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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-u p survey on 07/05/23 through 07/06/23.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to serve therapeutic diets as ordered for 2 of 5 sampled residents (#2 and #6) who had orders for a pureed diet (#2) and a mechanical soft (MS) diet (#6). The findings are: 1. Review of Resident #2's current FL2 dated 11/08/22 revealed: -Diagnoses included dementia without behavioral disturbance, abnormalities of gait and mobility, hypertensive chronic kidney disease. -There was an order for a mechanical soft diet. Review of Resident #2's diet orders dated 06/27/23 revealed an order for a pureed diet Review of a signed physician's order for Resident #8 dated 11/03/22 revealed there was an order to change the diet to pureed; resident may have regular diet snacks. Review of the facility's therapeutic diet list posted in the kitchen updated 07/05/23 revealed	D 310		

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D 310	Continued From page 1 Resident #2 was to be served a pureed diet. Review of the therapeutic menu spreadsheet for pureed diets for the lunch meal service on 07/05/23 revealed pureed fried chicken, mashed potatoes with gravy, pureed sliced carrots, pureed bread, and pureed fruit cobbler was to be served. Observation of Resident #2's lunch meal service on 07/05/23 between 12:26pm revealed: -Resident #2 was served pureed green beans, pureed sweet potatoes, ground chicken, and applesauce. -Resident #2 consumed 50% of the meal without any difficulties. Interview with the cook on 07/05/23 at 12:09pm revealed: -Resident #2 was served a pureed diet. -She pureed Resident #2's food by placing the food in a blender and adding a little water. -She usually pureed the whole meal, but she was in a rush trying to get Resident #2's food out and did not realize she did not puree his chicken. -She would puree Resident #2's chicken for him. Review of the therapeutic menu spreadsheet for pureed diets for the breakfast meal service on 07/06/23 revealed Resident #2 was to be served pureed hot cereal, pureed sausage patty, and pureed bread. Review of a different therapeutic menu spreadsheet for pureed diets (for reference) for the breakfast meal on 07/09/23 revealed: -The breakfast meal service for regular diets included bacon. -Bacon was not to be served to residents who were to be served pureed diets.	D 310		

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D 310	Continued From page 2 Observation of Resident #2's breakfast meal service on 07/06/23 at 8:00am revealed: -Resident #2 was served a bowl of regular hot oatmeal and the oats were whole, pureed bacon, and pureed bread. -Resident #2 consumed 25% of the meal without any difficulties. Interview with the cook on 07/05/23 at 8:01am revealed: -She served Resident #2 bacon, toast, and oatmeal. -She pureed the bacon and toast, but she did not puree the oatmeal. -She received training in food service from the previous cook. -She did not know about the therapeutic menu spreadsheets for pureed diets. -She used the regular menus to prepare meals for residents who had orders for pureed diets and just pureed the meals. -She did not know Residents #2's oatmeal should have been pureed or that he should not have been served bacon. -She would prepare Resident #2 a substitution for the bacon and puree his oatmeal. Interview with a personal care aide (PCA) on 07/06/23 at 9:11am revealed: -There was a therapeutic diet list in the kitchen that listed each resident and the diets they were to be served. -Resident #2 was listed to be served a pureed diet. -She looked at the meals before she served them to residents to make sure they were correct. -She noticed the pureed meals sometimes had clumps in it, but she did not take it back to the kitchen because she figured the cook prepared it correctly.	D 310		

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D 310	Continued From page 3 Interview with Resident #2 on 07/06/23 at 9:16am revealed: -He was served pureed food because he had trouble swallowing. -He ate some of the oatmeal, but he did not eat the other food items that were served to him for the breakfast meal on 07/06/23. -The food items served to him were pureed, but sometimes they were clumpy. -Sometimes he coughed when he ate his meals. Interview with Resident #2's primary care provider (PCP) on 07/06/23 at 10:29am revealed: -Resident #2 had a recent hospitalization and returned to the facility with recommendations for a pureed diet. -Resident #2 also did not have teeth. -Resident #2's current diet order was for a pureed diet. -He expected the facility to serve Resident #2 meals according to the pureed diet menu. -Resident #2 could aspirate and end up in the hospital if he was not served meals according to the pureed diet menu. Refer to the interview with the Administrator on 07/06/23 at 11:36am. 2. Review of Resident #6's current FL2 dated 10/18/22 revealed: -Diagnoses included vascular dementia, hypertension, hypothyroidism, and hyperlipidemia. -There was an order for a mechanical soft (MS) diet. Review of Resident 6's diet orders dated 04/06/23 revealed an order for a MS diet.	D 310		

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Review of the facility's therapeutic diet list posted in the kitchen updated 07/05/23 revealed Resident #6 was to be served a MS diet.

Review of the therapeutic menu spreadsheet for pureed diets for the breakfast meal service on 07/06/23 revealed Resident #6 was to be served cold or hot cereal, ground sausage patty, and toast were to be served.

Review of a different therapeutic menu spreadsheet for pureed diets (for reference) for the breakfast meal on 07/09/23 revealed:
-The breakfast meal service for regular diets included bacon.
-Bacon was not to be served to residents who were to be served MS diets.

Observation of Resident #6's breakfast meal service on 07/06/23 at 8:00am revealed:
-Resident #6 was served a bowl of cold cereal ground bacon, and toast.
-Resident #6 consumed 90% of the meal without any difficulties.

Interview with the cook on 07/05/23 at 8:01am revealed:
-She served Resident #6 ground bacon, toast, and oatmeal because he had orders for a MS diet.
-She received training in food service from the previous cook.
-She did not know about the therapeutic menu spreadsheets for pureed diets.
-She used the regular menus to prepare meals for residents who had orders for MS diets and just ground the meats.
-She did not know Resident #6's should not have been served bacon.
-She would prepare Resident #6 a substitution for

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D 310	Continued From page 5 the bacon. Interview with Resident #6's primary care provider (PCP) on 07/06/23 at 10:29am revealed: -Resident #6 had an order for a MS diet because he had swallowing problems. -He expected the facility to serve Resident #6 meals according to the MS diet menu. -Resident #6 could aspirate and end up in the hospital if he was not served meals according to the MS diet menu. Based on observations, record reviews, and interviews, it was determined Resident #6 was not interviewable. Refer to the interview with the Administrator on 07/06/23 at 11:36am. _____ Interview with the Administrator on 07/06/23 at 11:36am revealed: -The cook started working in the kitchen about a month and a half ago. -She was trained by another dietary staff. -She thought the cook was following the menus for therapeutic diets. -She did not know residents were not being served according to their therapeutic diets, and she did not know the cook did not know where the therapeutic diet spreadsheets were located.	D 310		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name;	D 367		

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D 367	Continued From page 6 (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews, observations and record reviews, the facility failed to ensure electronic medication administration records (eMAR) were accurate for 1 of 5 residents (Resident #2) related to documenting the resident's weights ordered weekly. The findings are: Review of Resident #2's current FL2 dated 11/08/22 revealed diagnoses included unspecified dementia without behavioral disturbances and stage 3 chronic kidney disease. Review of Resident #2's physician's orders dated 04/06/23, 06/27/23, and 06/29/23 revealed orders to check blood pressure weekly. Review of Resident #2's May 2023 electronic medication administration record (eMAR)	D 367		

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revealed:
-There was an entry for check blood pressure once weekly.
-There was documentation, with the initials of the medication aide (MA), indicating the resident's blood pressure was taken on 05/01/23, 05/08/23, 05/15/23, 05/22/23 and 05/29/23.
-There was no blood pressure documented on the May 2023 eMAR.

Review of Resident #2's June 2023 eMAR revealed:
-There was an entry for check blood pressure once weekly.
-There was documentation, with the initials of the MA, that the resident's blood pressure was taken on 06/05/23, 06/12/23, and in the hospital on 06/19/23, and 06/26/23.
-There were no blood pressures documented on the June 2023 eMAR.

Review of Resident #2's July 2023 eMAR from 07/01/23 to 07/05/23 revealed:
-There was an entry for check blood pressure once weekly.
-There was documentation, with the initials of the MA, that the resident's blood pressure was taken on 07/04/23.
-There was no blood pressure documented on the July 2023 eMAR.

Review of Resident #2's charting notes for May 2023, June 2023, and July 2023 revealed there were no blood pressures documented in the charting notes.

Review of Resident #2's blood pressure values recorded in the residents' monthly vitals book revealed:
-On 05/23/23, Resident #2's blood pressure was

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127/68.
-On 06/27/23, Resident #2's blood pressure was 120/70.

Review of Resident #2's hospital discharge summary dated 06/19/23 revealed a blood pressure value of 152/74 was documented.

Interview with the Administrator on 07/05/23 at 3:15pm revealed:
-Resident #2's blood pressure value should be documented on the eMAR.
-The eMAR was not displaying an area to document the weekly blood pressure.
-The MAs were supposed to add information, like the blood pressure in the charting notes if there was nowhere else on the eMAR to document information.
-There was a vital signs book for recording residents' routine monthly weights and blood pressure.
-There were no weekly blood pressures for Resident #2 recorded in the vital signs book.

Interview with the Memory Care Unit Coordinator (MCUC) 07/05/23 at 4:15pm revealed:
-She occasionally administered medications to residents and obtained blood pressures for residents including Resident #2.
-Resident #2's check blood pressure weekly order appeared on the eMAR screen every Monday.
-MAs, including herself, initialed the eMAR for the treatment prompt to leave the eMAR screen.
-The eMAR did not prompt for recording of the blood pressure.
-The pharmacy staff entered all orders for medications and treatments into the eMAR system.
-The pharmacy staff did not enter Resident #2's

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order for weekly blood pressure checks in a manner that prompted a place to record the blood pressure.
-The MAs should have entered Resident #2's blood pressure in the charting notes if there was no other place to enter the blood pressure.
-She had taken Resident #2's blood pressure 2 times in May when she was staffing the medication cart.
-She took the blood pressure and initialed for completing the treatment.
-She should have recorded the blood pressure in the charting notes, but there was no blood pressure information for review in the charting notes on the corresponding dates.
-She randomly audited residents' records for blank documentation on the eMAR, but she did not audit for Resident #2's missing weekly blood pressures.

Interview with a morning MA on 07/06/23 at 8:00am revealed:
-She had taken Resident #2's weekly blood pressure in the past.
-She initialed on the eMAR that she had completed the blood pressure.
-She did not documented the blood pressure on the eMAR, because no prompt for a blood pressure reading appeared on the eMAR.

Telephone interview with a pharmacist at the contracted pharmacy on 07/06/23 at 9:20am revealed:
-The pharmacy staff routinely entered orders for medications and treatment into the facility's eMAR system.
-There routinely was a prompt to document a blood pressure when the treatment order appeared.
-Resident #2's order for weekly blood pressure

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checks was entered into the eMAR system in such a manner that it would prompt for a value prior to documenting completion of the treatment.
-Medication orders routinely were "held" awaiting review, and approval by a facility staff (released) prior to appearing on the eMAR for administration.
-Orders for treatments were entered into the eMAR system by the pharmacy staff, but did not require a facility staff to "release" prior to appearing on the eMAR.
-The facility was responsible to review all orders entered by the pharmacy for accuracy and completeness.
-The facility could document information in the charting notes and/or call the pharmacy staff for assistance to customize or correct eMARs.

Telephone interview with Resident #2's primary care provider (PCP) on 07/06/23 at 10:00am revealed:
-He wanted Resident #2's weekly blood pressure checked to monitor the results.
-Resident #2 was in the hospital for urinary tract infection in June 2023 and he wanted to monitor vital signs for a little time to make sure the resident was doing well.
-He had seen some blood pressures documented on hospital discharge information and was not concerned Resident #2 may have extremely high blood pressure.
-In general, the facility staff called him for blood pressure readings for any resident if higher than their normal baseline.

Resident #2's blood pressure was checked by a MA on 07/06/23 at 10:35am with a value of 136/79 recorded on the blood pressure device.

Based on observations, interviews, and record

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D 367	Continued From page 11 reviews, it was determined Resident #2 was not interviewable.	D 367		