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
	HAL068035	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA HILLSBOROUGH	1911 ORANGE GROVE ROAD HILLSBOROUGH, NC 27278

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 08/09/23 through 08/11/23.	D 000	Responses to cited deficiencies do not constitute an admission or agreement of the facility. The truth of the facts alleged, or conclusions set forth I the Statement of Deficiency or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.	9/8/23
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#2) which resulted in a resident having 6 documented falls in 3 months. The findings are: Review of the facility's Fall Reduction Program Policy dated 11/2021 revealed: -The goal of the is to identify any fall risks a resident may have and consider interventions to mitigate the risk of fall and injury. -Update care plan/service plan with new interventions appropriate for cognitive level and relative to the conditions involving the fall. -A new intervention must be developed for each fall, or a determination made that the current interventions are appropriate. -Establish resident-specific interventions. -There was no information regarding increased	D 270	.0901 (b) Personal Care and Supervision DHW/Designee will educate staff on fall reduction policy. DHW/designee will review each fall and implement interventions on current care plan as needed. (Continued Sheet 2)	9/8/23

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeff G Palmisano, ED | TITLE | (X6) DATE: 8/31/23

Reviewed and Acknowledged Keisha Banks 09/08/2023

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D 270	Continued From page 1 supervision after a fall. Review of Resident #2's current FL2 dated 11/16/22 revealed: -Diagnoses included hypertension, mild cognitive impairment, osteoarthritis of the knees, and balance problems. -Resident #2 was intermittently disoriented. -Resident #2 was semi-ambulatory. -Resident #2 was continent of bowel and bladder and needed assistance with bathing and dressing. Review of Resident #2's care plan dated 10/15/23 revealed there was no documentation of the amount of assistance required for Resident #3's activities of daily living. Review of Resident #2's licensed health professional support review (LHPS) and evaluation form dated 06/15/23 revealed: -Resident #2 used a wheelchair for locomotion with 1 person assist to transfer and propel. -Staff reported no significant changes this quarter. Review of Resident #2's Physical Therapy Initial Evaluation dated 08/02/23 revealed: -The primary concern was falls and the goal was to reduce falls. -Per staff, Resident #2 had been falling out of bed when she tried to get to the restroom. -The physical therapist assessed Resident #2 required assistance with unlocking and locking the brakes of her wheelchair and with transferring from her wheelchair to the commode. Observation of Resident #2 on 08/09/23 at 9:56am revealed: -Resident #2 was seated in her wheelchair beside	D 270	DHW/designee will implement increased eyes-on safety checks for 72 hours post fall. DHW/designee will contact physician for a PT/OT evaluation of any resident with two or more falls in a two-week period. DHW/designee will educate residents on safety awareness practices. All residents with falls will be discussed at bi-weekly IDT meetings. All residents will receive an assessment every six months and upon change in conditions. Any residents with three or more falls in a 30-day period will be reassessed promptly.	

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D 270	Continued From page 2 her bed. -Resident #2 had a quarter rail on her bed; the bed rail base fit between the mattress and the box spring. -There were no alarms on Resident #2's bed or wheelchair. -There was not floor mat in the room. a. Review of Resident #2's Incident and Accident Report dated 06/12/23 at 10:37am revealed: -Resident #2 was found on the floor after having a fall in her bathroom. -Resident #2 was transferring to her wheelchair after using the restroom. -The wheelchair was not locked and rolled as Resident #2 went to sit down in it. -Resident #2 was assisted into her wheelchair by two staff. -There were no injuries documented. -The plan to prevent reoccurrence of the fall was to continue to educate Resident #2 regarding locking her wheelchair and use of call bell. Review of Resident #2's progress notes dated 06/12/23 at 10:37am revealed: -Resident #2 was observed sitting on her bottom in front of the commode in her bathroom. -Resident #2's was transferring to her wheelchair after using the restroom and her wheelchair was not locked; the wheelchair rolled away as Resident #2 went to sit down on it. -Resident #2's vital signs were taken. Review of Resident #2's Service Description dated 06/14/23 revealed: -Resident #2 had a history of falls. -She had ambulation/gait issues and used an assistive device: a walker and a manual wheelchair. -She required staff to escort or push her	D 270		

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D 270	Continued From page 3 wheelchair because of a physical limitation and required minimal physical assistance with transfers. -She was incontinent and had a physician's order to assist her to the restroom every 3 hours between the hours of 6:00am and 9:00pm. -She was cognitively impaired and impaired in safety awareness. -She had more than 1 fall in the last 3 months. -Staff was to continue to educate Resident #2 to push her call pendant when she needed assistance and remind her to lock her wheelchair with transfers. -There was no other information regarding interventions or increased supervision after falls. Telephone interview with the Director of Health and Wellness (DHW) on 08/11/23 at 12:00pm revealed: -She documented the progress note and completed the Incident/Accident Report dated 06/12/23. -Resident #2's PCP wrote an order in March 2023 for staff to assist with toileting every 3 hours as an intervention to help prevent falls. -All residents were checked on every 2 hours. -Resident #2 was checked on more often after a fall, but there was no specified amount of time to check on her. -There was documentation of staff checking on Resident #2 more often after falls because the facility documented by exception. Based on record reviews and interviews, there was no documentation of increased supervision implemented for Resident #2 after her fall on 06/12/23. b. Review of Resident #2's Incident and Accident Reports revealed there was not a report dated	D 270		

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D 270	Continued From page 4 07/14/23. Review of Resident #2's progress notes dated 07/14/23 (no time documented) revealed: -Resident #2 complained of left shoulder pain from fall on third shift. -There were no bruises or marks noticed. -The Resident Care Coordinator (RCC) was notified about the fall. Attempted telephone interview with the Supervisor who documented the 07/14/23 progress note on 08/10/23 at 11:42am was unsuccessful. Based on record reviews and interviews, there was no documentation of increased supervision or interventions implemented for Resident #2 after her fall on 07/14/23. c. Review of Resident #2's Incident and Accident Reports revealed there was not a report dated 07/18/23. Review of Resident #2's fall note dated 07/18/23 at 6:15am revealed: -Resident #2 was found sitting on her bottom in front of the bathroom. -Resident #2's family member/roommate pushed the call button for her and stated Resident #2 crawled into the bathroom after sliding herself out of bed. Review of Resident #2's progress note dated 07/18/23 at 6:15am revealed: -Resident #2's family member/roommate pushed the call button and stated Resident #2 was on the floor. -The medication aide (MA) observed Resident #2 sitting by the door of her bathroom.	D 270		

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D 270	Continued From page 5 -Resident #2's family member/roommate stated she crawled to the bathroom after she slid out of her bed. -Resident #2 was assessed and her vital signs were taken. -No injuries were observed. Telephone interview with the MA who documented the 07/18/23 progress note on 08/11/23 at 9:15am revealed: -Resident #2 fell twice during her shift with one of the falls being on 07/18/23 when her family member/roommate stated she crawled to the bathroom after sliding out of the bed onto the floor. -She thought Resident #2 was falling because she tried getting up on her own to go to the bathroom. -Her family member/roommate stated that she sometimes slid out of bed onto the floor without falling. -She did not remember if Resident #2 had any injuries when she fell on 07/18/23. -After the fall, she assisted Resident #2 back to bed. -She was not aware of any interventions implemented for Resident #2 after her fall on 07/18/23. -After a fall, staff were to check on residents every 2 hours, but she did not check every 2 hours on third shift because she did not want to bother residents too much at night. -The residents had a pendant to call for assistance and could use the pendant if they needed staff. -All residents were checked on every 2 to 3 hours. Based on record reviews and interviews, there was no documentation of increased supervision	D 270		

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D 270	Continued From page 6 or interventions implemented for Resident #2 after her fall on 07/18/23. d. Review of Resident #2's Incident and Accident Reports revealed there was not a report dated 07/27/23. Review of Resident #2's fall note dated 07/27/23 at 12:17pm revealed: -Resident #2 was found on the floor beside her bed. -Resident #2 lost her balance getting out of bed and fell to the floor. Review of Resident #2's progress note dated 07/27/23 at 12:17pm revealed: -A personal care aide (PCA) went to get Resident #2 to bring her to lunch found her on the floor beside her bed. -Resident #2 lost her balance getting out of bed and fell to the floor. -Resident #2's vital signs were taken. Interview with the Supervisor who documented the 07/27/23 progress note on 08/10/23 at 3:05pm revealed: -She observed Resident #2 on the floor in a seated position on 07/27/23. -It appeared Resident #2 had tried to transfer from the bed to the chair when she fell. -She assessed Resident #2 and took her vital signs. -She did not have any injuries. -Resident #2 fell often and she thought the main reason for her falls was because she tried to get into her wheelchair when it was unlocked. -Staff locked her wheelchair, but her family member/roommate wanted to keep the wheelchair unlocked. -She did not know of any interventions put in	D 270		

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D 270	Continued From page 7 place for Resident #2 after her fall on 07/27/23. -After Resident #2 fell, staff checked on her every 2 hours for 72 to make sure nothing changed. -MAs documented once per shift for 72 hours that there were no changes. -Staff normally checked on all residents every 2.5 to 3 hours depending on their needs. Based on record reviews and interviews, there was no documentation of increased supervision or interventions implemented for Resident #2 after her fall on 07/18/23. e. Review of Resident #2's Incident and Accident Report dated 08/04/23 at 7:30pm revealed: -Resident #2 was found on her knees on the floor beside her bed. -Resident #2 was trying to get to the restroom when she fell. -The wheelchair was not locked and rolled as Resident #2 went to sit down in it. -Resident #2 was assisted into her wheelchair by two staff. -Another resident stated Resident #2 did not fall and that she got on the floor herself. -There were no injuries documented. -The plan to prevent reoccurrence of the fall was to remind Resident #2 to use her pendent for help. Review of Resident #2's progress note dated 08/04/23 (no time documented) revealed: -Resident #2 paged for help and was found in her room on the floor on her knees crawling to get back in her wheelchair. -Resident #2's family member/roommate stated she did not fall and that she got on the floor by herself. -She was observed on her knees on the floor beside her bed.	D 270		

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D 270	Continued From page 8 -Resident #2's vital signs were taken. -No injuries occurred. Review of Resident #2's progress notes dated 08/05/23 at 8:17am revealed: -Resident #2's family member/roommate stated that Resident #2 did not fall on 08/04/23 and that she got on the floor by herself. -Her family member/roommate was educated on not letting Resident #2 get on the floor due to risk of injury. Attempted telephone Interview with the Supervisor who documented the 08/04/23 progress note 08/10/23 at 11:42am was unsuccessful. Based on record reviews and interviews, there was no documentation of increased supervision implemented for Resident #2 after her fall on 08/04/23. f. Review of Resident #2's Incident and Accident Report dated 08/05/23 at 4:00pm revealed: -Resident #2 was found on the floor on her knees beside her bed. -She was going to the bathroom. -She was assisted into her wheelchair by two staff. -Her family member stated Resident #2 got off the bed to her knees to get in her wheelchair. -There were no injuries documented. -The plan to prevent reoccurrence of the fall was to continue to remind Resident #2 to use her pendant. Review of Resident #2's progress note dated 08/05/23 (no date documented) revealed: -Resident #2 had another fall. -Resident #2's family member/roommate stated	D 270		

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D 270	Continued From page 9 she did not fall and that she just got down on the floor. -No injuries occurred. Review of Resident #2's progress note dated 08/06/23 at 10:18am revealed: -Resident #2's family member/roommate stated Resident #2 did not fall on 08/05/23 and that she got on the floor herself. -Education was provided again to Resident #2's family member/roommate on not letting Resident #2 get on the floor due to risk of injury. Attempted telephone Interview with the Supervisor who documented the 08/04/23 progress note on 08/10/23 at 11:42am was unsuccessful. Based on record reviews and interviews, there was no documentation of increased supervision implemented for Resident #2 after her fall on 06/12/23. Interview with Resident #2's family member/roommate on 08/10/23 at 10:50am revealed: -Resident #2 fell frequently. -Sometimes Resident #2 rolled onto her stomach, then lowered her legs to the floor. -He did not call staff when Resident #2 tried to get out of bed. -Staff took a long time to respond when he pushed the pendants to request assistance. -He tried to assist Resident #2 from the floor by himself and if he needed help, he called for staff to assist. -Staff liked to keep Resident #2's wheelchair locked, but he unlocked the wheelchair when he was not in the room with her so she could get to the bathroom if she needed to go; she could not	D 270		

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D 270	Continued From page 10	D 270		

unlock the wheelchair by herself.
-He kept a notebook of Resident #2's falls and documented falls on 06/19/23, 07/06/23, 07/12/23, 07/13/23, 07/15/23, 07/17/23, 07/18/23, 07/23/23, 07/25/23, 07/29/23, twice on 08/04/23, and twice on 08/05/23.
-Resident #2 received a quarter bed rail on 07/19/23, but it was not installed until 07/25/23; she used bed rail to help her get in and out of bed.

Interview with Resident #2 on 08/10/23 at 10:56am revealed:
-She fell most of the time when she ended up on the floor.
-She did not have any significant injuries when she fell.
-She hurt her shoulder after falling once, but she did not remember when.
-Staff had not done anything differently for her.
-She did not know how often staff checked on her.

Interview with a PCA on 08/10/23 at 2:49pm revealed:
-She assisted Resident #2 with toileting and ambulation in her wheelchair.
-Sometimes Resident #2 tried to go to the bathroom by herself and she had walked in on her several times attempting to go the bathroom by herself.
-She found Resident #2 sitting on the floor with her back to the bed in July 2023.
-She and a MA assisted Resident #2 from the floor.
-She was not told to do anything differently for Resident #2 after the fall and she did not remember if she was told to check on Resident #2 more often.
-She reported falls, observations, and any

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D 270	Continued From page 11 changes of residents who fell to the MA and the MA documented what she reported. Telephone interview with a MA on 08/11/23 at 9:15am revealed: -Resident #2 had fallen twice during her shift, but she did not remember when. -She thought Resident #2 was falling because she tried getting up on her own to go to the bathroom. -Her family member/roommate stated that she sometimes slid out of bed Interview with a representative at Resident #2's physical therapist's office on 08/11/23 at 9:44am revealed: -Resident #2 was referred for physical therapy on 07/14/23 and was evaluated for physical therapy services on 08/02/23. -She was scheduled to be seen twice a week. -Resident #2 was admitted for services with a primary concern of reducing falls. -Per staff reports, Resident #2's family member/roommate did not want to lock Resident #2's wheelchair. -There had only been two visits, on 08/07/23 and 08/09/23, and there has not been enough time to determine any improvements. Telephone interview with the facility's LHPS nurse on 08/11/23 at 9:51am revealed: -When she completed LHPS reviews, she reviewed progress notes, talked to the facility staff, and reviewed physical therapy notes to determine if a resident had fallen. -If she was aware of a resident falling, she documented the falls in her LHPS review. -Her recommendations would depend on the resident's circumstances surrounding the falls. -She did not have the facility's information	D 270		

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D 270	Continued From page 12 available and did not know right off if she documented she was aware of Resident #2's falls or if there were any recommendations. Telephone interview with the RCC on 08/11/23 at 11:11am revealed: -When a Resident had a fall, the MAs were to assess the resident for injuries and take the residents vital signs. -Staff were to assist the resident from the floor to a stable place to sit and contact the Resident's family and their PCP. -Staff were to keep an eye on the resident for a few days through 72-hour charting. -MAs were to document how the resident was doing on each shift for 72 hours. -There should have been documentation on each shift for 72 hours after each of Resident #2's falls. -To her knowledge, there had had not been any increased supervision or safety checks for Resident #2 after her falls. -The only intervention she was aware of was an order for physical therapy at the end of July 2023. -She was not sure who was responsible for determining and implementing interventions. -There was a weekly at risk meet where plans were discussed for residents who had falls. -Interventions were discussed in the weekly meetings, but sometimes the interventions did not come together. Telephone interview with the DHW on 08/11/23 at 12:00pm revealed: -After Resident #2's falls in June, July, and August 2023, physical therapy, occupational therapy, quarter length bed rails for mobility, and return demonstration of using the bed rail for mobility, using the call bell and unlocking her wheelchair were implemented as interventions. -She was responsible for identifying and	D 270		

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TERRABELLA HILLSBOROUGH	1911 ORANGE GROVE ROAD HILLSBOROUGH, NC 27278

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D 270	Continued From page 13 implementing interventions for Resident #2 after falls. -Staff checked on all residents every 2 hours. -There had not been any specified increased safety checks implemented for Resident #2 after falls. -If staff were checking on Resident #2 more often after a fall, there was no documentation of the increased checks because the facility documented by exception. -Staff were toileting Resident #2 every 3 hours and tried to get her to go to activities so that they could keep an eye on her. -After any resident had a fall, staff were to complete 72-hour charting notes where MAs documented once each shift for 3 days whether the resident was doing okay, had any pain or bruising resulting from the fall. Telephone interview with the Area Executive Director (AED) on 08/11/23 at 1:00pm revealed: -He expected for there to be increased safety checks and interventions put in place after Resident #2's falls. -If the interventions were not working, Resident #2 should have been asses for different interventions. -The DHW was responsible for ensuring interventions were implemented and other staff were responsible for reporting changes to the RCC, DHW or Administrator immediately. -All residents should have been checked on every 2 hours. -Increased safety checks were dependent on the resident's needs after a fall. -There would not be any documentation of increased safety checks because the staff charted by exception, but he expected that staff would have documented the implementation of increased checks.	D 270		

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D 270	Continued From page 14 Attempted telephone interview with Resident #2's primary care provider (PCP) on 08/11/23 at 8:21am was unsuccessful.	D 270		
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, record reviews, and interviews, the facility failed to ensure the implementation of an order for 1 of 5 sampled residents (#3) related to dressing the resident's toe wound twice daily. The findings are: Review of Resident #3's current, hospital FL2 dated 07/14/23 revealed diagnoses included hyperkalemia and diabetes mellitus with stage 2 chronic kidney disease. Review of Resident #3's previous physician's order dated 07/05/23 revealed: -Resident #3 was seen by his PCP for a diabetic foot ulcer of his left foot. -There was an order to keep the wound clean and covered and change the dressing every 12 to 24 hours.	D 276	.0902 (c) 3-4 implementation of Policy and Procedures DHW/designee will review all new orders daily and follow up promptly to clarify orders as necessary. All physician orders will be reviewed utilizing the current order processing system for accuracy.	9/8/23

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D 276	Continued From page 15 Review of Resident #3's hospital discharge summary dated 07/14/23 revealed: -The principal problem was hyperkalemia. -There was documentation Resident #3 had a left second toe blister. -There were no changes during the hospital admission. -Resident #3 was to receive wound care as recommended by his primary care provider (PCP). Review of Resident #3's physician's order dated 07/18/23 revealed an order to continue to dress Resident #3's left second toe cellulitis twice daily. Review of Resident #3's electronic Medication Administration Record (eMAR) for July 2023 revealed: -There was an entry for keep wound clean/covered and change dressing every 12 to 24 hours scheduled for 8:00am from 07/11/23 through 07/21/23. -There was an entry for keep wound clean/covered and change dressing every 12 to 24 hours scheduled for between 7:00am - 3:00am from 07/22/23 through 07/31/23. -There was documentation Resident #3's dressing was changed once daily from 07/11/23 through 07/31/23. Review of Resident #3's eMAR for August 2023 revealed there was not an entry for keep wound clean/covered and changed every 12-24 hours. Interview with the medication aide/supervisor (MA/S) on 08/10/23 at 3:05pm revealed: -She cleaned and covered Resident #3's left second toe during her shift. -He had a blister on his left second toe for about a month.	D 276		

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D 276	Continued From page 16 -She did not know if Resident #3 had an order to have his toe cleaned and covered twice a day. Interview with Resident #3 on 08/10/23 at 4:50pm revealed: -He was seen at his PCP's office on today, 08/10/23, for a routine visit. -The wound on his left second toe was about the same as it had been. -Facility staff was supposed to change the bandage on his toe twice a day, but they did not. -Usually staff changed the bandage on his toe once a day. -He thought he had the blister on his left second toe for a few weeks. Telephone interview with the Resident Care Coordinator (RCC) on 08/11/23 at 11:11am revealed: -Medication aides (MA), she, and the Director of Health and Wellness (DHW) were responsible for reviewing new orders and faxing them to the pharmacy. -She and the DHW reviewed orders completed by the MAs. -She or the DHW entered treatment orders onto the eMAR. -She knew Resident #2 had an order for an antibiotic, but she did not know he had orders to dress his second left toe twice daily. -She did not know why the order to dress Resident #2's second left toe twice daily was not entered onto the August 2023 eMAR. -She and the DHW conducted audits of different resident records 2 to 3 days a week to ensure all orders and paperwork were in compliance, but they did not compare the orders to the eMAR. Telephone interview with a MA on 08/11/23 at 11:46am revealed:	D 276		

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D 276	Continued From page 17 -Resident #3 had a blister on his left second toe and she changed the dressing every morning. -She thought the Resident #3's order for dressing was to change daily and if soiled. Telephone interview with the DHW on 08/11/23 at 12:00pm revealed: -She and the RCC were responsible for reviewing new orders and for entering treatment orders onto the eMAR as of 08/01/23 when the facility switched pharmacies. -Resident #3's order to continue to dress his second left toe twice daily should have been sent to the previous pharmacy, and the previous pharmacy would have entered the treatment order onto the eMAR. -She would have reviewed the order once completed to ensure it was on the eMAR. -She saw the order dated 07/05/23 to keep Resident #3's wound covered, clean, and change dressing every 12 to 24 hours. -She sent a clarification order within 48 hours of receiving this order to clarify dressing the wound once a day or twice a day, but she did not get a response from Resident #3's primary care provider (PCP). -She did not see the order to continue dress Resident #3's second left toe twice daily. -Staff have been dressing Resident #3's second left toe once daily. -Resident #3's treatment order had not been entered onto the August 2023 eMAR since the facility changed pharmacies in August 2023. Telephone interview with the Area Executive Director (AED) on 08/11/23 at 1:00pm revealed: -He was assisting the facility in the Administrator's absence. -He was not aware of Resident #3 have an order to dress his left second toe twice daily.	D 276		

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D 276	Continued From page 18 -The MAs, Supervisors, RCC, and the DHW were responsible for ensuring orders were processed and entered onto the eMAR. -He expected the order to dress Resident #3's toe twice daily to be implemented. Attempted telephone interview with Resident #3's PCP on 08/10/23 at 3:52pm was unsuccessful.	D 276		
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 serve therapeutic diets as ordered for 1 of 5 sampled residents (#2) who had an order for a mechanical soft (MS) diet with chopped meats (#6). The findings are: Review of Resident #2's current FL2 dated 11/16/22 revealed: -Diagnoses included hypertension, mild cognitive impairment, osteoarthritis of the knees, and balance problems. -There was an order for a low salt diet. Review of Resident #2's diet order dated 07/10/23 revealed an order for a MS diet with chopped meats. Review of the undated therapeutic diet list	D 310	.0904 (e) (4) Review of Therapeutic Diets All diet orders will be reviewed by DHW/designee and provided to DSD. In addition, recipe books will be in place with all diet extensions available for all dietary staff to review on a daily basis. DSD/designee will complete audits for ongoing compliance.	9/8/23

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D 310	Continued From page 19 revealed Resident #2 was to be served a MS diet with chopped meats. Review of the facility's therapeutic menu spread sheet for a MS diet with chopped meats for the lunch meal on 08/09/23 revealed: -Resident #2 was to be served soup of choice, chopped turkey/macaroni/cheese casserole, green peas, chocolate pudding with cookies, juice of choice or iced tea. -Alternative meal options included 1 slice of toast, chopped sausage patty, buttered green beans, egg salad sandwich, chopped ham and cheese sandwich, peanut butter and jelly sandwich without nuts, chopped hamburger on bun, 2 eggs of choice (no fried), baked potato without skin, baked sweet potato without skin, soft French fries. Observation of the lunch meal service on 08/09/23 between 12:00pm and 1:00pm revealed: -Resident #2 was served cream of beef and mushroom soup, a bacon/lettuce/tomato sandwich, green peas, potato chips, a slice of lemon bark, coffee, water, and tea. -Resident #2 ate 75% of the meal without difficulty. Interview with Resident #2 on 08/10/23 at 10:56am revealed: -She was supposed to be served meals with chopped meats. -It depended on who was serving the meal as to whether the meats were chopped or not. Interview with the Dietary Manager (DM) on 08/09/23 at 2:37pm revealed: -She asked the cook what was served to Resident #2 for the lunch meal on 08/09/223 and confirmed Resident #2 was served a BLT	D 310		

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D 310	Continued From page 20 sandwich and the bacon was chopped. -She thought the residents who had physician's orders for a MS diet with chopped meats could receive regular menu items with the regular menu meats chopped. -There was a MS chopped meats menu, but the menu title was MS and did not include chopped meats in the title. -She did not know that according to the MS chopped meats menu, Resident #2 should not have been served bacon. Interview with a cook on 08/10/23 at 10:39am revealed: -He used the regular menu and chopped the meats when he prepared meals for residents who had orders for MS with chopped meats diets. -He knew Residents with MS with chopped meats diets could not have bacon and had not served bacon to those residents. Interview with a second cook on 08/10/23 at 4:57pm revealed: -She prepared the lunch meal for Resident #2 on 08/09/23. -Resident #2 was to be served a MS diet with chopped meats. -She used the therapeutic diet menu for a MS diet with chopped meats to prepare Resident #2's meals. -She did not know bacon was not listed to be served on the MS with chopped meats menu. Telephone interview with the Area Executive Director (AED) on 08/11/23 at 1:00pm revealed: -He was assisting the facility in the Administrator's absence. -He expected dietary staff to follow the MS diet with chopped meats menu and to serve Resident #2 according to the menu.	D 310		

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D 310	Continued From page 21 Attempted telephone interview with Resident #2's primary care provider (PCP) on 08/11/23 at 8:21am was unsuccessful.	D 310		