STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081007	A. BUILDING: _____ B. WING _____	R 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTWELL HOME	401 US 221 S HIGHWAY RUTHERFORDTON, NC 28139

(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 completed an Annual and follow-up survey on 01/18/24.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#1) was tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #1's current FL2 dated 04/05/23 revealed: -Diagnoses included dementia, dialysis patient, and hypertension. -There were two documented TB skin tests dated 05/31/21 and 11/02/21. -There were no dates administered or documented results for the TB skin tests. Review of Resident #1's Resident Register	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081007	A. BUILDING: _____ B. WING _____	R 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTWELL HOME	401 US 221 S HIGHWAY RUTHERFORDTON, NC 28139

(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 234	Continued From page 1 revealed an admission date of 04/11/23. Interview with Resident #1 on 01/18/24 at 9:20am and 2:55pm revealed: -She had lived at the facility for almost a year. -She lived with a family member prior to this admission to the facility. -She could not remember if a TB skin test was placed upon admission to the facility. -She had received TB skin tests in the past. Interview with the facility's Registered Nurse (RN) on 01/18/24 at 2:17pm and 3:40pm revealed: -She was responsible for administering and reading TB skin tests for residents upon admission. -Resident #1 had lived at the facility prior and then went home to live with a family member. -Resident #1 was readmitted to the facility from a local hospital in April 2023. -She did not complete a TB skin test for Resident #1 upon readmission in April 2023. -She may have noticed the TB skin tests noted on Resident #1's FL2, however she did not follow-up with the hospital to obtain the dates of administration and the results.	D 234		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081007	A. BUILDING: _____ B. WING _____	R 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTWELL HOME	401 US 221 S HIGHWAY RUTHERFORDTON, NC 28139

(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 344	Continued From page 2	D 344		

admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to clarify a therapeutic diet order for 1 of 3 sampled residents (#1).

The findings are:

Review of Resident #1's current FL2 dated 04/05/23 revealed:
-Diagnoses included dementia, dialysis patient, and hypertension.
-There was an order for a renal diet.

Interview with Resident #1 on 01/18/24 at 9:20am revealed:
-She went to dialysis 3 days a week.
-She tried to watch her peanut butter intake.
-She did not drink orange juice.
-She ate the same foods as everyone else, she just ate them in moderation.

Review of the facility's therapeutic diet menu on 01/18/24 at 9:35am revealed:
-The regular diet lunch menu included chicken patty, creamed potatoes, beets, roll, mixed fruit, milk, coffee, or tea.
-There was no renal diet menu.
-There was a low sodium menu available.
-There was a low potassium/low protein menu available.

Interview with the facility Cook on 01/18/24 at 9:40am revealed:
-There was no renal diet available on the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081007	A. BUILDING: _____ B. WING _____	R 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTWELL HOME	401 US 221 S HIGHWAY RUTHERFORDTON, NC 28139

(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 344	Continued From page 3	D 344		

therapeutic menus.
-She was aware Resident #1 was ordered a renal diet as it was listed on the therapeutic diet list on the freezer door in the kitchen.
-She did not follow any of the therapeutic menus available for Resident #1.
-She served Resident #1 a regular diet with certain substitutions.
-She would serve Resident #1 cranberry juice or grape juice instead of orange juice.
-She did not serve Resident #1 seedy vegetables like cucumbers.
-Resident #1 ate very small amounts and knew the types of foods and beverages she was allowed as a dialysis patient.
-If she had questions about what items she was allowed to serve Resident #1, she would call the facility Manager or she would look it up on the internet.

Observation in the facility kitchen on 0/18/24 at 9:45am revealed:
-There was a list of all residents with therapeutic diet orders posted on the freezer door in the kitchen.
-Resident #1 was documented on the list to receive a renal diet.

Observation of the lunch meal and beverage service on 01/18/24 at 11:45am revealed:
-Resident #1 was served 2 baked chicken tenders, 1/2 cup of mashed potatoes, 1/2 cup of beets, 1 roll, 1 2 inch square of white cake with candy sprinkles on the top, and a 12 oz. diet orange soda.

Interview with the facility Registered Nurse (RN) on 01/18/24 at 2:17pm revealed:
-The kitchen staff had been trained to use the low potassium/low protein therapeutic diet menu for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081007	A. BUILDING: _____ B. WING _____	R 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTWELL HOME	401 US 221 S HIGHWAY RUTHERFORDTON, NC 28139

(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 344	Continued From page 4 residents ordered a renal diet. -There used to be a list in the kitchen of foods residents ordered renal diets should not have. -She noticed yesterday when she delivered groceries into the kitchen, the renal foods list was no longer there. -She did not know what happened to the list.	D 344		