7's physician's signed diet order dated 12/01/21 revealed an order for a FODMAP diet. Review of the facility's therapeutic diet list on 12/16/21 revealed Resident #7 did not have a diet listed next to her name; the diet list was dated 11/18/21. Review of the facility's therapeutic diet menu on 12/17/21 revealed it was for Spring/Summer 2021 and was for week 3; there was no FODMAP diet on the therapeutic diet menu. Interview with Resident #7 on 12/16/21 at 11:54am revealed: -She followed the FODMAP diet the best that she could; but she got confused as to what she was supposed to eat and not eat. -She did not feel the facility offered the foods she needed to follow the FODMAP diet. Interview with a diet aide on 12/17/21 at 2:26pm revealed: -She served food to the residents in the dining room. -Resident #7 ate her meals in the dining room. -The residents were given a menu to select their meal choices; the top right-hand corner of the menu had the resident's diet on it. -Resident #7 did not have a special diet on her menu. -None of the residents had a FODMAP diet listed on their menus; she did not know what a FODMAP diet was. Interview with the cook on 12/17/21 at 2:20pm revealed: -He had not seen the therapeutic diet menu in	D 296	Random audits will be conducted by the Regional Director of Clinical Services (RDCS) at community visits quarterly.	2/11/22

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D 296	Continued From page 8 about two weeks. -There were no residents on a FODMAP diet, and he had never heard of a FODMAP diet, so he did not know what it was. Interview with the Dining Service Director on 12/17/21 at 2:43pm revealed: -He had only been the Dining Service Director since Monday (12/13/21). -He had worked as a cook at the facility prior to becoming the Dining Service Director. -The last time he had seen the therapeutic diet menu had been about two weeks ago, but he had located the therapeutic diet menu on 12/16/21. -He did not know what a FODMAP diet was and he knew the FODMAP diet was not on the therapeutic diet menu. -He had not seen any guidance or a list for a FODMAP diet in the kitchen. Interview with the Administrator on 12/17/21 at 3:56pm revealed: -The Dining Services Director was responsible for the kitchen and was under the guidance of the corporate Dining Services Director. -The Dining Services Director and the kitchen were monitored by the corporate Dining Services Director. -She did not know the kitchen did not have guidance or a therapeutic diet menu for guidance when preparing the meals for the residents. -The kitchen staff now had a therapeutic diet menu to follow because the corporate Dining Services Director had provided them with one the day before. -The FODMAP diet was not on the therapeutic diet menu. -Resident #7's FODMAP diet order had been changed to a regular diet that day, 12/17/21 by Resident #7's primary care physician (PCP)	D 296		

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D 296	Continued From page 9 because the resident did not need to be on it anymore.	D 296		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observation and interviews the facility failed to maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff for 2 of 4 (Resident #6 and #7) sampled residents with physician's orders for a chopped diet (#6) and a fermentable, oligosaccharides, disaccharides, monosaccharides and polyols (FODMAP) diet (#7). The findings are: 1. Review of Resident #6's current FL-2 dated 05/26/21 revealed: -Diagnoses included nutritional marasmus, lower back pain, idiopathic peripheral autonomic neuropathy, nonrheumatic aortic stenosis, constipation, benign prostatic hyperplasia, and unspecified symptoms and signs with cognitive functions and anosmia. -There was no diet listed. -Resident #6 resided on the Assisted Living (AL)	D 309	Resident #6 and #7's diets have been updated and are on the current list of residents with physician ordered therapeutic diets for guidance of food service staff. All diet orders have been reviewed for each resident and a current copy of the current order given to the DSD to update the master Diet Order Sheet that is maintained in the kitchen and used to serve the correct resident with the correct diet. The DCS and the DSD will review diet orders weekly x4, finding will be reviewed in the quarterly Quality Improvement meeting.	2/11/22

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D 309	Continued From page 10 side of the facility. Review of a signed physician's order dated 12/15/21 revealed there was an order for a regular chopped diet. Observation of the kitchen on 12/16/21 at 7:41am revealed: -There was a diet list for the residents who resided on the AL side of the facility and a separate diet list for the residents who resided in the Special Care Unit (SCU). -The diet list for the AL was dated 11/18/21. -Resident #6 was listed as a regular diet with a regular consistency on the diet list. Observation of the breakfast meal on 12/16/21 from 7:15am to 8:22am revealed: -Resident #6 was given a menu to make his meal selections from. -The menu had one day's worth of meals for breakfast, lunch and dinner. -Resident #6's name was on one corner of the menu and the opposite corner had regular on it. -Resident #6 was served hot cereal for breakfast. Observation of the lunch meal on 12/16/21 from 11:30am to 12:15pm revealed: -Resident #6 was served whole meatballs, green peas and a biscuit. -He ate 100 percent of his meatballs and peas but did not eat all of his biscuit. -The therapeutic diet menu was not available for observation. Interview with Resident #6 on 12/17/21 at 5:17pm revealed: -He did not know he was ordered a chopped diet. -He had gotten new dentures a while ago, so he thought that was why he was ordered a chopped	D 309		

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D 309	Continued From page 11 diet. -It was difficulty to chew his food with his new dentures. -He had difficulty cutting his meat by himself. -It would have been nice if the kitchen staff had cut his meat for him. Interview with a diet aide on 12/17/21 at 2:36pm revealed: -She was the only staff that served the residents their food. -She knew what to serve the residents because their diets were on the top of the daily menus. -She had seen the diet list posted in the kitchen, but she did not follow it because no one had told her to follow or reference it when she served the residents. -She knew the residents who were ordered a chopped diet but Resident #6 was not one of them; he was ordered a regular diet. Interview with a cook on 12/17/21 at 2:15pm revealed: -He referenced the diet list posted on the wall when he plated the residents' food for meals. -He also looked at the daily menu with the resident's name and selections because the diets were also listed on the corner. -There was only one resident that had an order for a chopped diet, and it was not Resident #6. -He did not know Resident #6 was ordered a chopped diet. Refer to interview with the Dining Service Director on 12/17/21 at 9:37am. Refer to interview with the Resident Care Coordinator (RCC) on 12/17/21 at 3:32pm. Refer to interview with the Administrator on 12/17/21 at 3:56pm.	D 309		

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D 309	Continued From page 12 Attempted telephone interview with Resident #6's primary care provider (PCP) on 12/17/21 was unsuccessful. 2. Review of Resident #7's current FL2 dated 10/27/21 revealed there was no diet listed. Review of Resident #7's signed physician's orders dated 11/15/21 revealed an order for a fermentable, oligosaccharides, disaccharides, monosaccharides and polyols (FODMAP) and pureed diet. Review of Resident #7's physician's signed diet order dated 12/01/21 revealed an order for a FODMAP diet. Observation of the kitchen on 12/16/21 at 7:41am revealed: -There was a diet list for the residents who resided on the AL side of the facility and a separate diet list for the residents who resided in the Special Care Unit (SCU) posted on a bulletin board. -The diet list for the AL was dated 11/18/21. -Resident #7 did not have a diet listed on the diet list; the list was blank next to her name. Observation of the breakfast meal on 12/16/21 from 7:15am to 8:22am revealed: -Resident #7 was given a menu to make her meal selections from. -The menu had one day's worth of meals for breakfast, lunch and dinner. -Resident #7's name was on one corner of the menu and the opposite corner had regular and pureed on it. -Resident #7 was served pureed eggs, pureed bacon, grits, coffee and orange juice for	D 309		

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	HAL019021	A. BUILDING: _____ B. WING _____	12/20/2021

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D 309	Continued From page 13 breakfast. Observation of the lunch meal on 12/16/21 from 11:30am to 12:15pm revealed: -Resident #7 was served pureed pork, pureed green peas and mashed potatoes. -The kitchen did not have a FODMAP diet menu for review or guidance. Interview with Resident #7 on 12/17/21 at 11:10am revealed: -She knew she was ordered a FODMAP diet. -She followed the FODMAP diet as "best she could" but she really did not know what foods she needed to eat. -She got confused about what food she should select herself. Interview with a diet aide on 12/17/21 at 2:36pm revealed: -She was the only staff that served the residents their food. -She knew what to serve the residents because their diets were on the top of the daily menus. -She had seen the diet list posted in the kitchen, but she did not follow it because no one had told her to follow or reference it when she served the residents. -She did not know what a FODMAP diet was and she did not know of any residents that were on a FODMAP diet. Interview with a cook on 12/17/21 at 2:15pm revealed: -He referenced the diet list posted on the wall when he plated the residents' food for meals. -He also looked at the daily menu with the resident's name and selections because the diets were also listed on the corner. -He did not know what a FODMAP diet was and	D 309		

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D 309	Continued From page 14 he did not know of any residents that were on a FODMAP diet. Refer to interview with the Dining Service Director on 12/17/21 at 9:37am. Refer to interview with the Resident Care Coordinator (RCC) on 12/17/21 at 3:32pm. Refer to interview with the Administrator on 12/17/21 at 3:56pm. Attempted telephone interview with Resident #6's primary care provider (PCP) on 12/17/21 was unsuccessful. Interview with the Dining Service Director on 12/17/21 at 9:37am revealed: -There was a current diet list posted in the kitchen or staff to follow. -He knew the diet list was updated monthly and that he would be responsible for updating the diet list. -He did not know who gave him the information for the diet changes to update the diet list; he had only started working as the Dining Service Director on Monday, 12/13/21. -The residents were each given a daily menu to make their food selections from; the resident's name was on the left-hand side of the daily menu and the diet was listed on the top right-hand corner of the daily menu. -The personal care aides (PCAs) and the dietary aides followed the individual daily menus when serving the residents their food. -The cooks used the individual daily menus when plating food because the diets were on the top right-hand side. -He thought he would be responsible for updating the individual daily menu sheets once he was fully	D 309		

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D 309	Continued From page 15 trained. -It was important to maintain a current diet list and to have the diets on the daily menus correct because the cooks, personal care aides and the diet aides used them to serve the meals to the residents. -It was important to serve the residents the right diet because he did not want a resident on a pureed diet or a chopped diet to get the wrong food. -The residents were ordered a specific diet from the physician for a reason and that was why they should always be followed. Interview with the Resident Care Coordinator (RCC) on 12/17/21 at 3:32pm revealed: -She was also the facility's Registered Nurse (RN). -Diet orders were requested to be updated by the residents' primary care provider (PCP) every six months. -She made a copy of the signed diet orders and gave the copy to the Dining Service Director; the original went into the residents' records. -The Dining Service Director generated the diet list from the copy of the signed diet orders. -Any diet order changes were also discussed at shift change so the staff knew who had diet order changes. -The medication aides (MA), the Dining Service Director, the diet aides and the personal care aides (PCAs) monitored the dining room service to ensure the residents were served the correct diets. -All of the staff serving meals in the dining room had access to the resident diet list posted in the kitchen and should reference the list. Interview with the Administrator on 12/17/21 at 3:56pm revealed:	D 309		

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D 309	Continued From page 16 -The facility RN provided the Dining Service Manager with any diet order changes. -The Dining Service Manager was responsible for updating the resident diet list. -The diet list should have been updated the same day or the next day after the order change. -The copy of the physician signed diet order is placed in a binder in the kitchen and the list was updated at the same time. -The Dining Service Manager updated the daily menu selection sheets and the Corporate Dining Service Manager was updating the diet list. -The diet orders were done for a reason and should have been followed as written.	D 309		
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. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to serve therapeutic diets as ordered by the physician for 2 of 4 (Resident #6 and #7) sampled residents with physician's orders for a chopped diet (#6) and a fermentable, oligosaccharides, disaccharides, monosaccharides and polyols (FODMAP) diet (#7).	D 310	Resident #6 and #7's diets are current and listed on the Master Diet Order Sheet. A documented in-service has been conducted on 01/12/22-01/19/22 to include the DSD, all persons who admit new residents, and all persons who receive orders to ensure a copy of any new order is given to the DSD to ensure the most up to date diet order at all times, and that the DSD subsequently updates the Master Diet Order Sheet and Memory Care diet cards as warranted. The DSD and DCS will review diet orders weekly x4, and discuss at the quarterly Quality Improvement meeting.	02/11/22

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D 310	Continued From page 17 The findings are: 1. Review of Resident #6's current FL-2 dated 05/26/21 revealed: -Diagnoses included nutritional marasmus, lower back pain, idiopathic peripheral autonomic neuropathy, nonrheumatic aortic stenosis, constipation, benign prostatic hyperplasia, and unspecified symptoms and signs with cognitive functions and anosmia. -There no diet listed. -Resident #6 resided on the Assisted Living (AL) side of the facility. Review of a signed physician's order dated 12/15/21 revealed there was an order for a regular chopped diet. Observation of the kitchen on 12/16/21 at 7:41am revealed: -There was a diet list for the residents who resided on the AL side of the facility dated 11/18/21. -Resident #6 was listed as a regular diet with a regular consistency on the diet list. -The therapeutic diet menu was not available for observation in the kitchen. Observation of the breakfast meal on 12/16/21 from 7:15am to 8:22am revealed Resident #6 was served hot cereal for breakfast. Observation of the lunch meal on 12/16/21 from 11:30am to 12:15pm revealed: -Resident #6 was served whole meatballs, green peas and a biscuit. -He ate 100 percent of his meatballs and peas but did not eat all of his biscuit. Review of the facility's therapeutic diet menu on	D 310		

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D 310	Continued From page 18 12/17/21 revealed: -The menu was for Spring/Summer 2021 and was for week 3. -The menu included the chopped diet menu for lunch on 12/16/21; chopped meatballs were listed on the menu. Interview with Resident #6 on 12/17/21 at 5:17pm revealed: -He did not know he was ordered a chopped diet. -He had gotten new dentures a while ago, so he thought that was why he was ordered a chopped diet. -It was difficulty to chew his food with his new dentures. -He had difficulty cutting his meat by himself. -It would have been nice if the kitchen staff had cut his meat for him. Interview with a diet aide on 12/17/21 at 2:36pm revealed: -She was the only staff that served the residents their food. -She knew what to serve the residents because their diets were on the top of the daily menus. -She knew the residents who were ordered a chopped diet but Resident #6 was not one of them; he was ordered a regular diet. Interview with a cook on 12/17/21 at 2:15pm revealed: -There was only one resident that had an order for a chopped diet, and it was not Resident #6. -He did not know Resident #6 was ordered a chopped diet. Refer to interview with the Dining Service Director on 12/17/21 at 9:37am. Refer to interview with the Resident Care	D 310		

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D 310	Continued From page 19 Coordinator (RCC) on 12/17/21 at 3:32pm. Refer to interview with the Administrator on 12/17/21 at 3:56pm. Attempted telephone interview with Resident #6's primary care provider (PCP) on 12/17/21 was unsuccessful. 2. Review of Resident #7's current FL2 dated 10/27/21 revealed there was no diet listed. Review of Resident #7's signed physician's orders dated 11/15/21 revealed an order for a fermentable, oligosaccharides, disaccharides, monosaccharides and polyols (FODMAP) and pureed diet. Review of Resident #7's physician's signed diet order dated 12/01/21 revealed an order for a FODMAP diet. Observation of the kitchen on 12/16/21 at 7:41am revealed: -There was a diet list for the residents who resided on the AL side dated 11/18/21. -Resident #7 did not have a diet listed on the diet list; the list was blank next to her name. Observation of the breakfast meal on 12/16/21 from 7:15am to 8:22am revealed: -Resident #7 was given a menu to make her meal selections from. -The menu had one day's worth of meals for breakfast, lunch and dinner. -Resident #7 was served pureed eggs, pureed bacon, grits, coffee and orange juice for breakfast. Observation of the lunch meal on 12/16/21 from	D 310		

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D 310	Continued From page 20 11:30am to 12:15pm revealed: -Resident #7 was served pureed pork, pureed green peas and mashed potatoes. -The kitchen did not have a FODMAP diet menu for review or guidance. Review of the facility's therapeutic diet menu on 12/17/21 revealed it was for Spring/Summer 2021 and was for week 3; there was no FODMAP diet on the therapeutic diet menu. Interview with Resident #7 on 12/17/21 at 11:10am revealed: -She knew she was ordered a FODMAP diet. -She followed the FODMAP diet as "best she could" but she really did not know what foods she needed to eat. -She got confused about what food she should select herself. Interview with a diet aide on 12/17/21 at 2:36pm revealed: -She was the only staff that served the residents their food. -She knew what to serve the residents because their diets were on the top of the daily menus. -She did not know what a FODMAP diet was and she did not know of any residents that were on a FODMAP diet. Interview with a cook on 12/17/21 at 2:15pm revealed he did not know what a FODMAP diet was and he did not know of any residents that were on a FODMAP diet. Interview with the Dining Service Director on 12/17/21 at 9:37am revealed he was not familiar with a FODMAP diet and he did not know Resident #7 was ordered the FODMAP diet.	D 310		

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D 310	Continued From page 21 Interview with the Resident Care Coordinator (RCC) on 12/17/21 at 3:32pm revealed: -She knew what the FODMAP diet was; it was ordered for residents with irritable bowel syndrome (IBS) and gluten sensitivity. -There was a list of foods the resident should not eat. -She knew Resident #7 was on a FODMAP diet, but she was capable of selecting the foods she wanted. -She did not know if the kitchen had a list of items for the FODMAP diet. Refer to interview with the Dining Service Director on 12/17/21 at 9:37am. Refer to interview with the Resident Care Coordinator (RCC) on 12/17/21 at 3:32pm. Refer to interview with the Administrator on 12/17/21 at 3:56pm. Attempted telephone interview with Resident #6's primary care provider (PCP) on 12/17/21 was unsuccessful. _____ Interview with the Dining Service Director on 12/17/21 at 9:37am revealed: -There was a current diet list posted in the kitchen or staff to follow. -He knew the resident diet list was updated monthly and that he would be responsible for updating the diet list. -He did not know who gave him the information for the diet changes to update the diet list; he had only started working as the Dining Service Director on Monday, 12/13/21. -The residents were each given a daily menu to make their food selections from; the resident's name was on the left-hand side of the daily menu	D 310		

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D 310	Continued From page 22 and the diet was listed on the top right-hand corner of the daily menu. -The cooks used the individual daily menus when plating food because the diets were on the top right-hand side. -It was important to serve the residents the right diet because he did not want a resident on a pureed diet or a chopped diet to get the wrong food. -The residents were ordered a specific diet from the physician for a reason and that was why they should always be followed. Interview with the Resident Care Coordinator (RCC) on 12/17/21 at 3:32pm revealed: -She was also the facility's Registered Nurse (RN). -Diet orders were requested to be updated by the residents' primary care provider (PCP) every six months. -She made a copy of the signed diet orders and gave the copy to the Dining Service Director; the original went into the residents' records. -Any diet order changes were also discussed at shift change so the staff knew who had diet order changes. -The medication aides (MA), the Dining Service Director, the diet aides and the personal care aides (PCAs) monitored the dining room service to ensure the residents were served the correct diets. Interview with the Administrator on 12/17/21 at 3:56pm revealed: -The facility RN provided the Dining Service Manager with any diet order changes. -The copy of the physician signed diet order is placed in a binder in the kitchen for the Dining Service Manager to reference. -The Dining Service Manager updated the daily	D 310		

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D 310	Continued From page 23 menu selection sheets and the Corporate Dining Service Manager was updating the diet list. -The diet orders were done for a reason and should have been followed as written.	D 310		