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	HAL042006	A. BUILDING: _____ B. WING _____	04/13/2022

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 12, 2022 to April 13, 2022.	D 000		
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 observations, record reviews and interviews the facility failed to ensure an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of the dietary staff for 1 of 3 sampled residents (#3) with physician's orders for a mechanical soft diet. The findings are: Review of Resident #3's current FL-2 dated 01/18/22 revealed diagnoses included Alzheimer's disease and dysphasia. Review of Resident #3's physician's order dated 01/28/22 revealed, there was an order for a mechanical soft diet. Observation of the kitchen on 04/12/22 at 9:01am revealed: -There was a list of physician-ordered therapeutic diets posted.	D 309		

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-The posted therapeutic diet list was not dated.
-Resident #3's diet order listed was for a mechanical soft for meats only.

Interview with a cook on 04/12/22 at 9:03am revealed:
-He prepared the residents' meal based on the posted therapeutic diet list.
-He did not know when the list had been updated.
-The Dietary Manager was the person responsible for updating and posting the therapeutic diet list.

Observation of the lunch meal on 04/12/22 at 12:19am revealed:
-Resident #3 was served chicken nuggets, sweet potato fries, coleslaw, corn, applesauce, milk and lemonade.
-The chicken nuggets was the only food item that was chopped on Resident #3's lunch plate.
-Resident #3 consumed all of the chicken nuggets and at least ¾ of her meal.

Observation of the breakfast meal on 04/13/22 at 8:23am revealed:
-Resident #3 was served pancakes, fried bacon, scrambled eggs, mixed fruit, apple juice and milk.
-The fried bacon was the only food item that was chopped on Resident #3's breakfast plate.

Interview with Resident #3 on 04/13/22 at 8:23am revealed:
-She did not like her bacon chopped.
-The kitchen staff "cut up" her meats all the time.
-She "ate fine" and did not have any problems chewing and swallowing her food.

Interview with the medication aide (MA) on 04/14/22 at 8:39am revealed:
-Resident #3's meats were chopped because of

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D 309	Continued From page 2 her issues with swallowing. -Resident #3's meats was the only food item that had been chopped. Attempted telephone interview with the Dietary Manager on 04/14/22 at 12:26pm was unsuccessful. Interview with the Administrator on 04/14/22 at 12:50 pm revealed: -The Resident Care Coordinator (RCC) reviewed all diet orders and provided the Dietary Manager a list to be posted in the kitchen. -The RCC reviewed all new diet orders and updated the residents' diet list. -The residents' diet list was last updated on 04/11/22. -The RCC was the person responsible for updating the residents' diet list and ensuring the therapeutic diet orders were posted in the kitchen.	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, interviews, and record reviews the facility failed to ensure therapeutic	D 310		

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diets were served as ordered for 1 of 2 resident sampled (#3) with an order for mechanical soft diet.

The findings are:

Review of Resident #3's current FL-2 dated 01/18/22 revealed diagnoses included dysphagia (difficulty swallowing).

Review of the therapeutic diet list that the facility provided the team leader with on 04/12/22 at 9:45am revealed Resident #3 was on a mechanical soft diet.

Review of Resident #3's physician orders dated 01/28/22 revealed an order for a mechanical soft diet.

Review of Resident #3's previous diet order dated 08/20/21 revealed an order for a mechanical soft diet with instructions that entire meal with meats will be chopped.

Review of Resident #3's current care plan signed by her primary care provider (PCP) on 02/11/22 revealed dietary restrictions of mechanical soft diet.

Review of the Residents' lunch meal menu posted on 04/12/22 revealed:
-Chicken nuggets, sweet potato fries, corn, coleslaw, applesauce, water, juice of Residents' choice, milk (optional) and water was to be served for the lunch meal.
-There was not a mechanical soft therapeutic diet menu posted in the kitchen.

Observation of the lunch meal on 04/12/22 at 12:19am revealed:

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-Resident #3 was served chicken nuggets, sweet potato fries, coleslaw, corn, applesauce, milk and lemonade.
-The chicken nuggets was the only food item that was chopped on Resident #3's lunch plate.
-Resident #3 consumed all of the chicken nuggets and at least ¾ of her meal.

Observation of the breakfast meal on 04/13/22 at 8:23am revealed:
-Resident #3 was served pancakes, fried bacon, scrambled eggs, mixed fruit, apple juice and milk.
-The fried bacon was the only food item that was chopped on Resident #3's breakfast plate.

Interview with Resident #3 on 04/13/22 at 9:20am revealed:
-She was upset because she was given "bacon bits" this morning (04/13/22) for breakfast.
-She has always received full pieces of bacon before this morning (04/13/22).
-She has no difficulty swallowing, has all but one of her teeth, and chews all of her bites of food multiple times before swallowing.
-She believed she was on a regular diet and received the same meal as any of the other resident's that sat at the table with her in the dining room.

Telephone interview with Resident #3's family member on 4/13/22 at 9:30am revealed:
-She was not aware that Resident #3 was on a therapeutic diet.
-She attends Resident #'s PCP appointments and the PCP never mentioned Resident #3 being on a therapeutic diet.
-Resident #3 has no difficulty swallowing and chews her food completely before swallowing.

Interview with the medication aide (MA) on

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D 310	Continued From page 5 04/14/22 at 8:39am revealed: -Resident #3's meats were chopped because of her issues with swallowing. -Resident #3's meats was the only food item that had been chopped. Attempted telephone interview with Resident #3's PCP on 04/12/22 at 4:45pm, 04/13/22 at 10:36am and on 04/13/22 at 11:28am were unsuccessful. Telephone interview with the Dietary Manager on 04/14/22 at 12:26pm was unsuccessful. Interview with the Administrator on 04/14/22 at 12:50 pm revealed: -The Resident Care Coordinator (RCC) reviewed all diet orders and provided the Dietary Manager a list to be posted in the kitchen. -The RCC reviewed all new diet orders and updated the residents' diet list. -The residents' diet list was last updated on 04/11/22. -The RCC was the person responsible for updating the residents' diet list and ensuring the therapeutic diet orders were posted in the kitchen.	D 310		
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.	D 358		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents for record review including a medication for blood pressure that was administered more often than prescribed (#1) and a medication used to treat symptoms of dementia (#3) that was not administered for 27 days.

The findings are:

1. Review of Resident #1's current FL-2 dated 11/02/21 revealed:
-Diagnoses included end-stage renal disease, hyperlipidemia, atherosclerosis, hypertension and chronic obstructive pulmonary disease.
-There was an order for isosorbide dinitrate 20mg to be administered each Monday, Wednesday and Friday at bedtime (Isosorbide dinitrate is a medication used to treat high blood pressure).

Review of Resident #1's current physician's orders dated 01/11/22 revealed isosorbide mononitrate was ordered to be administered everyday on Monday, Wednesday and Friday at 5:00pm.

Review of Resident #1's February 2022 electronic medication administration record (eMAR) revealed:
-There was a computer entry for isosorbide mononitrate 20mg tablet to be administered at 5:00pm.
-The frequency was entered as once a day every other day with special instructions to take one tablet by mouth everyday on Monday, Wednesday and Friday at 5:00pm.
-There was documentation of administration

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D 358	Continued From page 7 every other day beginning Wednesday 02/02/22. -There was documentation of administration on Tuesday 02/05/22, Thursday 02/10/22, Saturday 02/12/22, Sunday 02/20/22, Tuesday 02/22/22, Thursday 02/24/22 and Saturday 02/26/22. -There was no documentation of administration on Monday 02/07/22, Wednesday 02/09/22, Monday 02/21/22, Wednesday 02/23/22 and 02/25/22. Review of Resident #1's March 2022 eMAR revealed: -There was a computer entry for isosorbide mononitrate 20mg tablet to be administered at 5:00pm. -The frequency was entered as once a day every other day with special instructions to take one tablet by mouth everyday on Monday, Wednesday and Friday at 5:00pm. -There was documentation of administration every other day beginning 03/02/22. -There was documentation of administration on Sunday 03/06/22, Tuesday 03/08/22, Thursday 03/10/22, Saturday 03/12/22, Sunday 03/20/22, Tuesday 03/22/22, Thursday 03/24/22 and Saturday 03/26/22. -There was no documentation of administration on Monday 03/07/22, Wednesday 03/09/22, Friday 03/11/22, Monday 03/21/22, Wednesday 03/23/22 and Friday 03/25/22. Review of Resident #1's April 2022 eMAR revealed: -There was a computer entry for isosorbide mononitrate 20mg tablet to be administered at 5:00pm. -The frequency was entered as once a day every other day with special instructions to take one tablet by mouth everyday on Monday, Wednesday and Friday at 5:00pm.	D 358		

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-There was documentation of administration every other day beginning 04/01/22.
-There was documentation of administration on Sunday 04/03/22, Tuesday 04/05/22,Thursday 04/07/22 and Saturday 04/09/22.
-There was no documentation of administration on Monday 04/04/22, Wednesday 04/06/22 and Friday 04/08/22.

Observation of Resident #1's medications on hand on 04/13/22 at 10:42am revealed:
-There was a bubble pack labeled isosorbide mononitrate 20mg to be administered every Monday, Wednesday and Friday at 5:00pm.
-Mon, Wed, and Fri was written in red ink on the label.

Interview with a Medication Aide (MA) on 04/13/22 at 10:42am revealed:
-Special instructions for administration of medications were always written in red on the label and she had seen it done for the isosorbide prescribed to Resident #1.
-She was not sure who wrote the instructions in red on the label but it was done to alert staff administering medications to special instructions.
-Staff administering medications should always read through the instructions prior to administering any medication.

Interview with a second MA on 04/13/22 at 10:53am revealed:
-Mon, Wed, Fri had always been on the medication label for Resident #1.
-Isosorbide should not have been administered every other day since the instructions were to administer the medication on Monday, Wednesday and Friday.
-Staff administering medications should always check the name of the resident, medication,

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dose, and instructions on the eMAR against the label on the bubble pack to ensure they are administering medications as prescribed.

Telephone interview with Resident #1's primary care provider (PCP) on 04/13/22 at 12:01pm revealed an extra doses of isosorbide would decrease his blood pressure but it had not; however, medications should have been administered as prescribed.

Attempted interview with the Resident Care Coordinator on 04/12/22 and 04/13/22 was unsuccessful.

Interview with the Regional Area Director on 04/13/22 at 10:00am revealed:
-She reviewed Resident #1's medications the previous week and did not realize the frequency was incorrect on the eMAR.
-Medication Aides (MAs) were not reading through the instructions on the screen when the administration time came up on the eMAR every other day but should be.
-The RCC was responsible for ensuring orders were entered correctly on the eMAR.
-She had attempted to correct the frequency on the eMAR and the system would default to every other day frequency and she was not aware until survey.

2. Review of Resident #3's current FL-2 dated 01/18/22 revealed diagnoses included Alzheimer's disease and hypertension.

Review of Resident #3's physician orders dated 01/28/22 revealed there was an order for Quetiapine 25mg, take one tablet twice a day (Quetiapine is a medication used to manage symptoms of dementia).

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D 358	Continued From page 10 Review of Resident #3's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Quetiapine 25mg with instructions to administer 1 tablet twice a day, scheduled for administration at 9:00am and 9:00pm. -Quetiapine 25mg was documented as administered twice a day from 02/01/22 through 02/15/22. -Quetiapine 25mg was not documented as administered twice a day from 02/16/22 through 02/28/22. Review of Resident #3's March 2022 eMAR revealed: -There was an entry for Quetiapine 25mg with instructions to administer 1 tablet twice a day, scheduled for administration at 9:00am and 9:00pm. -Quetiapine 25mg was documented as administered twice a day from 03/16/22 through 03/31/22. -Quetiapine 25mg was not documented as administered twice a day from 03/01/22 through 03/15/22. Observation of Resident #3's medication on hand on 04/12/22 at 2:40pm revealed Resident #3 had Quetiapine 25mg available for administration on the medication cart. Review of Resident #3's facility progress notes for February 2022 and March of 2022 revealed there was no documentation of resident complaining of nausea or vomiting, no reported instances of insomnia and no behaviors noted. Interview with Resident #3 on 04/13/22 at 9:20am	D 358		

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revealed:
-The medication aides (MA) administer her medications to her in the morning and at night.
-She was familiar with her medications but could not recall all the names of her medications.
-She was not aware if she received her Quetiapine in February and March as scheduled.
-She did not have any nausea, vomiting or inability to sleep that she can recall in the last three months (Nausea, vomiting and insomnia are side effects of Quetiapine withdrawal).

Telephone interview with Resident #3's family member on 04/13/22 at 9:30am revealed:
-She was not aware that Resident #3 was not receiving her Quetiapine in February 2022 and March 2022 as scheduled.
-The resident was on automatic refills from her pharmacy and should have had plenty of the medication to be administered.
-She expected the staff at the facility to notify her if the resident was out of medication or not receiving medication so that she could call the pharmacy.
-She had not noticed any changes in Resident #3's behavior in February and March of 2022.

Interview with the lead MA on 04/13/22 at 12:35pm revealed:
-When Resident #3 returned from a hospitalization, the Quetiapine order was accidentally entered on the eMAR with an end date of 30 days.
-She was responsible for the error and she should have entered the order with an open-end date onto the eMAR.
-She completed a medication cart audit where she compared Resident #3's eMAR to what was on the medication cart and she removed the Quetiapine from the cart when the order fell off

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the eMAR 02/16/22 which was 30 days after her hospitalization.
-Resident #3's automatic refill supply of medication came to the facility around 03/16/22 and they sent Quetiapine.
-She reviewed Resident #3's physician orders 03/16/22 and that is when she realized that Resident #3 should be receiving Quetiapine.
-She did not notify the resident's PCP or the resident's family member that she missed the 27 days of Quetiapine.
-She was going to complete a medication error report today (04/13/22) and notify the PCP according to the facility's policy.

Attempted interview with the Resident Care Coordinator on 04/12/22 and 04/13/22 was unsuccessful.

Interview with the Administrator on 04/13/22 at 12:55pm revealed:
-She was not aware that Resident #3 missed 12 days of Quetiapine in February and 15 days of Quetiapine in March.
-She expected Resident #3 to receive her Quetiapine as ordered.

Attempted telephone interview with Resident #3's contracted pharmacy on 04/13/22 at 9:07am and 04/13/22 at 11:01am were unsuccessful.

Attempted telephone interview with Resident #3's PCP on 04/12/22 at 4:45pm, 04/13/22 at 10:36am and on 04/13/22 at 11:28am were unsuccessful.