5/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011329	A. BUILDING: _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMINY VALLEY RETIREMENT CENTER	2189 SMOKEY PARK HIGHWAY CANDLER, NC 28715

(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 survey 04/02/24 - 04/04/24.	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, interviews, and record rev ews, the facility failed to notify the primary care provider (PCP) for 1 of 3 sampled residents (#2) of missed doses of a medication used to prevent blood clots, missed doses of a medication used to slow the pulse rate, a missed post surgical follow-up appointment, missed routine PCP appointments for chronic conditions, the resident being jailed for 5 days, and the resident discharging himself from the facility to move into an apartment. The findings are: Review of Resident #2's current FL2 dated 12/20/23 revealed: -Diagnoses included atrial fibrillation (an irregular, often rapid heart beat that commonly causes poor blood flow), blind, retinitis pigmentosa (a rare inherited degenerative disease that causes severe vision impairment), and chronic pain. -The resident was ambulatory. -The resident was legally blind. -The level of care was domiciliary. Review of Resident #2's Resident Register revealed: -A facility admission date of 01/02/24.	D 273	D273 Twice a week the Rcc will review the exception sheet and compare to the missed medication forms and notify the physician of any missed medications. Fax confirmation or physician signature. The facility will have this proceedure in place no later than June 30, 2024 - the RCC will be supervised by management.	6-30-24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Wright — TITLE: Administrator — (X6) DATE: May 15, 2024

STATE FORM 6899 M60T11 If continuation sheet 1 of 23

Recieved + Acknowledged AMJ 5/20/24

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D 273	Continued From page 1 -Resident #2 was his own responsible person. Review of Resident #2's Care Plan dated 01/08/24 revealed: -The resident required limited staff assistance with eating, toileting, ambulation/locomotion, and transfers. -The resident required extensive staff assistance with bathing, dressing, and grooming/personal hygiene. 1. Review of Resident #2's current FL2 dated 12/20/23 revealed an order for Xarelto (a medication used to prevent blood clots) 20mg 1 tablet daily. Review of Resident #2 physician order dated 01/31/24 revealed Xarelto 20mg 1 tablet daily with supper. Review of Resident #2's January 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Xarelto 20mg 1 tablet daily scheduled at 5:00pm. -Xarelto was documented as administered on 8 occurrences out of 27 opportunities from 01/02/24 to 01/31/24. -The Xarelto was documented as not administered on 8 occurrences (01/05/24, 01/10/24, 01/11/24, 01/17/24, 01/22/24, 01/23/24, 01/25/24, and 01/26/24) due to the resident being "out of facility." Review of Resident #2's February 2024 eMAR revealed: -There was an entry for Xarelto 20mg 1 tablet daily scheduled at 5:00pm. -Xarelto was documented as administered on 22 occurrences out of 28 opportunities from	D 273		

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D 273	Continued From page 2 02/01/24 to 02/29/24. -The Xarelto was documented as not administered on 6 occurrences (02/05/24, 02/06/24, 02/07/24, 02/14/24, 02/16/24, and 02/26/24) due to the resident being "out of facility." Review of Resident #2's March 2024 eMAR revealed: -There as an entry for Xarelto 20mg 1 tablet daily scheduled at 5:00pm. -Xarelto was documented as administered on 17 occurrences out of 31 opportunities from 03/01/24 to 03/31/24. -The Xarelto was documented as not administered on 14 occurrences (03/04/24, 03/05/24, 03/06/24, 03/07/24, 03/09/24, 03/11/24, 03/12/24, 03/13/24, 03/14/24, 03/15/24, 03/18/24, 03/20/24, 03/21/24, and 03/22/24) due to the resident being "out of facility." Review of Resident #2's April 2024 eMAR revealed: -There as an entry for Xarelto 20mg 1 tablet daily scheduled at 5:00pm. -Xarelto was documented as not administered on 3 occurrences from 04/01/24 to 04/04/24 out of 3 opportunities (04/01/24, 04/02/24, and 04/03/24) due to the resident being "out of facility." Observation of Resident #2's available medications on 04/03/24 at 2:10pm revealed: -There was one bubble pack of Xarelto 20mg tablets with 5 tablets remaining in the pack. -The bubble pack of 30 tablets was dispensed on 02/03/24. Interview with the Resident Care Coordinator (RCC) on 04/02/24 at 10:40am revealed: -Resident #2 was out of facility.	D 273	When residents have outside appointments and return without a visit Summary the Rcc. will notified the appointment Scheduler to contact the outside provider to fax over visit Summary. If not received by end of the next bussiness day a follow up call will be place by appt scheduler. This process will continue until Summary is received. At which time the report/Summary	

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D 273	Continued From page 3 -Resident #2 signed himself out of the facility on 04/01/24 and had not yet returned to the facility. -Resident #2 missed his scheduled medications when he was on leave from the facility. Interview with the RCC on 04/03/24 at 1:10pm revealed: -She was primarily responsible for notifying physicians when residents missed scheduled medications. -On 02/08/24, she called Resident #2's PCP office to notify him Resident #2 had missed three consecutive doses of Xarelto on 02/05/24, 02/06/24, and 02/07/24. -On 03/14/24, she called Resident #2's PCP office to notify him Resident #2 had missed three consecutive doses of Xarelto on 03/11/24, 03/12/24, and 03/13/24. -On 04/02/24, she faxed a list of missed doses of Xarelto from 03/03/24 to 04/01/24 to Resident #2's PCP office and had requested the PCP review, sign the document, and fax back acknowledgment of having seen the information. Interview with the Operations Manager on 04/03/24 at 3:35pm revealed: -The RCC was primarily responsible for notifying the PCP when a resident missed three doses of a scheduled medication. -Medication aides (MA) were also trained to notify the PCP when a resident missed three doses of a scheduled medication. Telephone interview with a MA on 04/04/24 at 8:32am revealed: -Resident #2 frequently missed his scheduled Xarelto due to being out of facility. -On 03/13/24, Resident #2 was out of facility and he was unable to administer the Xarelto to him. -He informed the RCC on 03/14/24 at the end of	D 273	Will be given to R.C.L. The facility will have this Proceedure in place no later than June 30, 2024 This Proceedure will be Supervised by Management	6-30-24

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D 273	Continued From page 4 his shift that Resident #2 had missed three consecutive doses of Xarelto. -The RCC was responsible for notifying the PCP about the missed doses of Xarelto. Telephone interview with Resident #2's PCP on 04/04/24 at 9:15am revealed: -Resident #2 was prescribed Xarelto for atrial fibrillation. -Atrial fibrillation predisposed people to forming blood clots which could cause an ischemic stroke (blockage of an artery). -Xarelto reduced the risk of stroke by 50%. -Resident #2 having missed multiple doses of Xarelto would increase the resident's risk of having an ischemic stroke by 5%. -The Xarelto could safely be restarted after having missed doses. -He was not made aware Resident #2 had missed 5-15 doses of Xarelto each month for the last 3 months. -He did not see a telephone encounter note in their office system, however the facility may have communicated the missed Xarelto and the conversation just did not get logged into their system. -Even if he had known about the missed Xarelto doses, it would not have "changed anything" knowing what he did about Resident #2's behaviors. Interview with the Administrator on 04/04/24 at 1:15pm revealed: -Staff were expected to notify resident's physician's when a resident missed three doses of a scheduled medication. -The MAs were responsible to report missed scheduled medications to the RCC. -The MAs reported missed doses of medications after every shift to the RCC.	D 273		

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D 273	Continued From page 5 -The RCC reviewed missed medication reports daily through the week to see scheduled medications that were not administered. -The RCC was responsible for contacting the physician to let them know when a resident missed doses of a scheduled medication. Attempted interview with Resident #2 on 04/04/24 at 9:50am and 11:26am was unsuccessful. 2. Review of Resident #2's current FL2 dated 12/20/23 revealed an order for metoprolol (used to lower blood pressure and heart rate) 50mg 1 tablet daily. Review of Resident #2 physician order dated 01/31/24 revealed Metoprolol ER 50mg 1 tablet daily. Review of Resident #2's January 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for metoprolol ER 50mg 1 tablet every day scheduled at 8:00am. -Metoprolol was documented as administered on 26 occurrences out of 28 opportunities. -The metoprolol was documented as not administered on 4 occurrences (01/05/24, 01/12/24, and 01/18/24) due to the resident being "out of facility." Review of Resident #2's February 2024 eMAR revealed: -There was an entry for metoprolol ER 50mg 1 tablet every day scheduled at 8:00am. -Metoprolol was documented as administered on 26 occurrences out of 29 opportunities. -The metoprolol was documented as not administered on 3 occurrences (02/03/24, 02/06/24, and 02/07/24) due to the resident being	D 273		

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D 273	Continued From page 6 "out of facility." Review of Resident #2's March 2024 eMAR revealed: -There was an entry for metoprolol ER 50mg 1 tablet every day scheduled at 8:00am. -Metoprolol was documented as administered on 24 occurrences out of 31 opportunities. -The metoprolol was documented as not administered on 7 occurrences (03/05/24, 03/06/24, 03/12/24, 03/13/24, 03/14/24, 03/21/24, 03/22/24) due to the resident being "out of facility." Review of Resident #2's April 2024 eMAR revealed: -There was an entry for metoprolol ER 50mg 1 tablet every day scheduled at 8:00am. -Metoprolol was documented as administered on 2 occurrences out of 4 opportunities from 04/01/24 to 04/04/24. -The metoprolol was documented as not administered on 2 occurrences (04/02/24 and 04/03/24) due to the resident being "out of facility." Interview with the Resident Care Coordinator (RCC) on 04/02/24 at 10:40am revealed: -Resident #2 was out of facility. -Resident #2 signed himself out of the facility on 04/01/24 and had not yet returned to the facility. -Resident #2 missed his scheduled medications when he was on leave from the facility. Review of Resident #2's record revealed there was no documentation of the PCP being notified of Resident #2's missed doses of metoprolol from January 2024 to April 2024. Interview with the RCC on 04/04/24 at 11:00am	D 273		

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D 273	Continued From page 7 revealed: -Resident #2 was in jail for 5 days one month. -The resident had missed his scheduled medications during this time. -She did not notify Resident #2's PCP about the reason for the resident missing his scheduled medications while he was jailed. Interview with the Operations Manager on 04/03/24 at 3:35pm revealed: -The RCC was primarily responsible of notifying the PCP when a resident missed three doses of a scheduled medication. -Medication aides (MA) were also trained to notify the PCP when a resident missed three doses of a scheduled medication. Telephone interview with Resident #2's PCP on 04/04/24 at 9:15am revealed: -Resident #2 was prescribed metoprolol for atrial fibrillation. -He was not made aware Resident #2 had missed 2-7 doses of metoprolol in the last 3 months. -He did not see a telephone encounter note in their office system, however the facility may have communicated the missed metoprolol and the conversation just did not get logged into their system. -Even if he had known about the missed metoprolol doses, it would not have "changed anything" knowing what he did about Resident #2's behaviors. -He did not know how much the metoprolol was helping with Resident #2's atrial fibrillation because it had been "awhile" since he had seen the resident to evaluate him. -The metoprolol could safely be restarted after having missed doses.	D 273		

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D 273	Continued From page 8 Interview with the Administrator on 04/04/24 at 1:15pm revealed: -Staff were expected to notify resident's physician's when a resident missed three doses of a scheduled medication. -The MAs were responsible to report missed scheduled medications to the RCC. -The MAs reported missed doses of medications after every shift to the RCC. -The RCC reviewed missed medication reports daily through the week to see scheduled medications that were not administered. -The RCC was responsible for contacting the physician to let them know when a resident missed doses of a scheduled medication. Attempted interview with Resident #2 on 04/04/24 at 9:50am and 11:26am was unsuccessful. 3. Review of Resident #2's same day discharge summary dated 01/31/24 revealed: -The reason for the admission was for a right inguinal hernia repair. -There was an order to follow-up at the same day surgery center on 03/05/24 at 2:15pm. Review of Resident #2's record revealed there were no notes regarding a post surgical follow-up for the right inguinal hernia repair. Telephone interview with the facility transportation staff on 04/04/24 at 8:57am revealed: -She was responsible for scheduling resident appointments and arranging transportation for the residents to appointments. -Resident #2 scheduled all of his own appointments and she would arrange transportion to those appointments for him. -She did not know if Resident #2 went to the post-operative follow-up appointment for his	D 273		

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D 273	Continued From page 9 inguinal hernia repair. -She had not taken Resident #2 to a follow-up appointment for his inguinal hernia repair. Telephone interview with a representative from Resident #2's same day surgery center on 04/04/24 at 9:32am revealed: -Resident #2 had been a no call and no show for the follow-up post-operative appointment scheduled on 03/05/24. -The missed follow-up appointment on 03/05/24 had never been rescheduled. Telephone interview with a Registered Nurse (RN) from Resident #2's same day surgery center on 04/04/24 at 10:02am revealed: -Resident #2 was a no call and no show for the appointment scheduled on 03/05/24. -The appointment was rescheduled for 03/12/24. -The appointment on 03/12/24 was a no call and no show. -The post-operative appointment for a inguinal hernia repair was done to ensure everything was holding with the repair. -As long as Resident #2 had not had any problems, it was not necessary for the resident to be seen post-operatively. -There was a very low risk of infection with an inguinal hernia repair. -Any signs of infection would have been visible to the resident externally. Interview with the Administrator on 04/04/24 at 1:15pm revealed: -She would have expected staff to take Resident #2 to his follow-up post operative appointment as scheduled. -If the resident was not available, she would expect staff to reschedule the appointment and let Resident #2 know the appointment had been	D 273		

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D 273	Continued From page 10 rescheduled. -The post operative appointment that was missed on 03/05/24 was rescheduled to 04/02/24. -The staff rescheduled the appointment as she would have expected. -All they could do was hope Resident #2 would cooperate and be present, so he could be taken to the appointment. Attempted interview with Resident #2 on 04/04/24 at 9:50am and 11:26am was unsuccessful. 4. Interview with the Resident Care Coordinator (RCC) on 04/02/24 at 10:40am revealed: -Resident #2 was out of facility. -Resident #2 signed himself out of the facility on 04/01/24 and had not yet returned to the facility. Interview with the Resident Care Coordinator (RCC) on 04/03/24 at 1:10pm revealed: -Resident #2 had an appointment to see his PCP "today" (04/03/24) at 2:45pm. -Resident #2 signed himself out of the facility on 04/01/24 and had not yet returned to the facility. -Resident #2 handled all his own appointment scheduling. -She had not received any orders from Resident #2's PCP in a while. Telephone interview with the facility transportation staff on 04/04/24 at 8:57am revealed: -Resident #2 had an appointment at his PCP scheduled for 04/03/24 at 2:45pm. -Resident #2 was out on leave as of 04/01/24 and had not returned on the morning of 04/03/24. -She called and rescheduled Resident #2's PCP appointment the morning of 04/03/24 because Resident #2 was not back from leave. -She rescheduled the appointment for later in April because and some medical providers would	D 273		

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D 273	Continued From page 11 stop seeing a resident who was a no call and no show for several appointments. Telephone interview with a representative from Resident #2's PCP office on 04/03/24 at 4:00pm revealed: -Resident #2 did not show for an appointment he had scheduled to see his PCP that day (04/03/24) at 2:45pm. -Facility staff had notified their office that morning not to expect Resident #2 to make the appointment. Telephone interview with Resident #2's PCP on 04/04/24 at 9:15am revealed: -Resident #2 had not attended an appointment with him since December 2023. -The appointment scheduled for 04/03/24 had been rescheduled for "next week." -He did not know how Resident #2 medical conditions were doing as he had not seen the resident since December 2023. Interview with the Administrator on 04/04/24 at 1:15pm revealed: -If the resident was not available, she would expect staff to reschedule the PCP appointment and let Resident #2 know the appointment had been rescheduled. -All they could do was hope Resident #2 would cooperate and be present, so he could be taken to the appointment. Attempted interview with Resident #2 on 04/04/24 at 9:50am and 11:26am was unsuccessful. 5. Interview with the Resident Care Coordinator (RCC) on 04/03/24 at 1:00pm revealed: -Resident #2 frequently left the facility. -The longest amount of time Resident #2 had	D 273		

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D 273	Continued From page 12 been gone was 5 days in a row and one of those days was because the resident had been jailed. Interview with the RCC on 04/04/24 at 11:00am revealed: -She did not notify Resident #2's PCP when she became aware the resident was jailed in March 2024. -Resident #2 saw an outside physician instead of using the house PCP who made weekly visits to the facility. -She did not even consider notifying the PCP about the jailing as this was not a situation she had encountered before. Interview with the Health and Wellness Director on 04/04/24 at 11:15am revealed: -Resident #2 was arrested on 03/11/24 and charged with trespassing and disorderly conduct. -Resident #2 was jailed for 5 days on the charges obtained on 03/11/24. Interview with the Operations Manager on 04/04/24 at 11:21am revealed: -She was talking to Resident #2 on his cell phone during his arrest on 03/11/24. -She notified Resident #2's family member about the arrest. -She did not notify Resident #2's PCP about the arrest and jailing of the resident. Interview with the Administrator on 04/04/24 at 1:22pm revealed: -The facility did not have a policy concerning contacting the PCP when a resident was arrested and jailed. -The facility did not have a policy because they typically did not have residents who were getting arrested and jailed.	D 273		

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D 273	Continued From page 13 Attempted interview with Resident #2 on 04/04/24 at 9:50am and 11:26am was unsuccessful. Attempted interview with Resident #2's PCP on 04/04/24 at 12:02pm was unsuccessful. 6. Interview with the Resident Care Coordinator (RCC) on 04/04/24 at 11:00am revealed: -Resident #2 returned to the facility late in the evening on 04/03/24. -Resident #2 came to see her early on 04/04/24 to let her know he was discharging himself that day (04/04/24). -Resident #2 told her he had obtained an apartment. -Resident #2 gave her the address of the apartment. -Resident #2 had a key for the apartment. Interview with the RCC on 04/04/24 at 1:25pm revealed: -She had not contacted Resident #2's PCP for notification Resident #2 was moving out of the facility to an apartment on 04/04/24. -Every resident at the facility saw the contracted PCP except Resident #2, so the contracted PCP would be aware of his moving out of the facility if he had been her patient. -It never occurred to her to contact Resident #2's PCP to inform them that he was moving out of the facility to an apartment on 04/04/24. Attempted interview with Resident #2 on 04/04/24 at 9:50am and 11:26am was unsuccessful. Attempted interview with Resident #2's PCP on 04/04/24 at 12:02pm was unsuccessful.	D 273		

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D 312	Continued From page 14	D 312		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a resident requiring assistance with her meal in the dining room was treated with respect, consideration, and dignity as evident by staff standing while providing feeding assistance to this resident. The findings are: Observation of the lunch meal on 04/02/24 beginning at 11:50am revealed: -There were 18 residents in the dining room at 11:50am. -There was 1 resident seated at the first table to the left upon entrance to the dining room. -A personal care aide (PCA) stood beside the resident and assisted the resident with her food and beverage at the lunch meal. -At no time did the PCA sit while providing assistance to the resident at the lunch meal. Interview with the PCA on 04/02/24 at 12:12pm revealed: -There was only one resident that needed assistance with meals. -The resident did not always require assistance, but she did on 04/02/24 at the lunch meal.	D 312		

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D 312	Continued From page 15 -The PCA normally stood beside the resident to provide assistance with meals. -If she brought a chair to sit beside the resident, it blocked the other residents from coming in and out of the dining room. Interview with the Resident Care Coordinator (RCC) on 04/02/24 at 2:10pm revealed: -She did not think staff had been told not to stand to assist residents at mealtimes. -She thought the PCA probably did not know she should not be standing beside the resident to give assistance during the meal. -She expected the staff to sit down beside the resident when providing assistance at mealtimes. Interview with the Administrator on 04/03/24 at 2:07pm revealed: -There was one resident who periodically required assistance at mealtimes. -Any staff assisting a resident with their meal should be sitting beside them and not standing over them to maintain their dignity. Based on record review and observation, it was determined the resident on 04/03/24 at 2:26pm was not interviewable.	D 312	Management will have training and documentation to reflect that the staff have been train on resident rights and dignity. 6/30/24 Management will train staff on proper technique with assisting at mealtimes.	
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION	D 338		

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D 338	Continued From page 16 Based on observations, interviews, and record reviews, the facility failed to ensure the rights of all residents were maintained during meal service by not providing seating for all residents and serving a resident (#3) food products the resident was documented as allergic to. The findings are: 1. Resident #3's current FL2 dated 02/15/24 revealed: -Diagnoses included diabetes type 1 and gastric reflux. -There were no orders on the FL2 listing food allergies. The admission face sheet dated 02/15/24 indicated Resident #3 had food allergies that included fish containing products, peanuts, lactose products and tomatoes. Review of the February, March, and April 2024 electronic medication administration records (eMARs) revealed there was documentation Resident #3 had food allergies that included fish containing products, peanuts, lactose products and tomatoes. Review of the resident allergy list in the kitchen on 04/02/24 at 9:52am revealed Resident #3 was listed without food allergies and on a regular diet. Review of Resident #3's care plan dated 02/19/24 revealed a regular diet without dietary restrictions. Review of the referral for allergy testing dated 02/22/24 revealed a consultation for Resident #3 to have an appointment with an allergy specialist.	D 338	Facility will ensure enough seating for all residents	

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D 338	Continued From page 17 Observation of the lunch meal on 04/02/24 beginning at 11:50am revealed: -Resident #3 was observed eating ravioli with tomato sauce and sprinkled cheese, potato wedges, green beans, mixed fruit, and a dinner roll. -Resident #3 also had 2 unopened, rectangular packages of ketchup on her lunch plate. Interview with Resident #3 on 04/02/24 at 12:01pm and 04/03/24 at 10:24am revealed: -She was allergic to fish, peanuts, lactose products and tomatoes. -On 04/02/24 at the lunch meal she was served ravioli with tomato sauce and sprinkled cheese, along with 2 ketchup packets for her potato wedges. -She did not want the alternate meal, so she ate what she was served for lunch. -Tomatoes caused her to have a "horrible rash." -Cheese (lactose products) gave her "diarrhea." -Fish products caused her to have a "horrible rash." -Peanuts caused her airway to close and was "unable to breathe." -For her lunch meal on 04/02/24 she had become very itchy after eating the tomato sauce in the ravioli. -She had an epinephrine auto-injector (an injectable medication for severe allergic reactions) that she wanted to use for her itching. -The RCC called her PCP, and she did not give an order for the epinephrine auto-injector since it was only for use in severe allergic reactions. -She has not had to use her epinephrine auto-injector since she was admitted to the facility. -The facility staff had her medical file before she moved to the facility in February 2024. -The staff should know what she can and cannot	D 338	Upon admission the R.C.C. with a member of management will review all documentation to check for allergies. Initials from R.C.C. and management will reflect review. Once documentation is reviewed the RCC will give notice to Kitchen staff to sign acknowledging diet orders. The R.C.C. will sign with management once all steps are completed	

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D 338	Continued From page 18 have because it was in her medical record. Interview with the Resident Care Coordinator (RCC) on 04/02/24 at 2:10pm revealed: -She was responsible for informing the kitchen staff know when a new resident was admitted to the facility what the resident's diet was and if there were any food allergies. -She thought she had told the cook, but apparently, she did not. -Resident #3 told the RCC her back was itching after consuming her lunch meal on 04/02/24. -Resident #3 wanted to use her epinephrine auto-injector to stop the itching. -The RCC called Resident #3's Primary Care Provider (PCP) and was told the epinephrine auto-injector was only for anaphylactic shock and was not to be used for itching. -The PCP told the RCC Resident #3 could not take Benadryl (a medication used to treat itching and pain) due to her history of seizures, so Resident #3 needed to be transported to the hospital for evaluation and treatment. -Emergency Medical Services (EMS) was contacted and arrived at the facility less than 10 minutes after being dispatched. -Resident #3 refused to allow the EMS workers to assess her back and she also refused transport to the Emergency Room (ER) for evaluation and treatment. Interview with a cook on 04/03/24 at 9:30am revealed: -When she was notified of a new resident admission, she would ask the medication aide (MA) if the new resident was on a special diet, needed adaptive equipment, or had any food allergies. -Residents food allergies were documented on the allergy list kept in the kitchen.	D 338		

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D 338	Continued From page 19 -She was not informed that Resident #3 had any food allergies when she asked the MA upon Resident #3's admission to the facility. -Resident #3 was not on the allergy list for any food allergies prior to 04/02/24. Telephone interview with Resident #3's PCP on 04/03/24 at 10:45am revealed: -When Resident #3 was admitted to the facility in February 2024 there were numerous food and medication allergies listed in her medical chart. -Resident #3 told the PCP she knew what she could and could not eat. -Resident #3 was able to tell the PCP what she was allergic to and what her reactions were. -Resident #3 was seen by an allergist for allergy testing in March of 2024, but Resident #3 negated the results during allergy testing by rubbing/scratching the testing areas. -Resident #3 did not complete her allergy testing and left the allergist office, but a 2nd attempt to retest her for allergies has been scheduled for some time in May 2024. -Facility staff are aware of the incomplete test results and the upcoming appointment in May 2024 to attempt a retest. -Resident #3 should not be receiving any food listed as an allergy until allergy testing has been completed and she was able to review the results. Interview with the Administrator on 04/03/24 at 2:07pm revealed: -When Resident #3 was admitted to the facility, there was no previous allergy testing submitted with her medical record. -Resident #3's PCP gave a referral in February 2024 for allergy testing to verify she was allergic to everything listed in her transfer papers. -While waiting for her allergy testing, the facility	D 338		

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should have followed the list of food allergies and not served these to Resident #3.
-The allergy information for Resident #3 did not get relayed from the RCC to the dietary department cooks, so they were not aware of what Resident #3's food allergies were.

2) The facility resident census on 04/02/24 was 28.

Observation of the lunch meal on 04/02/24 beginning at 11:50am revealed:
-There were 18 residents in chairs and wheelchairs in the dining room.
-There were no additional chairs observed in the dining room for resident seating.
-One resident was observed to enter the dining room and exit twice while the lunch meal was being served and consumed by other residents.
-Other residents were observed waiting in the hallway outside the dining room during the lunch meal.

Interviews with several residents waiting for their lunch meal on 04/02/24 revealed:
-It usually occurred two to three times a week that the residents cannot go into the dining room and eat because there were not enough seats.
-It was very annoying to have to wait to eat.
-The wait time could be 20 minutes or longer.
-It was difficult smelling the food, being hungry, but being unable to eat.
-One resident had to wait to eat lunch today until a seat became available.
-It was embarrassing to walk in and out of the dining room and not be able to find a place to sit down and eat.
-The same resident said it was the third or fourth time this had happened to her in the past week.
-It was frustrating not to be able to go into the

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D 338	Continued From page 21 dining room and eat when it was lunch time. Interview with the Resident Care Coordinator on 04/02/24 at 2:10pm revealed: -There used to be two mealtimes because of the size of the dining room. -The staff had gradually stopped doing this over the past few months. -The two mealtimes had not "officially" been discontinued. -Staff would clean the table area a resident had been eating at and another resident would often ask to go ahead and come in to eat. -Staff would allow a resident waiting at mealtime to come into the dining room as soon as each resident completed their meal and left the dining room. -There were not enough tables and chairs in the dining room to accommodate all the residents during one scheduled sitting for meals. Interview with the Administrator on 04/03/24 at 2:07pm revealed: -The facility had enough chairs for all the residents to have a seat in the dining room. -The chairs were not set up in the dining room for the full capacity of residents for the lunch meal on 04/02/23. -She did not want it to be overcrowded in the dining room. -They need to go back to consistently having 2 seatings for each mealtime to accommodate all residents. The facility failed to ensure residents rights were maintained related to respect and dignity and care and services by not providing seating in the dining room in accordance with resident census and not offering a scheduled second seating during the lunch meal service, resulting in	D 338		

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D 338	Continued From page 22 residents feeling embarrassed and frustrated after they enter the dining room then had to exit after finding there was no seating availability and serving a resident two food products that she was allergic to, placing the resident at risk for an allergic reaction. This failure was detrimental to the health, safety, and well-being of all residents and constitutes a Type B Violation. This facility provided a plan of protection in accordance with 131D-34 for this violation on 04/03/24. THE CORRECTION DATE FOR THIS VIOLATION SHALL NOT EXCEED MAY 19, 2024.	D 338		