STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051047	A. BUILDING: _____ B. WING	R 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW ASSISTED LIVING	250 HIGHWAY 210 WEST SMITHFIELD, NC 27577

(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, follow-up, and complaint investigation survey from 07/31/24 to 08/01/24.	D 000	Response to the cited deficiencies do not constitute an admission of agreement by the facility of the facts alleged or conclusions set forth in the statement of deficiencies. Plan of correction is prepared solely as a matter of compliance with the law.	
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure plumbing equipment was maintained in a safe and operating condition for one toilet observed leaking. The findings are: Observation on 07/31/24 at 8:15am revealed: -In room 210 and 212 there was a shared bathroom toilet. -There was standing black water around the toilet on the bathroom floor. -There was a gap between the bathroom floor and the toilet that appeared to be leaking water. Interview with a resident on 07/31/24 at 8:20am revealed: -The toilet between rooms 210 and 212 had been broken and leaking water for two years. -Housekeeping staff cleaned up the water daily but it continued to leak. -There was always water on the floor in the bathroom. -He told housekeeping and maintenance about the toilet leak multiple times.	D 105	Repair was made at time of finding during survey. On 8/8/24 Maintenance Binder was created. The location of binder is at the Med Station. Orders reported or requested will be placed in binder. Binder to be checked 3 times daily by maintenance staff. Maintenance Supervisor will follow up on orders. Staff inserviced on binder and the proper use 8/28/24. Inservice/training completed by Maintenance Director.	8/28/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cynthia Tassi Tanner | TITLE: Executive Director | (X6) DATE: 9-11-24

Jamaal Willis

Reviewed and Acknowledged 09/13/24

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D 105	Continued From page 1 Interview with a second resident on 07/31/24 at 8:35am revealed: -The toilet between rooms 210 and 212 had been broken and leaking water for four years. -Water was always on the floor in the bathroom. -He has talked to multiple staff about the leak. -Maintenance had attempted to fix the leak but had not been successful. Interview with a housekeeping staff member on 07/31/24 at 8:40am revealed: -She had been aware of the leak for about a week. -She cleaned the floor and moped the water up daily. -There was standing water on the bathroom floor daily. -She believed the facility was waiting on a part to fix the toilet leak. Interview with the maintenance assistant on 07/31/24 at 8:50am revealed: -The toilet between rooms 210 and 212 had been an issue for about four months. -The floor was cleaned everyday by housekeeping staff. -The toilet continued to leak and there was standing water on the floor constantly. -He fixed the wall behind the toilet that was damaged from the water. -He fixed the toilet but it continued to shift at the base from the weight of being used which caused the leak. Interview with the Resident Care Coordinator (RCC) on 07/31/24 at 9:00am revealed: -She was not aware that the toilet between rooms 210 and 212 had been leaking. -It was the responsibility of the maintenance	D 105		

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D 105	Continued From page 2 assistant to fix any plumbing issues in the facility. Interview with the Executive Director (ED) on 07/31/24 at 9:30am revealed: -She was aware that the toilet between rooms 210 and 212 had been leaking. -She was informed the toilet was sealed and the leak was fixed the prior week. -It was the responsibility of the maintenance assistant to fix environmental issues in the facility.	D 105		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure personal care assistance for 1 of 5 sampled residents (#4) who required assistance with toenail care. The findings are: Review of the facility's body evaluations sheet not dated revealed: -Complete body audits were to be completed on all residents after any hospitalization or more often as the community had determined. -Under the "nails" section, staff would address whether or not nails were cleaned, had smooth edges, and were short.	D 269	Nail kits purchased for each resident. Kit includes 2 files, 1 nail clipper and one nail brush. Items placed in each residents bathroom. PCA's will complete nail care on all non diabetic residents on shower day. PCA to note nail care on shower sheets. Med Techs to sign off on shower sheets. RCC to complete random checks weekly. Inservice all PCA & Med Techs on nail care. Inservice and training completed by RCC on 8/28/24. RCC will monitor monthly.	8/28/24

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D 269	Continued From page 3	D 269		

-If staff could not check "clean", they would clean the nails and check cleaned.
-If staff could not check "smooth edges", they would file the nails and check filed.
-If staff could not check the nails were "short", they would trim the nails and check trimmed. -Exception: staff was not to trim the nails of diabetic residents, if staff could not check that the nails were short and the resident was diabetic, staff would check the follow up needed section. -The Resident Care Coordinator (RCC) would be responsible for arranging Podiatry visit for toenails and/or ask the Licensed Health Professional Support (LHPS) nurse to trim fingernails.
-The completed form should be placed in the designated area immediately after completion for the Executive Director (ED)/RCC designee review and/or follow up
-The ED/RCC designee would review within 24 hours and determine if follow-up was required. -Follow up by the ED/RCC designee would begin immediately and all interventions documented in the care notes.
-Follow-up would be completed and interventions in place within 48 hours
-The RCC was responsible for maintaining a list of all residents with follow-up interventions in place and monitoring to ensure they were being done.

Review of Resident #4's current FL-2 dated 09/11/23 revealed:
-Diagnoses included displaced intertrochanteric fracture of the left femur, hypertension, peripheral vascular disease, chronic obstructive pulmonary disease, osteoarthritis, macular degeneration, and dermatitis.
-The resident was ambulatory and required assistance with bathing and dressing.

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D 269	Continued From page 4 Review of Resident #4's Resident Register revealed an admission date of 09/12/23. Review of Resident #4's current care plan dated 10/09/23 revealed the resident required limited assistance with activities of daily living such as toileting, grooming and personal hygiene. Review of Resident #4's electronic progress notes for January 2024 revealed on 01/28/24 at 2:34pm, the resident's left big toe and right big toe needed to be looked at by a doctor on "Tuesday". Interview with Resident #4's family member on 07/29/24 at 2:35pm revealed: -On 02/27/24 she took pictures of Resident #4's toenails and found the big toenail to be curved, long in length, and discolored and the other toenails long in length. -She immediately showed the medication aide (MA) the resident's feet and was told the facility did not cut toenails and it was the responsibility of the family to make the appointment. Observation of the picture provided by Resident #4's family member revealed: -Picture of the resident's left great toe showed the toenail was curved, long in length and was yellowish and brownish in color. -Picture of the resident's left second and third toes showed the toenails were long in length. -Picture of the resident's right great toe showed the toenail was yellowish and brownish in color. -Picture of the resident's right second, third, and fourth toes showed the toenails were long in length. Review of Resident #4's Podiatry exam note	D 269	

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D 269	Continued From page 5 dated 03/27/24 revealed: -A comprehensive foot exam was performed. -All dystrophic and/or mycotic nails were debrided in length and thickness as needed to prevent pain and other symptoms. -A nail nipper was used to debulk nails and a dremel tool was used to file smooth. Interview with a personal care aide (PCA) on 08/01/24 at 10:47am revealed: -She did not remember Resident #4's feet needing attention when she gave her showers. -When she did her bath/shower observation she would look for anything out of the ordinary or that was not there the last time she checked. -If there were anything out of the ordinary such as sores, marks, or issues with toenails, she would check it off on the bath/shower sheet and place it in the RCC's box to notify to check the resident's body. -She did not file toenails because the podiatrist came every three months. Interview with a MA on 08/01/24 at 11:30am revealed: -Resident #4 had imbalance issues but no one made him aware that there were issues with her toes, and he had not observed any issues. -The PCA was responsible for checking and observing the body during a bath/shower and notifying the MAs regarding any issues. -He would then notify the RCC or place the shower sheet in the RCC's box to notify them of the issue. Interview with the RCC on 08/01/24 at 12:00pm revealed: -She was not notified that Resident #4 needed to see the podiatrist and if she had been notified, she would have made the appointment to take	D 269		

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D 269	Continued From page 6 her to the podiatrist per the responsible party's approval to do so. -She was responsible for scheduling the podiatrist appointment if there was a need for this service outside of the in-house visit every three months. Interview with the Administrator on 08/01/24 at 12:45pm revealed: -When there were any issues with a resident's foot, they were to immediately see the in-house podiatry. -If she had been told by the family that the resident needed to be seen by a podiatrist, she would have scheduled that appointment. -Resident #4 was placed on the podiatrist schedule and seen in March 2024. -The PCA could provide basic nail care to residents except those who were diabetic, but Resident #4's toenails were too thick for the staff to handle. -The PCA should be using the body evaluations procedure (sheet located on the wall in the MA area to go by) when assessing a resident's body. -During bath/shower the PCA should observe the entire body and if any issues were found, notify the MA who should review the area then notify the RCC with the issues who then scheduled an appointment and notified the family. -She did not know why Resident #4 did not see the podiatrist sooner. Attempted telephone interview with Resident #4's podiatrist on 08/01/24 at 8:25am, 9:20am, and 10:20am was unsuccessful.	D 269			
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	D 273			

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D 273	Continued From page 7 to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (#5) related to failing to inform a primary care provider (PCP) of blood pressure readings outside of parameters. The findings are: Review of Resident #5's current FL-2 dated 12/12/23 revealed: -Diagnoses included hypertension, diabetes mellitus type 2, hyperlipidemia and atherosclerotic heart disease, major depressive disorder, bipolar disease, moderate intellectual disabilities and benign prostatic hyperplasia. -There was an order for lisinopril (lisinopril is used to treat high blood pressure and heart failure)10mg, take one tablet every morning. Review of Resident #5's Resident Register revealed he was admitted to the facility on 03/17/20. Review of Resident #5's physician order sheet dated 12/12/23 revealed there was an order for lisinopril 10mg, take one tablet every morning. Review of Resident #5's primary care provider's (PCP) visit note dated 07/16/24 revealed: -The resident's hypertension was currently managed with lisinopril 10mg. -There were no reported symptoms of chest pain, shortness of breath, difficulty breathing, headaches, dizziness, or palpitations (feelings of having a fast-beating, fluttering or pounding	D 273	Chart audit conducted by RCC to identify all parameters completed by 8/23/24. Will continue chart audits weekly by RCC. Inservice/training/education conducted on parameters and follow-up completed by RCC on 8/28/24. Medication Administration refresher course scheduled for all Med Tech's 9/3/24 by RN. Monthly staff meeting for continuing education will be held by RCC & ED.	8/28/24 9/3/24

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D 273	Continued From page 8 heart), however today his blood pressure reading was slightly elevated at 164/80. -Given his blood pressure reading today, the decision was made to adjust his medication regimen. -The dosage of lisinopril was increased to better manage the hypertension. -He was to be closely monitored for any potential side effects and to ensure blood pressure control. -Orders for the visit included, lisinopril 10mg was discontinued, lisinopril 20mg was ordered to take one tablet daily, and blood pressure was to be checked daily for seven days, with parameters to notify PCP of systolic blood pressure less than 90 or greater than 150. Review of Resident #5's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for lisinopril 10mg, take one tablet every morning, scheduled at 9:00am. -There was documentation lisinopril was administered at 9:00am 07/01/24 through 07/16/24. -There was an entry for lisinopril 20mg, take one tablet once per day, scheduled at 9:00am. -There was documentation lisinopril 20mg was administered at 9:00am 07/17/24 through 07/30/24. -There was an entry to check blood pressure once a day for 7 days and to notify the PCP if the systolic blood pressure was less than 90 or greater than 150. -There was documentation that Resident #5's blood pressure was checked daily at 9:00am on 07/17/24 through 07/23/24. -On 07/17/24, Resident #5's blood pressure was documented as 172/78. -There was no documentation that Resident #5's PCP had been contacted.	D 273		

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D 273	Continued From page 9 -On 07/18/24, Resident #5's blood pressure was documented as 152/78. -There was no documentation that Resident #5's PCP was notified. -One 07/20/24, Resident #5's blood pressure was documented as 168/63. -There was no documentation that Resident #5's PCP was notified. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable. Interview with a medication aide (MA) on 08/01/24 at 9:47am revealed: -If a resident had blood pressure readings outside of provider ordered parameters, the resident 's PCP was contacted, and the contact was documented in the eMAR system in the medication pass notes. -All PCP contact and contact attempts were documented in the medication pass notes. -She checked Resident #5's blood pressure on 07/17/24. -She was not sure why she did not contact Resident #5's PCP, she thought she must have been distracted or busy. -She should have contacted Resident #5's PCP and documented the call in the medication pass notes. Interview with a second MA on 08/01/24 at 11:13am revealed: -The MAs documented contact with the residents' PCP in the medication pass notes. -She checked Resident #5's blood pressure on 07/18/24. -She should have contacted Resident #5's PCP regarding Resident #5's blood pressure on 07/18/24 and documented in the medication pass	D 273		

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D 273	Continued From page 10 notes. -She could not remember why she did not contact Resident #5's PCP regarding his blood pressure being outside of the ordered parameters. Interview with the Resident Care Coordinator (RCC) on 08/01/24 at 11:30am revealed: -The MAs documented any contact with the residents' PCP in the medication pass notes in the eMAR system. -If a resident had orders for blood pressure checks with parameters, the MAs were responsible to contact the resident's PCP if the blood pressure was outside of the parameters. -She was not aware that Resident #5's PCP was not contacted on the 3 occasions that his blood pressure reading was outside of the provider ordered parameters. -The MAs were expected to read and follow all orders for the residents. -The MAs should have contacted Resident #5's PCP regarding his elevated blood pressure readings. Interview with the Executive Director on 08/01/24 at 11:58am revealed: -If a resident had provider ordered parameters for blood pressure checks, the MAs were expected to notify the PCP if the readings were outside of the ordered parameters. -All contact or contact attempts with the residents' PCP should have been documented in the medication pass notes in the eMAR system. -She was not aware that Resident #5's PCP was not contacted when he had blood pressure readings outside of the provider ordered parameters. -She expected the MAs to follow the provider's orders for the residents.	D 273		

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D 273	Continued From page 11 Telephone interview with Resident #5's PCP on 08/01/24 at 12:09pm revealed: -She prescribed lisinopril for Resident #5 for hypertension. -She increased Resident #5's lisinopril earlier this month from 10mg to 20mg daily to obtain better control of his blood pressure. -The risks of high blood pressure included stroke, kidney disease, and vision problems. -She wanted Resident #5's blood pressure monitored after the lisinopril dosage increase to make sure he tolerated the new dose, to make sure his blood pressure did not drop too low and to make sure his blood pressure was being controlled. -She had not been notified of the 3 occasions when Resident #5's blood pressure was outside of ordered parameters. -She expected the facility to notify her when a resident's blood pressure was outside of ordered parameters.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure physician orders for fall mat were implemented for 1 of 5 sampled residents (#1).	D 276		

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D 276	Continued From page 12 The findings are: Review of Resident #1's current FL-2 dated 07/19/24 revealed: -Diagnoses included type 2 diabetes, hyperlipidemia, dementia, macular degeneration, hypertension, cerebral infarction, atherosclerotic heart disease, chronic atrial fibrillation, and a cardiac pacemaker. -The resident was semi-ambulatory. Review of Resident #1's Resident Register revealed he was admitted to the facility on 08/17/23. Review of Resident #1's medical record revealed a signed physician's order dated 06/25/24 for a fall mat to be placed at the bedside. Review of Resident #1's primary care provider (PCP) progress note date 06/25/24 revealed: -The resident experienced a fall yesterday that resulted in leg pain. -The resident was sent to the emergency department (ED) for evaluation. -The knee x-rays showed no signs of fracture or dislocation, but there was fluid accumulation in the left knee joint. -The resident continued to have pain in the left knee and hips. -X-rays of the left knee and bilateral hips were ordered. -A fall mat was ordered to be placed on the floor at the resident's bedside. Observation of Resident#1's room on 07/31/24 at 2:47pm revealed: -Resident #1's room was on the 100 hall of the facility.	D 276	Floor mat was corrected immediately during survey. Chart audit completed to identify physician orders. Any findings found will be reported to PCP. Education with RCC in regards to interventions in place and completed by Executive Director 8/28/24 Inservice/education to all Med Tech and PCA's on interventions completed by RCC on 8/28/24. Monthly staff meeting for continuing education will be held by RCC & ED.	8/23/24 8/28/24 8/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051047	A. BUILDING: _____ B. WING	R 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW ASSISTED LIVING	250 HIGHWAY 210 WEST SMITHFIELD, NC 27577

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D 276	Continued From page 13 -There was a yellow band labeled "fall risk" taped to his bedside table. -The resident was sitting in his recliner. -There was no fall mat in Resident #1's room. Interview with Resident #1 on 07/31/24 at 2:47pm revealed: -He denied having any falls. -He did not know what a fall mat was and did not think he had one. Interview with Resident #1 on 08/01/24 at 10:31am revealed: -He used his recliner during the daytime hours. -He slept in his bed during the nighttime hours. Observation of Resident #1's room on 08/01/24 at 8:12am revealed: -Resident #1 was sitting in his recliner. -There was no fall mat in Resident #1's room. Interview with a personal care aide (PCA) on 07/31/24 at 2:58pm revealed: -She thought Resident #1 had a fall mat in the past maybe around early May 2024, but she was not sure. -She could not locate a fall mat in Resident #1's room. Interview with a medication aide (MA) for the 100 hall on 07/31/24 at 2:18pm revealed no residents in the facility had fall mats currently that she was aware of. Telephone interview with a representative with the facility's contracted pharmacy provider on 08/01/24 at 9:10am revealed they did not provide durable medical equipment (DME) for the residents	D 276	

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D 276	Continued From page 14 Telephone interview with a representative with the facility's contracted DME provider on 08/01/24 at 10:25am revealed no orders for a fall mat for Resident #1 had been received from the facility. Interview with the Resident Care Coordinator (RCC) on 08/01/24 at 8:56am revealed: -She or the Executive Director were responsible for processing the PCP's orders that included DME orders. -Fall mats were typically only ordered for residents that received hospice services. -She was not aware of an order for a fall mat from 06/25/24 for Resident #1. -She was not sure why she was not aware that a fall mat had been ordered for Resident #1. -After the PCP visited with the residents, she or the Executive Director faxed orders to the pharmacy and followed up on the orders daily until the medication or DME item were received. -Orders for a fall mat would have been sent to the DME provider. -She performed chart audits on 4-5 residents' record weekly. -The chart audits included review of two-step TB, licensed health professional support (LHPS) evaluations, pharmacy reviews and signed physicians order sheets to make sure they were signed every 6 months. -She did not review physicians' orders during the chart audits. -It was the RCC or the Executive Director's responsibility to ensure orders were complete and faxed. Interview with the Executive Director on 08/01/24 at 10:05am and 11:38am revealed: -The RCC or herself were responsible for processing the PCP's orders. -Resident #1's PCP orders for a fall mat should	D 276		

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D 276	Continued From page 15 have been faxed to the facility's DME provider by the RCC. -Resident #1's orders for a fall mat were never faxed to the DME provider. -She thought there was some question that Resident #1 slept in his recliner and that may have been why the fall mat was not ordered. -She expected all DME orders to be faxed to their DME provider and there should have been follow up when the items were not delivered. -Chart audits were preformed weekly on random residents. -During the chart audits, the PCP's orders were compared to the electronic medication administration record (eMAR) to make sure everything matched. -Resident #1's fall mat should have been ordered on 06/25/24. -The fall mat order for Resident #1 should have been caught during a chart audit. Interview with Resident #1's responsible party (RP) on 08/01/24 at 1:44pm revealed: -Resident #1 had a fall a few weeks ago, -Resident #1 would sometimes roll out of bed or try to get up without assistance. -He did not have a fall mat at his bedside. -She had considered purchasing a fall mat for Resident #1 but had not. Telephone interview with Resident #1's PCP on 08/01/24 at 12:09pm revealed: -A fall mat was ordered for Resident #1 after he had a fall and hit his left knee. -If Resident #1 rolled out of bed, the fall mat would help prevent injury. -She was not aware that Resident #1 did not have a fall mat in place. -She expected her orders to be carried out and initiated.	D 276		

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D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there was a matching therapeutic diet menu for 3 of 3 sampled residents (#1, #2, and #5) who had physician's orders for ground diets. The findings are: Observation of the kitchen on 07/30/24 at 9:05am revealed: -There were therapeutic diet menus being referenced for meal preparation. -Therapeutic diets on the diet list included regular/no added salt, mechanical soft, pureed and low concentrated sweets. -There was no ground diet on the therapeutic diet menu available. 1. Review of Resident #1s current FL-2 dated 07/19/24 revealed: -Diagnoses included type 2 diabetes, hyperlipidemia, dementia, heart disease, muscular degeneration, and gastroesophageal reflux.	D 296	Chart audit completed to review all diet orders completed on date of Survey. Repeat chart audit completed to review and update all orders. All diet orders to be reviewed and signed by physician. All new diet orders copied and given to dietary manager. All diet orders reviewed and updated every 6 months. RCC to monitor during chart reviews monthly.	8/23/24 8/28/24 8/28/24

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D 296	Continued From page 17 -There was an order for low concentrated sweets, no added salt and ground diet. Review of Resident #1's diet order sheet dated 03/19/24 revealed: -There was an order for low concentrated sweet and no added salt diet. -There was an order for a texture modified diet of ground which consisted of ground meat, no raw fruit of vegetables, bread was allowed. Observations during the initial kitchen tour on 07/30/24 at 9:00am revealed: -There was a folder in the kitchen with resident diet orders. -Resident #1 was listed as requiring a ground diet and regular liquids. Refer to interview with the Dietary Manager (DM) on 07/31/24 at 2:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/31/24 at 2:15pm. Refer to telephone interview with the facility's Regional Dietitian on 07/31/24 at 3:45pm. Refer to the interview with the Executive Director (ED) on 07/31/24 at 4:00pm. 2. Review of Resident #2's current FL-2 dated 09/28/23 revealed diagnoses included type 2 diabetes, coronary artery disease, chronic kidney disease, and heart failure. Review of Resident #2's diet order sheet dated 06/25/24 revealed a texture modified diet of ground which consisted of ground meat, no raw fruit of vegetables, bread was allowed.	D 296		

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D 296	Continued From page 18 Observations during the initial kitchen tour on 07/30/24 at 9:00am revealed: -There was a folder in the kitchen with resident diet orders. -Resident #1 was listed as requiring a ground diet. Refer to interview with the Dietary Manager (DM) on 07/31/24 at 2:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/31/24 at 2:15pm. Refer to telephone interview with the facility's Regional Dietitian on 07/31/24 at 3:45pm. Refer to the interview with the Executive Director (ED) on 07/31/24 at 4:00pm. 3. Review of Resident #5s current FL-2 dated 12/12/23 revealed diagnoses included type 2 diabetes, hyperlipidemia, bipolar disorder, moderate intellectual disabilities, and hypertension. Review of Resident #5's diet order sheet dated 03/19/24 revealed: -There was an order for a low concentrated sweet diet. -There was an order for a texture modified diet of ground meat which consisted of ground meat, no raw fruit of vegetables, bread was allowed. Observations during the initial kitchen tour on 07/30/24 at 9:00am revealed: -There was a folder in the kitchen with resident diet orders. -Resident #5 was listed as requiring a ground diet.	D 296		

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D 296	Continued From page 19 Refer to interview with the Dietary Manager (DM) on 07/31/24 at 2:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/31/24 at 3:30pm. Refer to telephone interview with the facility's Regional Dietitian on 07/31/24 at 3:45pm. Refer to the interview with the Executive Director (ED) on 07/31/24 at 4:00pm. _____ Interview with the Dietary Manager (DM) on 07/31/24 at 2:00pm revealed: -She used the mechanical soft menu to prepare the therapeutic diets for residents with ground diets. -The Regional Dietician created the diet menus for the facility. -She believed that ground diets and mechanical soft were the same. -There was no ground diet on the therapeutic menu. -She was responsible for ensuring residents received their therapeutic diet as ordered. Interview with the Resident Care Coordinator (RCC) on 07/31/24 at 3:30pm revealed: -The Regional Dietician is responsible for creating the therapeutic diet orders. -She expected the therapeutic diet menus to match the therapeutic diet orders. Telephone interview the facility's Regional Dietitian on 07/31/24 at 3:45pm revealed: -The facility offered ground and chopped diets to residents. -She expected the DM to use the mechanical soft	D 296		

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D 296	Continued From page 20 therapeutic menu to prepare ground and chopped diets. -As long as the meat was a safe consistency then it was correct. Interview with the Executive Director on 07/31/24 at 4:00pm revealed: -She expected the DM to get clarification for the diet menus from the Regional Dietician. -The Regional Dietician was responsible for ensuring the therapeutic menus were accurate.	D 296		
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 review the facility failed to ensure a therapeutic diet was served as ordered for 2 of 2 sampled residents (#1, and #5) with a diet order for thickened liquids. The findings are: 1. Review of Resident #1s current FL-2 dated 07/19/24 revealed: -Diagnoses included type 2 diabetes, hyperlipidemia, dementia, heart disease, muscular degeneration, and gastroesophageal reflux. -There was an order for low concentrated sweets, no added salt and chopped diet.	D 310	Chart audit completed to review all diet orders completed on date of Survey. Repeat chart audit completed to review and update all orders. All diet orders to be reviewed and signed by physician. All new diet orders copied and given to dietary manager. All diet orders reviewed and updated every 6 months. RCC to monitor during chart reviews monthly.	8/23/24 8/28/24 8/28/24

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D 310	Continued From page 21 Review of Resident #1's diet order sheet dated 03/19/20 revealed: -There was an order for low concentrated sweet and no added salt diet. -There was an order for a texture modified diet of ground meat. -There was an order for liquids were to be nectar thickened liquids. Observations during the initial kitchen tour on 07/30/24 at 9:00am revealed: -There was a folder in the kitchen with resident diet orders. -Resident #1 was listed as requiring a ground diet and regular liquids. Observation of breakfast service for Resident #1 on 07/31/24 at 7:30am revealed: -Eggs and cheese, bacon/sausage, hashbrowns, and raisin toast were on the menu. -His plate consisted of raisin bread, oatmeal, hashbrowns, and ground sausage. -He was served orange juice, water with ice and a carton of milk, all regular consistency liquids. Observation of lunch service for Resident #1 on 07/31/24 at 12:30pm revealed: -Stuffed shells, Italian vegetable blend, breadsticks, and ice cream were on the menu. -His plate consisted of stuffed shells, Italian vegetable blend, and a breadstick cut in half. -He was served tea with ice, water with ice and a carton of milk, all regular consistency liquids. Refer to interview with a dietary aide (DA) on 07/31/24 at 12:00pm Refer to interview with the Dietary Manager (DM) on 07/31/24 at 2:00pm.	D 310		

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D 310	Continued From page 22 Refer to interview with the Resident Care Coordinator (RCC) on 07/31/24 at 2:15pm. Refer to the interview with the Executive Director (ED) on 07/31/24 at 2:30pm. Refer to telephone interview with Resident #1's primary care provider (PCP) on 08/01/24 at 12:10pm. 2. Review of Resident #5s current FL-2 dated 12/12/23 revealed: -Diagnoses included type 2 diabetes, hyperlipidemia, bipolar disorder, moderate intellectual disabilities, and hypertension. -There was no information about diet documented. Review of Resident #5's diet order sheet dated 03/19/24 revealed: -There was an order for a low concentrated sweet diet. -There was an order for a texture modified diet of ground meat. -There was an order for regular liquids. Observations during the initial kitchen tour on 07/30/24 at 9:00am revealed: -There was a folder in the kitchen with resident diet orders. -Resident #5 was listed as requiring a ground diet and regular liquids. Observation of breakfast service for Resident #5 on 07/31/24 at 7:30am revealed: -Eggs and cheese, bacon/sausage, hashbrowns, and raisin toast were on the menu. -His plate consisted of raisin bread, oatmeal, hashbrowns, and ground sausage. -He was served nectar thick orange juice, nectar	D 310		

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D 310	Continued From page 23 thick water, and a carton of regular milk. Observation of lunch service for Resident #5 on 07/31/24 at 12:30pm revealed: -Stuffed shells, Italian vegetable blend, breadsticks, and ice cream were on the menu. -His plate consisted of stuffed shells, Italian vegetable blend, and a breadstick cut in half. -He was served nectar thick tea, nectar thick water and a carton of regular milk. Refer to interview with a dietary aide (DA) on 07/31/24 at 12:00pm Refer to interview with the Dietary Manager (DM) on 07/31/24 at 2:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/31/24 at 2:15pm. Refer to the interview with the Executive Director (ED) on 07/31/24 at 2:30pm. Refer to telephone interview with Resident #1's primary care provider (PCP) on 08/01/24 at 12:10pm. Interview with a dietary aid on 07/31/24 at 12:00pm revealed: -Dietary aides were supposed to know the resident's diets. -The resident's diet orders are in a folder in the kitchen. -He knew that Resident #5 was given nectar thick liquids. -He knew that Resident #1 was given regular liquids. Interview with the Dietary Manager on 07/31/24 at	D 310		

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D 310	Continued From page 24 2:00pm revealed: -The resident's diet orders were in a folder in the kitchen. -Resident #1 had a diet order for ground meat, low concentrated sweets, and no added salt. -Resident #1 had been getting regular liquids for at least a year. -Resident #1 should have been getting nectar thickened liquids. -Resident #5 had a diet order for ground meat, and low concentrated sweets. -Resident #5 had been getting nectar thickened liquid for at least a year. -Resident #5 should have been getting regular fluids. -The Resident Care Coordinator was responsible for giving updated diet orders to the Dietary Manager. -She was responsible for ensuring the residents got their therapeutic diet as ordered. Interview with the Resident Care Coordinator (RCC) on 07/31/24 at 2:15pm revealed: -Resident #1 was getting a ground diet and regular liquids. -Resident #1 should have been getting nectar thickened liquids. -Resident #5 was getting a ground diet and thickened liquids diet. -Resident #5 should have been getting regular liquids. -She was responsible for giving dietary orders to the Dietary Manager. -She expected the Dietary Manager to serve therapeutic diets as ordered by the primary care provider (PCP). -She was concerned that Resident #1 could choke if he was not given the proper liquid consistency.	D 310		

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D 310	Continued From page 25 Interview with the Executive Director on 07/31/24 at 2:40pm revealed: -The RCC was responsible for getting updated diet orders to the Dietary Manager. -She expected the Dietary Manager to serve residents therapeutic diets as ordered. -She was concerned that Resident #1 could choke if he was not given the proper liquid consistency. Telephone interview with the primary care provider (PCP) on 08/01/24 at 12:10pm revealed: -The original nectar thickened liquids order for Resident #1 was ordered by the previous care provider. -She was not sure why the nectar thickened liquids order was put into place for Resident #1. -She continued the nectar thickened liquids order when she began providing care to the resident. -She had no concerns about Resident #1 receiving regular liquids since he had not had any problems over the past year. -She had no concern with Resident #5 receiving nectar thickened liquids instead of regular.	D 310		
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:	D 358	Chart audit to identify all parameters completed. Inservice/training/education conducted on parameters and follow-up completed by RCC. Staff to go through Medication Administration refresher course on 9/3/24. Education will be by RN.	8/23/24 8/28/24 9/3/24

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	HAL051047	A. BUILDING: _____ B. WING _____	R 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW ASSISTED LIVING	250 HIGHWAY 210 WEST SMITHFIELD, NC 27577

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D 358	Continued From page 26 Based on observations, record reviews, and interviews, the facility failed to ensure medication was administered as ordered for 1 of 5 residents sampled with sliding scale insulin orders (#1) for insulin dependent diabetes mellitus. The findings are: Review of the provided facility's medication administration policy 02/20/18 revealed: -Under Medication Administration, 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 the orders by a licensed prescribing practitioner which are maintained in the resident's record and the facility's policies and procedures. -The facility shall ensure that medications are administered to the residents within one hour before or one after the prescribed or scheduled time unless precluded by emergency situations. -The resident's medication administration record (MAR) shall be accurate and include the following information. -The resident's name. -The name of the medication and or treatment order. -The strength and dosage or quantity of the medication administered. -The reason or justification for the administration of medications or treatments as needed and documentation of the resulting effect on the resident. -The date and time of administration. -Documentation of any omission of medications or treatments and the reason for omission, including refusals. -The name or initials of the person administering the medication or treatment, if initials are used, a	D 358		

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D 358	Continued From page 27 signature equivalent to those initials is to be documented and maintained with the MAR. Review of Resident #1's current FL-2 dated 07/19/24 revealed diagnoses included type 2 diabetes, hyperlipidemia, dementia, macular degeneration, hypertension, cerebral infarction, atherosclerotic heart disease, chronic atrial fibrillation, and cardiac pacemaker. Review of Resident#1's Resident Register revealed he was admitted to the facility on 08/17/23. Review of Resident #1's primary care provider's (PCP) progress note dated 05/13/24 revealed; -Under interval history, there was a triage note dated 04/11/24 that humalog 100units/ml was sent on 04/11/24 to inject four times per day per sliding scale, if blood sugar is 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, if blood sugar is greater than 400, call the PCP, give within 15 minutes of food. Review of Resident #1's signed physician order sheet dated 07/19/24 revealed there was an order for humalog 100unit/ml kwikpen (a short-acting insulin used to treat high blood sugars) inject four times daily per sliding scale: 151-200=1 unit, 201-251=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, if greater than 400, call the primary care provider (PCP), give within 15 minutes of food. Review of Resident #1's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for humalog 100unit/ml kwikpen (a short-acting insulin used to treat high	D 358		

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D 358	Continued From page 28 blood sugars) inject four times daily per sliding scale: 151-200=1 unit, 201-251=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, if greater than 400, call the primary care provider (PCP), give within 15 minutes of food, scheduled at 7:15am, 11:45am, 5:15pm and 8:00pm. -There was a space provided to document the resident's finger stick blood sugar (FSBS), the amount of insulin units administered, the injection site location and the administering medication aide's (MA) initials. -At 8:00pm on 05/25/24, there was no documentation of the resident's FSBS, the number of insulin units administered, the injection location site and the administering MA's initials. Review of Resident #1's July 2024 eMAR revealed: -There was an entry for humalog 100unit/ml kwikpen (a short-acting insulin used to treat high blood sugars) inject four times daily per sliding scale: 151-200=1 unit, 201-251=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, if greater than 400, call the primary care provider (PCP), give within 15 minutes of food, scheduled at 7:15am, 11:45am, 5:15pm and 8:00pm. -There was a space provided to document the resident's finger stick blood sugar (FSBS), the amount of insulin units administered, the injection site location and the administering medication aide's (MA) initials. -At 5:15pm on 07/27/24, there was no documentation of the resident's FSBS, the number of insulin units administered, the injection location site and the administering MA's initials. Interview with a MA on 08/01/24 at 9:47am revealed:	D 358		

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D 358	Continued From page 29 -If a resident did not receive a treatment or medication, the MA documented a reason why. -There should never be blanks on the residents' eMAR. Interview with a second MA on 08/01/24 at 10:44am revealed: -There should never be blanks or gaps on the residents' eMAR. -If a medication or treatment was not administered, there should always be a reason documented. -The eMAR system allowed the MAs to document situations such as resident refusals, residents being out of the facility or order changes. -He was not sure why there was no documentation of Resident #1's FSBS and sliding scale insulin on one occasion in May 2024 and on one occasion in July 2024. Interview with the Resident Care Coordinator (RCC) on 08/01/24 at 11:30am: -If a resident did not receive an ordered treatment or medication, the MAs documented a reason why on the eMAR system. -She was not aware there was no documentation of FSBSs and sliding scale insulin administration for Resident #1 on one occasion in May 2024 and on one occasion in July 2024. -It was possible the MA had to deal with an emergency and forgot to document Resident #1's FSBS and sliding scale insulin. -There should never be gaps or blanks on the residents' eMAR. -She tried to pull the residents' eMARs at least monthly if not once a week to review for completeness, but she did not have a set schedule for this. -She had gotten behind and could not remember when she was last reviewed the eMARs for the	D 358		

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D 358	Continued From page 30 residents. Interview with the Executive Director (ED) on 08/01/24 at 11:38am revealed: -There should never be blanks or omissions on the residents' eMAR. -The MAs were to always document a reason for a treatment or medication being missed. -She expected provider orders to be administered and completed as ordered and documented. -She found out today from the facility's Regional Director, the facility's contracted pharmacy sent an "alert" email if there was a missed or late medication. -The "alert" email was sent to the Regional Director's email address and the previous ED's email address, but not to the current ED's email address. -She had corrected her email address with the facility's contracted pharmacy so moving forward she would receive the "alert" emails regarding missed or late medications and treatments for the residents. Telephone interview with Resident #1's PCP on 08/01/24 at 12:09pm revealed: -Resident #1 was on sliding scale insulin for elevated blood sugar. -Elevated blood sugar could cause diabetic ketoacidosis (a complication of diabetes in which acids build in the blood to levels which can be life-threatening), kidney problems, vision problems, poor wound healing and stroke. -It was important for Resident #1's FSBS to be checked especially at 8:00pm after a meal and snacks. -If the resident had a high carbohydrate meal or sweets for snacks, he may need insulin coverage for elevated blood sugars. -She expected Resident #1's FSBS to be	D 358		

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D 358	Continued From page 31 checked and documented four times per day as ordered, and the appropriate amount of insulin administered and documented.	D 358		