STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025041	A. BUILDING: _____ B. WING _____	R 08/17/2023

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TRUEWOOD BY MERRILL, NEW BERN	2701 AMHURST BOULEVARD NEW BERN, NC 28562

(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 and Follow Up Survey on 08/15/23 to 08/17/23.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled medication aides (MA) (Staff A, Staff B and Staff C) who were administering medications had completed the medication clinical skills competency validation checklist. The findings are: 1. Review of the Staff A's, MA, personnel record revealed: -Staff A's hire date was 10/04/18. -There was no documentation of a medication	D 125		

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D 125	Continued From page 1 clinical skills competency validation checklist. Interview with Staff A on 08/17/23 at 2:15pm revealed: -He worked at the7:00am to 3:00pm Monday - Friday and on some Saturdays and Sundays as needed. -He had administered medications to the residents. -He had initialed on the Medication Administration Record (MAR) after he administered medication. -He had completed a medication clinical skills competency validation checklist in 2018 with the previous facility's Registered Nurse (RN). Observation of medication pass on 08/16/23 at 7:51am revealed Staff A administered to a resident. Review of a resident's August 2023 medication administration record (MAR) revealed: -There was documentation to complete finger sticksblood sugar checks 3 times daily at 7:00am, 12:00pm and 5:00pm daily. -There was documentation to administered Lispro insulin 100 units at 8:00am, 12:00pm and 5:00pm daily. -There was an entry of Lispro insulin 100 units was administered on 08/17/23 at 8:00am. Refer to the interview with the Resident Care Coordinator (RCC) on 08/17/23 at 1:32pm. Refer to interview with the Administrator on 08/17/23 at 2:20pm. 2. Review of Staff B's, MA, personnel record revealed: -Staff B's hire date was not noted in her employee record.	D 125		

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D 125	Continued From page 2 -There was no documentation of a medication clinical skills competency validation checklist. Attempted telephone interview with Staff B on 08/17/23 at 1:48pm was unsuccessful. Refer to the interview with the RCC on 08/17/23 at1:32pm. Refer to interview with the Administrator on 08/17/23 at 2:20pm. 3. Review of Staff C's, MA personnel record revealed: -Staff C's hire date was 06/15/22. -There was no documentation of a medication clinical skills competency validation checklist. Attempted telephone interview with Staff C on 08/17/23 at 1:50pm was unsuccessful. Refer to the interview with the RCC on 08/17/23 at1:32pm. Refer to interview with the Administrator on 08/17/23 at 2:20pm. _____ Interview with the RCC on 08/17/23 at 1:32pm revealed: -Staff A, Staff B and Staff C had administered medication to the residents. -The current RN completed the medication clinical skill checklist. -Staff A, Staff B, and Staff C had completed the medication clinical skill checklist with the previous RN. -She did not know who was responsible for ensuring the medication clinical skill checklist was completed	D 125		

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D 125	Continued From page 3 Interview with the Administrator on 08/17/23 at 2:20pm revealed: -She did not know Staff A, Staff B and Staff C had not completed the medication clinical skill checklist. -She completed random audits on at least two employee records weekly. -Her last employee audit was on 08/10/23. -She or the RCC were responsible for ensuring the staff had completed all required trainings.	D 125		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration.	D 164		

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This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure 3 of 3 sampled medication aides (Staff A, Staff B, and C) completed training on the care of diabetic residents prior to the administration of insulin.

The findings are:

1. Review of the Staff A's, medication aide (MA), personnel record revealed:
-Staff A's hire date was 10/04/18.
-There was no documentation of training on diabetic care for residents.

Interview with Staff A on 08/17/23 at 2:15pm revealed:
-He worked the7:00am to 3:00pm Monday - Friday and on some Saturdays and Sundays as needed.
-He had administered insulin to residents who had an order for insulin.
-He could not remember if he had completed the training on diabetic care.

Observation of medication pass on 08/16/23 at 7:51am revealed Staff A administered medication to a resident.

Review of a resident's August 2023 medication administration record (MAR) revealed:
-There was documentation to complete finger sticksblood sugar checks 3 times daily at 7:00am, 12:00pm and 5:00pm daily.
-There was documentation to administered Lispro

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insulin 100 units at 8:00am, 12:00pm and 5:00pm daily.
-There was an entry of Lispro insulin 100 units was administered on 08/17/23 at 8:00am.

Refer to the interview with the Resident Care Coordinator (RCC) on 08/17/23 at 1:32pm.

Refer to interview with the Administrator on 08/17/23 at 2:20pm.

2. Review of Staff B's, medication aide (MA), personnel record revealed:
-Staff B hire date was not noted in her employee record.
-There was no documentation of training on diabetic care for residents.

Attempted telephone interview with Staff B on 08/17/23 at 1:48pm was not successful.

Refer to the interview with the RCC on 08/17/23 at 1:32pm.

Refer to interview with the Administrator on 08/17/23 at 2:20pm.

3. Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C's hire date was 06/15/22.
-There was no documentation of training on diabetic care for residents.

Attempted telephone interview with Staff C on 08/17/23 at 1:50pm was not successful.

Refer to the interview with the RCC on 08/17/23 at1:32pm.

Refer to interview with the Administrator on

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D 164	Continued From page 6 08/17/23 at 2:20pm. Interview with the RCC on 08/17/23 at 1:32pm revealed: -Staff A, Staff B and Staff C had administered insulin to the residents that had insulin orders. -The current RN had completed the diabetic care training. -Staff A, Staff B, and Staff C had completed the diabetic care training with the previous RN. -She did not know who was responsible for ensuring the diabetic care training was completed. Interview with the Administrator on 08/17/23 at 2:20pm revealed: -She was not aware of the MAs needed diabetic care training. -She completed random audits on at least two employee records weekly. -Her last employee audit was on 08/10/23. -She or the RCC were responsible for ensuring the staff had completed all required training.	D 164		
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.	D 296		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic diet menus for food service guidance for 1 of 5 sampled residents (#1) with physician's orders for a 2-gram sodium diet.

The findings are:

1.Review of Resident #1's current FL-2 dated 04/12/23 revealed:
-Diagnoses included cellulitis of left lower extremity, phlebitis and thrombophlebitis, morbid obesity, hypertension, muscle weakness, fibromyalgia, congestive heart failure and hyperlipidemia.
-There was an order for a regular no added salt diet.

Review of Resident #1's medical record on 08/16/23 revealed a Physician's Visit Form dated 05/11/23 with an order for a 2-gram sodium diet.

Interview with Resident #1 on 08/15/23 at 10:15am revealed:
-The food at the facility was "too fancy" and it is up to the residents to do the best they can if they were on special diets.
-The food can be too salty.
-She must watch her salt intake and does not add table salt.
-She bought her own snacks such as unsalted saltines and unsalted cashews.

Review of the facility's Prescribed Diet policy dated 04/20/21 revealed:
-The facility offers residents options that allow for a limited range of special dietary need.
-Residents must have the ability to follow their

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prescribed diet by making food selections that will support their diet restrictions.
-The facility will assist with guiding residents receiving assisted living services to appropriate choices for diets we offer, but residents have the right to choices that are not within the restrictions of their prescribed diet.
-Diets available at the facility included regular diet, consistent carbohydrate diet and heart healthy diet.
-The Heart healthy diet was described as based on the regular diet and intended for lowering the risk of heart disease by limiting the intake of fat, cholesterol, and sodium. To prevent the diet from being too restrictive for the elderly, the fat is restricted to less than or equal to 30% of total calories and the sodium is restricted to 2000-2500mg per day. Liberal use of salt-free seasonings is encouraged to produce a flavorful and appealing diet. If desired, salt substitutes must be physician ordered. Highly salted or cured foods are avoided. Limited amounts of salt are used in cooking.

Observation of Resident #1's breakfast meal service on 08/17/23 at 8:37am revealed:
-Resident #1 was served scrambled eggs and a bowl of cantaloupe and honeydew melon.
-She said she had turkey bacon that she had already eaten and a glass of orange juice that she finished,
-She left the scrambled eggs and bowl of mixed melon on her plate.
-There was a saltshaker on the table.
-It could not be determined if Resident #1 was served the correct therapeutic diet due to a 2-gram sodium menu was not available for guidance.

2nd Interview with Resident #1 on 08/17/23

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D 296	Continued From page 9 9:25am revealed: -She only ate the turkey bacon for breakfast because the eggs were not real eggs, and she did not like cantaloupe. -She knew she had to watch her salt intake. -She knew not to add salt to her food. -She purchased her own food because the facility's food was often too salty. -She was having groceries delivered that morning that included tuna, sardines, unsalted crackers, and unsalted cashews. -She had chronic kidney disease and had been told she had too much protein. -When she went to meals, she was served the same foods as the other residents in the dining room. -Before she ordered something like soup from the facility's kitchen, she asked the other residents if it was salty. Interview with the Resident Care Coordinator (RCC) on 8/16/23 at 11:59am revealed: -All the residents in the Assisted Living Unit received a low sodium, low sugar diet. -She stated Resident #1's nephrologist was told they could not accommodate a 2-gram sodium diet. -Resident #1 was non-compliant with her diet and dined out often with her husband or had food delivered in. -Resident #1 also ordered groceries that included snacks and cookies. Interview with a Personal Care Aide (PCA) on 08/16/23 at 12:02 revealed: -She attended Resident #1's 05/11/23 nephrology appointment. -She saw the diet order for a 2-gram sodium diet and called and notified the medication aide while she and Resident #1 were still at the nephrology	D 296		

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appointment.
-The MA told her the facility could not provide a 2-gram sodium diet for Resident #1.
-She said the nephrologist "got mad" and left the room after she told him the facility could not provide a 2-gram sodium diet.
-The nephrologist's nurse came back into the exam room and told her that nephrologist still wanted Resident #1 to be on a 2-gram sodium diet.

Interview with the Executive Chef on 08/16/23 at 12:57pm revealed:
-All of the residents were on the same diet.
-All of the residents received a low sodium diet.
-She did not add salt to meals.
-Salt and pepper shakers were on all the tables because the residents do not have assigned seats and could sit wherever they like.
-It was the resident's right to have salt and pepper.
-She did not serve processed food.
-She only served fresh food, seasoned with herbs, and used low-sodium soup bases.

Interview with the Administrator on 08/17/23 at 1:00pm revealed:
-When a resident had a new diet order, the RCC would enter the diet order into the electronic health record and would notify the Executive Chef verbally and the diet order would also be printed on a weekly report for the Executive Chef.
-The facility provided a liberalized low sodium/heart healthy diet for all the residents, and she thought the sodium content was between 2000 to 3000mg per day.
-The facility could not provide a 2-gram sodium diet.
-If Resident #1 required a 2-gram sodium diet, she would have to be discharged.

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D 296	Continued From page 11 -She planned to have the RCC contact the nephrologist to request a no added salt/heart healthy diet. Attempted telephone interview with Resident #1's nephrologist on 08/16/23 at 3:56pm and 08/17/23 at 11:05am were unsuccessful. Attempted telephone interview with Resident #1's primary care provider on 08/17/23 at 11:10am was unsuccessful.	D 296		
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. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to administer medications as ordered to 1 of 5 sampled residents (#1) to include two medications used to treat high blood pressure, congestive heat failure and fluid retention. The findings are: Review of Resident #1's current FL-2 dated 04/12/23 revealed: -Diagnoses included cellulitis of left lower extremity, phlebitis and thrombophlebitis, morbid	D 358		

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D 358	Continued From page 12 obesity, hypertension, muscle weakness, fibromyalgia, congestive heart failure and hyperlipidemia. a. Review of Resident #1's current FL2 dated 04/12/23 revealed an order for furosemide 40mg one tablet once per day for congestive heart failure (furosemide is used to treat fluid retention and swelling caused by congestive heart failure, liver disease, kidney disease and other medical conditions). Review of Resident #1's record revealed: -There was an order dated 5/11/23 to decrease furosemide to 20mg one tablet per day. -There was a date and time stamped fax confirmation that the 05/11/23 Physician's Visit Form was faxed to the facilty's contracted pharmacy on 07/17/23 at 3:16pm. Review of Resident #1's June 2023 electronic medication administration (eMAR) revealed: -There was an entry for furosemide 40mg take one tablet every day for congestive heart failure. -There was documentation that furosemide 40mg was administered at 9:00am 06/01/23 through 06/30/23. Review of Resident #1's July 2023 eMAR revealed: -There was an entry for furosemide 40mg take one tablet every day for congestive heart failure. -There was documentation that furosemide was administered at 9:00am 07/01/23 through 07/17/23. -There was documentation that furosemide was not administered on 07/18/23, no exception was documented. -There was documentation that Furosemide 40mg was discontinued on 07/19/23.	D 358		

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D 358	Continued From page 13 -There was an entry for furosemide 20mg take one tablet daily for congestive heart failure with a start date of 07/19/23, -There was documentation that furosemide 20mg was administered at 9:00am 07/19/23 through 07/31/23. Interview with a pharmacist at the facility's contracted pharmacy provider on 08/16/23 at 3:36pm revealed: -A Physician's Visit Form for Resident #1 dated 05/11/23 with orders to decrease furosemide to 20mg once daily was received on 07/17/23 via fax. -The facility was contacted via fax on 07/18/23 to clarify if the order was current since it was dated 05/11/23. -No response was received, and the pharmacy contacted the facility by phone and verified the furosemide 20mg order was current. -Furosemide 20mg, 7 tablets, were dispensed and delivered on 07/19/23 for a 1-week supply. -Furosemide 20mg, 28 tablets, were dispensed and delivered on 07/23/23 for a 28-day supply Refer to interview with Resident #1 on 08/16/23 at 11:16am. Refer to interview with a medication aide (MA) on 08/16/23 at 11:29am. Refer to interview with a personal care aide (PCA) on 08/16/23 at 12:02pm. .Refer to interview with the Resident Care Coordinator (RCC) on 08/16/23 at 12:10pm. Refer to interview with the Administrator on 08/16/23 at 4:06pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025041	A. BUILDING: _____ B. WING _____	R 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUEWOOD BY MERRILL, NEW BERN	2701 AMHURST BOULEVARD NEW BERN, NC 28562

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D 358	Continued From page 14 Attempted telephone interviews with Resident #1's nephrologist on 08/16/23 at 3:56pm and 08/17/23 at 11:10am were unsuccessful. Attempted telephone interview with Resident #1's primary care provider (PCP) on 08/17/23 at 11:05am was unsuccessful. b. Review of Resident #1's current FL-2 dated 04/12/23 revealed an order for Metolazone 2.5mg, 1 tablet, by mouth twice weekly (metolazone is used to treat high blood pressure and fluid retention). Review of Resident #1's record revealed: -There was an order dated 5/11/23 to increase metolazone 2.5mg to one tablet by three times per week. -There was a date and time stamped fax confirmation that the Physician's Visit Form was faxed to the facility's contracted pharmacy 07/17/23 at 3:16pm. Review of Resident #1's June 2023 eMAR (electronic medication administration record) revealed: -There was an entry for metolazone 2.5mg take one tablet by two times per week for fluid retention. -There was documentation metolazone was administered at 9:00am on the week of 06/02/23 on 06/02/23, the week of 06/05/23 administered on 06-05-23 and 06/09/23, the week of 06/12/23 administered on 06/12/23 and 06/16/23,the week of 06/19/23 administered on 06/19/23 and 06/23/23, and the week of 06/26/23 administered on 06/26/23 and 06/30/23.	D 358		

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D 358	Continued From page 15 Review of Resident #1's July 2023 eMAR revealed: -There was an entry for metolazone 2.5mg take one tablet by mouth two times per week for fluid retention. -There was documentation metolazone 2.5mg was administered at 9:00am on the week of 07/03/23 administered on 7/03/23 and 07/07/23, the week of 07/10/23 administered on 07/10/23 and 07/14/23 and the week of 07/17/23 administered on 07/17/23. -There was documentation metolazone 2.5mg take one tablet by mouth twice per week for fluid retention was discontinued on 07/19/23. -There was an entry for metolazone 2.5mg take on tablet by mouth three times week with a start date of 07/19/23. Interview with Resident #1 on 08/16/23 at 11:16am revealed: -She had an appointment with the nephrologist a few months ago and last week. -She had chronic kidney failure. -She was told she had too much protein. -A staff member attended the appointment with her at the August appointment, but she thought she was dropped off for her previous appointment a few months ago but was not sure. -She was given a folder by the facility that contained her medical information and a form for the physician to complete and took this with her to the May appointment and gave it to the staff at the nephrology office. -The folder was returned to her at the completion of the May appointment. -When she returned to the facility, she gave the folder to a staff at the Nurse's station. -She did not remember what staff member was at the desk. -She was not sure if there were new medication	D 358		

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D 358	Continued From page 16 orders. Interview with a pharmacist at the facility's contracted pharmacy provider on 08/16/23 at 3:36pm revealed: -A Physician's Visit Form for Resident #1 dated 05/11/23 with orders to increase metolazone 2.5mg to three times per week was received on 07/17/23 via fax. -The facility was contacted via fax on 07/18/23 to clarify if the order was current since it was dated 05/11/23. -No response was received, and the pharmacy contacted the facility by phone and verified the metolazone order was current. -Metolazone 2.5mg, 3 tablets, were dispensed and delivered on 07/19/23 for a 1-week supply. -Metolazone 2.5mg, 12 tablets,were dispensed and delivered on 07/23/23 for a 28-day supply Interview with a MA on 08/16/23 at 11:29am revealed: -Residents' medical information was printed and placed in a folder and taken to outside appointments. -A Physician Visit Form was placed in the folder as well for new orders and were given to the provider at the appointment. -Upon return from an appointment, the folder containing the Resident's medical information and the Physician Visit Form were to be placed on the desk at the nurse's station. -The MAs were responsible for reviewing the Physician's Visit Form for new orders. -If there were new orders, the MAs foxed the Physician's Visit Form to the Resident's pharmacy. -The pharmacy would enter the new orders and the Resident Care Coordinator (RCC) would approve the new orders.	D 358		

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D 358	Continued From page 17 Interview with a personal care aide (PCA) on 08/16/23 at 12:02pm revealed: -She attended the 05/11/23 nephrology appointment with Resident #1. -She took a folder with Resident #1's medical information and a physician's order sheet to the 05/11/23 appointment. -She gave Resident #1's folder to the nephrology office staff and the folder was returned to her at the completion of the appointment. -Upon return to the facility she gave Resident #1's folder to the MA at the Nurse's station. -She could not recall which MA she gave Resident #1's folder to. Interview with the Resident Care Coordinator on 08/16/23 12:10pm revealed: -When residents had an outside physician/provider appointment, a folder containing their medical information and a Physician's Visit Form is sent with them. -Upon return from the appointment, the folder containing the Physician's Visit Form was to be returned to the MAs or to the RCC. -The MAs or the RCC review the Physician's Visit Form for new orders and if there are new orders, the Physician's Visit Form is faxed to the facility's contracted pharmacy. -The pharmacy enters the new orders in the resident's eMAR and sends back to the facility and the RCC reviews and approves the new orders. -She did not know why the 05/11/23 Physician's Visit Form was not sent to the pharmacy until 07/17/23. -She said the nephrologist may not have sent the Physician's Visit Form back. -She did not know why the order was missed. -She did not know why the 05/11/23 orders were	D 358		

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D 358	Continued From page 18 not faxed to the pharmacy until 07/17/23. -She did not know how or who discovered the 05/11/23 Physician's Visit for Resident #1. -She completed monthly chart audits but did not compare the orders to the eMAR. -Resident #1's nephrologist was not notified that the medication orders given on 05/11/23 were not initiated until 07/17/23. -She expected all new orders for the residents to be reviewed and sent to the contracted pharmacy. Interview with the Administrator on 08/16/23 at 4:06pm revealed: -She expected all physician's orders to be reviewed and sent to pharmacy. -There should not have been a more than 2 months delay in Resident #1's orders being initiated. Attempted telephone interviews with Resident #1's nephrologist on 08/16/23 at 3:56pm and 08/17/23 at 11:10am were unsuccessful. Attempted telephone interview with Resident #1's primary care provider (PCP) on 08/17/23 at 11:05am was unsuccessful.	D 358		