Received via electronic mail 06/23/2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

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D 000	Initial Comments The Adult Care Licensure Section completed an annual survey on May 24, 2023 and May 25, 2023.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure follow-up to meet the routine health care needs of 1 of 3 sampled residents (#1) who had been refusing to use his continuous positive airway pressure (CPAP) machine. The findings are: Review of Resident #1's current FL2 dated 06/21/22 revealed diagnoses included chronic obstructive pulmonary disease, hypoxia, hypertension, and allergies. Review of Resident #1's physician's orders dated 11/29/22 revealed an order for CPAP at bedtime with oxygen at 3 liters per minute, on at bedtime and off in the morning. Review of Resident #1's electronic Medication Administration Record (eMAR) for April 2023 revealed: -There was an entry for CPAP at bedtime with oxygen at 3 liters per minute, on at bedtime and off in the morning. -There was documentation Resident #1 refused the CPAP 23 times between 04/01/23 and	D 273		

Reviewed and acknowledged 06/26/2023.

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D 273	Continued From page 1 04/30/23. Review of Resident #1's eMAR for 05/01/23 through 05/23/23 revealed: -There was an entry for CPAP at bedtime with oxygen at 3 liters per minute, on at bedtime and off in the morning. -There was documentation Resident #1 refused the CPAP 6 times between 05/01/23 and 05/23/23. Interview with Resident #1 on 05/25/23 at 12:55pm revealed: -He was supposed to wear a CPAP at night due to lung problems. -He often refused to wear his CPAP at night because the CPAP made him feel like it was more difficult for him to breath with it on. -He wore the CPAP at night sometimes when he felt like he needed it to breathe. Interview with a medication aide (MA) on 05/25/23 at 2:13pm revealed: -After a resident refused a medication or treatment 3 times, the MA was to let the Administrator know about the refusals. -She had worked on second shift a few times and did not know Resident #1 refused his CPAP; he would sometimes put it on and took it off, but he did not totally refuse it. -She had not contacted Resident #1's PCP regarding refusals. Interview with a second MA on 05/25/23 at 3:27pm revealed: -Resident #1 refused his CPAP often. -MAs were to let the residents' PCP and the Administrator know after 3 refusals. -She did not remember if she let Resident #1's PCP or the Administrator know about Resident	D 273	**D273-** In service provided for All MA's on 5/25/2023. MA's report <u>every</u> refusal directly to Physician and provides copy to Nurse/RCC/Administrator. After 3 refusals Nurse will require written action taken from the ordering Physician.	5/25/2023

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D 273	Continued From page 2 #1's refusals. Telephone interview with Resident #1's primary care provider (PCP) on 05/25/23 at 1:30pm revealed: -The facility had discussed noncompliance with her generally, but she did not know Resident #1 refused to wear his CPAP, 23 times in April 2023, and 6 times in May 2023. -She expected the facility to notify her when Resident #1 refused his CPAP so many days in each month. -There were no negative impact to Resident #1 with CPAP refusals over the last 2 months, but there could be negative impacts if Resident #1 did not use his CPAP over a longer period of time -Resident #1 did not have increased difficulty with breathing within the last 2 months. Interview with the Administrator on 05/25/23 at 2:27pm revealed: -After 3 refusals, staff should have notified her and/or the resident's PCP. -Usually, staff called her to notify her of refusals. -Staff had not notified her of Resident #1 refusing his CPAP 23 times in April 2023 and 6 times in May 2023. -Second or third shift MAs should have notified Resident #1's PCP or notified her because she was in the facility when second shift arrived and before third shift went home. Interview with the Executive Director (ED) on 05/25/23 at 3:02pm revealed: -If a resident refused medications consistently, the MA supervisor or the Administrator, were to reach out to the resident's provider regarding the refusals. -She would also reach out to the physician if the Administrator or the MA supervisor had trouble	D 273		

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D 273	Continued From page 3 getting a response from the resident's provider. -She did not know about Resident #1's CPAP refusals in April 2023 and May 2023, and the refusals should have been reported to Resident #1's provider.	D 273		
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 observations, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 3 sampled residents (#3) related to an order for a daily blood pressure (BP) check. The findings are: Review of Resident #3's current FL2 dated 07/26/22 revealed diagnoses included essential hypertension, diabetes mellitus, and hypervolemic hyponatremia. Review of Resident #3's physician's orders dated 02/14/23 revealed an order to check Resident #3's BP once daily. Review of Resident #3's electronic Medication Administration Records (eMARs) for April 2023, and May 2023 from 05/01/23 through 05/24/23	D 276	**D276-** In service conducted for all MA's Including community policy and training provided on how to enter Physicians orders on electronic MAR. All vitals to be entered by MA's. Nurse to complete 2nd check to ensure vitals are entered in electronic MAR.	5/25/2023

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D 276	Continued From page 4 revealed there was no entry for daily BP checks. Interview with a medication aide (MA) on 05/25/23 at 10:27am revealed: -Resident #3 did not currently have an order to check her BP daily. -She checked Resident #3's BP once, but she did not remember when. -If Resident #3 had a current order for BP checks, the readings would be documented on the MAR. Interview with the Administrator on 05/25/23 at 10:40am revealed: -She began working as the Administrator on March 2023. -She had not seen Resident #3's order for daily BP checks. -She guessed it was an oversight. Interview with a pharmacist at the facility's contracted pharmacy on 05/25/23 at 10:44am revealed BP checks would not show up on Resident #3's profile at the pharmacy because the facility entered their own orders for all vital signs, with the exception of blood glucose checks on the eMAR. Interview with Resident #3 on 05/25/23 at 1:20pm revealed: -She was supposed to have her BP checked due to issues with her heart. -She thought staff checked her BP once a week. Interview with a medication aide (MA) on 05/25/23 at 2:13pm revealed: -MAs faxed new orders to the pharmacy. -She also would ask the Administrator to look at new orders as well. -If a new order included a treatment, the order was faxed to the pharmacy and placed in a stack	D 276		

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D 276	Continued From page 5 of documents for Resident #3's PCP to review and sign off on. -MAs could not enter treatment orders on the eMAR. -She thought the pharmacy entered BP orders on the eMAR. Interview with a second MA on 05/25/23 at 3:27pm revealed: -She did not know about Resident #3's physician's order for daily BP checks. -MAs faxed medication and treatment orders to the pharmacy so that the orders could be entered on the eMAR. -She did not know the pharmacy did not enter orders for BP checks onto the eMAR. -She had not entered any orders for BP checks onto the eMAR and she did not know who at the facility entered BP orders. Telephone interview with Resident #3's primary care provider (PCP) on 05/25/23 at 1:30pm revealed: -She was making adjustments to Resident #3's medications and ordered daily BP checks for her. -She did not know the facility had not implemented the order for daily BP checks. -She expected the facility to implement the order for daily BP checks when they were ordered in March 2023. Interview with the Administrator on 05/25/23 at 2:27pm revealed: -She and the MAs were responsible for reviewing new physician's orders and following through with them. -She knew Resident #3 had her BP checked monthly with her monthly vital sign checks, but she did not know about Resident #3's physician's order for daily BP checks.	D 276		

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D 276	Continued From page 6 -MAs were able to enter BP checks onto the eMAR. -The MA who received the order for daily BP checks would have been responsible for entering the order for daily BP checks on the eMAR so that the order could be implemented. Interview with the Executive Director (ED) on 05/25/23 at 3:02pm revealed: -She did not know about Resident #3's physician's order for daily BP checks. -The facility Nurse had been responsible for following through with physician's orders, but there was not a Nurse employed at the facility at that time. -There were MA supervisors who were following up with physician's orders when there was not a Nurse at the facility. -BP checks were to be entered on the eMAR for documentation. -She did not know the pharmacy did not enter orders for BP checks on the eMAR.	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 any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by:	D 296	**D 296-** DSD will provide matching therapeutic menu modifications for residents who are prescribed therapeutic diets.	6/30/2023

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D 296	Continued From page 7 Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic diet menus for food service guidance for 2 of 2 sampled residents (#1 and #2) with physician's orders for a no added salt (NAS) diet (#1) and a low concentrated sweets (LCS) diet (#2). The findings are: 1. Review of Resident #1's current FL2 dated 06/21/22 revealed: -Diagnoses included chronic obstructive pulmonary disease, hypoxia, hypertension, and allergies. -There was an order for a NAS diet. Observation of the kitchen on 05/02/23 at 2:45pm revealed there were no therapeutic diet menus available for a NAS diet. Observation of Resident #1's lunch meal service on 05/24/23 between 12:00pm and 12:37pm revealed: -Resident #1 was served vegetable soup, shrimp and grits, mixed vegetables, water, and tea. -Resident #1 consumed 100% of the meal. -It could not be determined if Resident #1 was served the correct therapeutic diet due to a NAS menu was not available for staff guidance. Interview with Resident #1 on 05/25/23 at 12:55pm revealed: -He usually did not order dessert with his meals. -He did not know he was on a NAS diet, but he did not add salt to his meals. Telephone interview with Resident #1's primary care provider (PCP) on 05/25/23 at 1:30pm revealed:	D 296		

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D 296	Continued From page 8 -NAS was the most appropriate diet for Resident #1. -She expected the facility to follow a menu for a NAS diet for Resident #1. Refer to interview with the Dietary Manager (DM) on 05/24/23 at 10:21am. Refer to interview with a dietary aide on 05/25/23 at 1:01pm. Refer to interview with a personal care aide (PCA) on 05/25/23 at 1:18am. Refer to interview with the Administrator on 05/25/23 at 2:27pm. Refer to interview with the Executive Director (ED) on 05/25/23 at 3:02pm. 2. Review of Resident 2's current FL2 dated 03/27/23 revealed: -Diagnoses included acute failure to thrive, and diabetes mellitus 2 with diabetic peripheral angiopathy without gangrene. -There was an order for a LCS diet with a regular texture. Observation of the kitchen on 05/02/23 at 2:45pm revealed there were no therapeutic diet menus available for a LCS diet. Observation of Resident #2's lunch meal service on 05/24/23 between 12:00pm and 12:37pm revealed: -Resident #1 was served vegetable soup, saltine crackers, 2 pieces of tiramisu cake, water, tea, and coffee. -Resident #1 took 2 marmalade jelly packets from the table supply of jelly packets and added it to	D 296		

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D 296	Continued From page 9 his crackers. -Resident #1 consumed 100% of the meal. -It could not be determined if Resident #1 was served the correct therapeutic diet due to a NAS menu was not available for staff guidance. Interview with Resident #2 on 05/24/23 at 12:15am revealed: -He did not think he was on a special diet. -He chose his meals from the food options listed on the menu sheets provided by staff. Telephone interview with Resident #1's primary care provider (PCP) on 05/25/23 at 1:30pm revealed she expected for Resident #1 to be served a LCS diet as ordered according to a LCS menu. Refer to interview with the Dietary Manager (DM) on 05/24/23 at 10:21am. Refer to interview with a dietary aide on 05/25/23 at 1:01pm. Refer to interview with a personal care aide (PCA) on 05/25/23 at 1:18am. Refer to interview with the Administrator on 05/25/23 at 2:27pm. Refer to interview with the Executive Director (ED) on 05/25/23 at 3:02pm. Interview with the Dietary Manager (DM) on 05/24/23 at 10:21am revealed: -The facility did not have therapeutic menus available. -He created the daily menus and residents had an option of food items to choose from the menus.	D 296		

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D 296	Continued From page 10 -There were dessert options with no sugar added and fresh fruit available for residents who had diet orders for NCS or LCS; water, unsweetened tea, and diet soda were also available. -He had worked at other facilities where he used therapeutic menus to prepare food, but he had not seen any therapeutic diet menus at this facility. -There were no therapeutic menus at the facility, because the facility also had independent living residents whom the dietary staff also prepared and served meals to. -He did not know who was responsible for ensuring therapeutic menus were available for guidance in meal preparation for residents with therapeutic diet orders. Interview with a dietary aide on 05/25/23 at 1:01pm revealed: -He had not seen any therapeutic menus available for guidance in preparing meals for residents ordered therapeutic diets. -He followed the regular menus for all diets, but there were sugar free dessert options available. -He plated the meals according to the what the residents ordered from the regular menu. Interview with a personal care aide (PCA) on 05/25/23 at 1:18am revealed: -She assisted with serving meals in the dining room during her shift. -The dietary staff had a list of residents with their diets and used the list to prepare plates. -She did not know all the residents' diet orders; she just served each resident their plates prepared by the dietary staff. Interview with the Administrator on 05/25/23 at 2:27pm revealed: -She knew there should be matching menus for	D 296		

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D 296	Continued From page 11 each therapeutic diet. -She did not know why there were no matching menus available. -The DM was responsible for ensuring there were menus available. Interview with the Executive Director (ED) on 05/25/23 at 3:02pm revealed: -She did not know there should have been a matching therapeutic menu for each therapeutic diet order. -She was responsible for ensuring there were matching therapeutic menus available.	D 296		