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
	HAL023048	A. BUILDING: _____ B. WING _____	R 01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SHELBY	1550 CHARLES ROAD SHELBY, NC 28152

(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 conducted an annual survey and follow-up survey on 01/19/22 through 01/20/22.	D 000	10A NCAC13F .0904 (e)(4) Nutrition and Food Service 10A NCAC 13F .0904(e)(4) 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	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: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to ensure therapeutic diets were served as ordered for 3 of 3 sampled residents (Residents #3 and #6) with an order for nectar thickened liquids and (Resident #5) with an order for a diabetic diet. The findings are: 1.Review of Resident #6's current FL2 dated 07/15/21 revealed: -Diagnoses included severe dementia, Parkinsonism and asthma. -She was constantly disoriented and the recommended level of care was a special care unit. -There was no diet order indicated.	D 310	Each staff member providing/assisting with dining services will be educated by DHW/Jordan Yost (Kindred Speech Therapist) in serving therapeutic diets as directed by MD. Executive Director obtained Simply Thick to utilize in both food and liquids to maintain compliance with prescribed diet. ED/designee will monitor meal service for adherence weekly for 4 weeks then monthly thereafter. Dining Service Director/designee will ensure sugar free options are available on menu for those on carbohydrate restricted diets. Staff/servers will be educated by DHW/designee in providing/ encouraging sugar free choices. ED/designee will monitor weekly for 4 weeks then monthly observations for compliance.	02/02/22 01/19/22 01/19/22 02/02/22 01/2/22

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Slagans — TITLE: Executive Director — (X6) DATE: 02/11/2022

STATE FORM 6899 50CO11 If continuation sheet 1 of 12

Reviewed and acknowledged by Sharon Dunton RN on 02/17/2022

Type text here

Sharon Dunton RN

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D 310	Continued From page 1 Review of Resident #6's physician order dated 09/21/21 revealed a referral for speech therapy evaluation. Review of Resident #6's Primary Care Physician (PCP) visit note dated 10/06/21 revealed: -She was evaluated by speech therapy on 10/04/21. -The speech therapist recommended nectar thickened liquids related to Resident #6's swallowing difficulty. Review of diet order sheet dated 10/06/21 revealed the PCP ordered a mechanically altered diet with nectar thick liquids. Review of diet order list located in the kitchen on 01/19/22 revealed Resident #6 was to be served a mechanically altered diet with nectar thick liquids. Interview with the Dietary Manager (DM) on 01/19/22 at 10:06am revealed: -Resident #6 required nectar thick liquids. -The facility purchased pre-thickened water, iced tea and orange juice for residents that required thickened liquids. Review of therapeutic diet menus on 01/19/22 revealed: -There were instructions on how to modify the regular diet to accommodate therapeutic diets. -There were not instructions on how to modify the regular diet to accommodate for nectar thickened liquids. Review of the lunch menu for 01/19/22 revealed vegetable medley soup, a choice of turkey casserole or crab salad with rolls, fruit toss, brussel sprouts with lemon sauce, strawberry	D 310		

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D 310	Continued From page 2 mousse and milk offered at every meal. Observation of the lunch meal service for Resident #6 on 01/19/22 at 12:00pm revealed: -She was served nectar thick water, nectar thick iced tea, vegetable medley soup, turkey casserole, chopped brussel sprouts with lemon sauce and fruit toss in fruit juices. -The broth in the vegetable medley soup was thin liquid. -She consumed two spoonfuls of the vegetable medley soup with the broth when the soup was removed because the broth was not nectar thick. Interview with a personal care aide (PCA) that served lunch to Resident #6 on 01/19/22 at 12:07pm revealed she thought the soup was thickened since the kitchen put Resident #6's name on it. Interview with the DM on 01/19/22 at 12:07pm and 4:30pm revealed: -Resident #6 was served a soup with thin liquid for lunch on 01/19/22. -Resident #6 was served prepackaged beverages that were nectar thickened and the kitchen did not thicken her vegetable soup. -She did not think that Resident #6's vegetable soup required thickening to a nectar thick consistency. -The facility disposed of their stock of thickening powder on 01/12/22 because it had expired. -She was trained on thickened liquids and looked up information related to thickening liquids on the internet. Interview with Special Care Unit Coordinator (SCC) for the B hall on 01/20/22 at 9:25am revealed: -The PCAs and medication aides (MA) were only	D 310		

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D 310	Continued From page 3 responsible for pouring pre-thickened beverages for residents that required thickened liquids. -The kitchen was responsible for thickening anything else such as soup. -She and the staff had not been trained on how to thicken liquids. -She was not aware that soup should be thickened for a resident that was ordered nectar thickened liquids. Interview with a MA on 01/20/22 at 9:40am revealed: -He had worked at the facility for 5 years and had not been asked to thicken any beverages or foods. -He did not have access to thickening powder that would be used to thicken beverages and foods such as soup. Telephone interview with Resident #6's Speech Therapist on 01/20/22 at 9:33am revealed: -He recommended nectar thick liquids for Resident #6 because she coughed and showed signs of aspiration after she consumed thin liquids during a bedside swallow on 10/04/21. -All of her liquids, including soup, should be thickened to a nectar consistency. -If Resident #6 consumed enough of a thin liquid then she would be at risk for aspiration. -Signs of aspiration after eating or drinking included: coughing, throat clearing and eyes watering. Interview with Resident #6's PCP on 01/19/22 at 2:40pm revealed: -Resident #6 was ordered nectar thick liquids based on the Speech Therapist's recommendations. -Resident #6 could aspirate on thin liquids which could lead to aspiration pneumonia.	D 310		

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D 310	Continued From page 4 -Signs of aspiration included coughing, congestion, shortness of breath and a fever; however, if a resident aspirated a small amount of liquid then they may not show visible signs of aspiration. -Residents that had breathing issues or lowered immune systems are at larger risk for aspiration pneumonia. -She would expect all of Resident #6's liquids to be thickened to a nectar thick consistency. -She also expected any food that included a liquid, such as soup, to be thickened to a nectar thick consistency. -She was not aware that Resident #6 was offered thin liquids. -She did not want the facility to offer Resident #6 thin liquids unless the Speech Therapist approved. Refer to the interview with the Administrator on 01/19/22 at 3:58pm. Based on observations and interviews Resident #6 was not interviewable. Attempted telephone interview with the facility's contracted Registered Dietitian on 01/19/22 at 3:12pm was unsuccessful. 2.Review of Resident #3's current FL2 dated 09/16/21 revealed: - Diagnoses included Dementia. - Pureed diet with nectar thickened liquids. Review of Resident #3's physician's diet order dated 10/15/21 revealed a pureed diet with nectar thickened liquids. Review of Resident #3's Diet Clarification Form	D 310		

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D 310	Continued From page 5 dated 12/22/21 revealed a diet order for Regular diet with no liquid consistency listed. Interview with the Dietary Manager (DM) on 01/19/22 at 9:22am revealed: -She identified Resident #3 as a recipient of nectar thickened liquids per dietary order notebook. -Resident #3 was ordered a regular diet with nectar thickened liquids. -She was responsible for ordering foods and beverages for the facility. -She was responsible for thickening soup. -PCA's were responsible for pouring of the beverages for meals from the pre-thickened cartons of beverages located in resident refrigerator on Special Care Unit (SCU) C Hall in the resident dining room. Observation of the DM plating Resident #3's lunch meal on 01/19/22 at 11:47am revealed: -The DM scooped a serving of turkey casserole and a serving of brussels sprouts on a plate. -She ladled a serving of vegetable medley soup from a large container on the steam table into a bowl. -She did not thicken the soup after it was ladled into the bowl. -The plate and bowl were placed on a tray and the dietary aide put the tray in an insulated cart. Review of therapeutic diet menus on 01/19/22 revealed there was not a menu for nectar thickened liquids for the vegetable medley soup. Observation of the dining room on 01/19/22 from 12:00pm to 12:29pm revealed: -Resident #3 was seated at table with a glass of nectar thickened water and a glass of nectar thickened tea.	D 310		

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D 310	Continued From page 6 -Resident #3 received a regular diet of vegetable medley soup, turkey pasta casserole, brussels sprouts with lemon sauce and strawberry mousse for dessert that was delivered from the kitchen on the insulated cart. -PCA added crushed crackers upon Resident #3's request to the vegetable medley soup. -The resident consumed 90% of the soup. Interview with the personal care aide (PCA) on 01/19/22 at 12:06pm revealed: - Resident #3 received a regular diet with nectar thickened liquids according to the resident diet list posted on the resident refrigerator. -The kitchen staff were responsible for thickening any food items like the vegetable soup. -Beverages came prepackaged and pre-thickened and did not require thickening. Interview with the Special Care Unit Coordinator (SCC) on 01/20/22 at 9:25am revealed: -Each unit had a list of resident diets placed on the unit refrigerator. -The Health and Wellness Director (HWD) or Resident Care Coordinator (RCC) were responsible for providing the kitchen with any new or updated diet orders received. -She knew Resident #3 was on a regular diet with nectar thickened liquids but was not aware that liquid consistency was not listed on diet clarification order. Interview with the Primary Care Provider (PCP) on 01/20/22 at 9:30am revealed: -Resident #3 should receive nectar thickened liquids due to history of swallowing issues and recent esophageal dilation. -He expected the facility to provide nectar thickened consistency for any foods with liquids or to provide an appropriate alternative.	D 310		

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D 310	Continued From page 7 -He identified aspiration as potential harm to resident if resident did not receive nectar thickened liquids. Interview with the HWD on 01/20/21 at 10:10am revealed: -She or the RCC were responsible for providing the kitchen with any new or updated diet orders. -Resident #3 was receiving a regular diet with nectar thickened liquids. -She was responsible to contact the PCP for a diet clarification order. -She knew Resident #3's diet order should have been clarified but did not clarify. Refer to the interview with Administrator on 01/19/22 at 3:58pm. Attempted telephone interview with facility contracted Registered Dietitian on 01/19/22 at 3:12pm was unsuccessful. 3. Review of Resident #4's current FL2 dated 09/22/21 revealed: -Diagnoses included diabetes mellitus, hypertension, hyperlipidemia, and gastroesophageal reflux disease. -There was an order for a no concentrated sweets diet. Review of Resident #4's primary care provider's (PCP) order dated 10/06/21 revealed the resident's diet was changed to a consistent carbohydrate diet. Review of the facility's therapeutic diet list on 01/19/22 revealed Resident #4 was to be served a consistent carbohydrate diet. Review of the facility's regular diet menu for lunch	D 310		

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D 310	Continued From page 8 on 01/19/22 revealed: -Entrée choices included crab salad on a roll with vegetable medley soup or turkey casserole. -Side item choices included brussel sprouts with lemon sauce or fruit toss. -The dessert for the day was strawberry mousse. Review of the facility's therapeutic diet menu for consistent carbohydrate diet for lunch on 01/19/22 revealed the strawberry mousse was to be sugar free. Observation of Resident #4's lunch meal service on 01/19/22 at 12:25pm revealed the resident was served crab salad on a roll, vegetable medley soup, brussel sprouts with lemon sauce, coffee, and water. Observation of Resident #4 on 01/19/22 at 12:39pm revealed the resident was served regular strawberry mousse dessert. Interview with the Dietary Manager on 01/19/21 at 12:46pm revealed: -Resident #4 was supposed to receive the sugar free strawberry mousse on the consistent carbohydrate diet. -The staff who had served Resident #4's dessert served the regular strawberry mousse instead of the sugar free version which was stored in plastic serving containers with lids. Interview with Resident #4's PCP on 01/19/22 at 2:59pm revealed: -She had been informed Resident #4 had received a regular dessert at lunch on 01/19/22. -The resident should have been served sugar free dessert. -She closely monitored the resident's blood sugars.	D 310		

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D 310	Continued From page 9 -The resident was often "noncompliant" with the consistent carbohydrate diet. Interview with the medication aide (MA) on 01/20/22 at 3:42pm revealed: -She had served Resident #4 the regular strawberry mousse dessert at lunch on 01/19/21. -She gave the resident "the wrong dessert." -The Dietary Manager had told her "afterward" the sugar free strawberry mousse was stored in the plastic containers with lids. Interview with the Administrator on 01/19/22 at 3:58pm revealed: -The facility's contracted menu provider had instructions on how to modify food from the regular diet to be appropriate for therapeutic diets. -She expected the kitchen to serve therapeutic diets as ordered. Interview with the Administrator on 01/19/22 at 3:58pm revealed: -The facility's contracted menu provider had different diet inserts that would instruct the kitchen how to prepare therapeutic diets. -The thickened liquid diet insert should have been printed out and kept with the other recipes. -The facility used pre-thickened beverages for residents that required thickened liquids. -The PCAs and MAs were responsible for thickening liquids that were not pre-thickened. -All of the thickening powder was thrown away on 01/12/22 because it was expired. -The DM was supposed to order more thickening powder on 01/17/22. -She was not aware of what the kitchen was doing during the last 7 days when the facility did not have any thickening powder. -She expected the kitchen to substitute food that	D 310		

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D 310	Continued From page 10 was of an appropriate consistency until the thickening powder arrived. -She expected the kitchen to prepare the therapeutic diets as ordered. The facility failed to ensure therapeutic diets were served as ordered to 3 of 3 sampled residents related to two residents who had an order for nectar thick liquid diet who were served a vegetable medley soup with thin liquid which could lead to aspiration pneumonia (#3, #6) and one resident on a consistent carbohydrate diet who was served a regular diet strawberry mousse which could lead to elevated blood sugars (#4). This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/19/22 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 6, 2022.	D 310	Type text here	Type text here
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. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents received care and	D912	G.S. 131D-21(2) Declaration of Resident's 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. DHW/designee will review diet orders to ensure each residents is receiving the correct diet as ordered by MD. Dining	01/20/22

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D912	Continued From page 11 services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to therapeutic diets. The findings are: Based on observations, interviews and record reviews the facility failed to ensure therapeutic diets were served as ordered for 3 of 3 sampled residents (Residents #3 and #6) with an order for nectar thickened liquids and (Resident #5) with an order for a diabetic diet.. [Refer to tag 310, 10A NCAC 13F .0904(e)(4) Type B Violation)].	D912	Service /designee will review same and will educate/communicate with servers to ensure correct diets are served at each meal.	