

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL043024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2021
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NAME OF PROVIDER OR SUPPLIER SENDER'S REST HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 40 RAWLS CLUB ROAD FUQUAY VARINA, NC 27526
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and a complaint investigation on August 11 - 12, 2021.	D 000		
D 310	<p>10A NCAC 13F .0904(e)(4) Nutrition and Food Service</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interview, the facility failed to ensure therapeutic diets were served as ordered for 1 of 2 sampled residents who had an order for a pureed diet with nectar thickened liquids (#5).</p> <p>The findings are:</p> <p>Review of Resident #5's current FL2 dated 10/14/20 revealed: -Diagnoses included Alzheimer's Disease, generalized weakness and a cardioembolic stroke. -The diet order section was blank.</p> <p>Review of Physician's Order form dated 08/04/21 revealed an order for a pureed diet with nectar thickened liquids.</p> <p>Review of the week at a glance menu posted in</p>	D 310		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 310	<p>Continued From page 1</p> <p>the kitchen revealed the lunch meal service for 08/11/21 was beef pot roast, rice orzo pilaf, garlic green beans, buttery carrots, fresh biscuit, beverage of choice and strawberry ice cream.</p> <p>Review of the facility's recipe book revealed: -Instructions on how to modify regular texture foods to the correct modified diet consistency. -There were no instructions on how to modify the consistency of ice cream.</p> <p>Review of the diet order report in the kitchen revealed Resident #5 was to be served a pureed diet with nectar thick liquids.</p> <p>Observation of the lunch meal service on 08/11/21 at 12:00pm revealed: -Resident #5 was served pureed pot roast, mashed potatoes, pureed green beans and pureed cauliflower. -A single serving of container of commercially made chocolate ice cream was placed next to his plate of food. -He had three beverages in front of him which included: thin water with ice, thin iced tea and a pre-thickened nutritional supplement. -A personal care aide (PCA) was preparing to assist feed Resident #5 with his meal.</p> <p>Observation of the lunch meal service on 08/11/21 from 12:10pm- 12:45pm revealed: -Resident #5 had eaten all of the pureed foods on his plate. -He was offered sips of the pre-thickened nutritional supplement. -He was not offered any of the thin liquid beverages that were in front of him. -The PCA took the lid off of the container of chocolate ice cream and brought a spoonful of ice cream to Resident #5's lips.</p>	D 310		

Division of Health Service Regulation

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D 310	<p>Continued From page 2</p> <p>Interview with the PCA on 08/11/21 at 12:45pm revealed: -She knew Resident #5 was on a pureed diet with nectar thick liquids. -She thought ice cream was considered a nectar thick liquid. -She did not remember if she received training related to identifying thickened liquids. -A medication aide (MA) and the Dietary Manager (DM) told her ice cream was considered a thickened liquid.</p> <p>Interview with the dietary aide (DA) on 08/11/21 at 12:45pm revealed: -She was responsible for pouring the beverages and bringing residents' food out to their table. -She knew that Resident #5 required thickened liquids but forgot to thicken his water and iced tea. -The facility did not have any pre-thickened beverages on hand. -She thought ice cream was allowed when residents required thickened liquids. -She learned about thickened liquids when she was hired.</p> <p>Interview with the DM on 08/11/21 at 12:50pm revealed: -She had been working in the kitchen for the last year and was promoted to DM three months ago. -She was trained by a DM that worked at an alternate location. -She thought ice cream was a thick liquid.</p> <p>Telephone interview with the Hospice Registered Nurse (RN) on 08/12/21 at 11:02am revealed: -The facility notified her that Resident #5 was choking on meals so his diet was changed to puree with nectar thick liquid on 08/04/21</p>	D 310		

Division of Health Service Regulation

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D 310	<p>Continued From page 3</p> <p>-She discussed the risk of aspiration pneumonia due to difficulty swallowing with the Resident Care Coordinator (RCC) during her visit on 08/04/21.</p> <p>-Hospice expected the facility or family to provide nectar thick liquids to Resident #5.</p> <p>-If Resident #5 consumed consistencies that were not nectar thick then he could aspirate and develop aspiration pneumonia which would need to be treated with antibiotics.</p> <p>Interview with the Regional Executive Director on 08/11/21 at 1:00pm revealed ice cream should not be given to a resident who required thickened liquids and staff should have looked up an appropriate dessert substitution in the substitution book.</p> <p>Based on record review it was determined that Resident #5 was not interviewable.</p>	D 310		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>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:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 2 residents observed during the medication pass received their medications as ordered by the primary care physician (PCP) including a</p>	D 358		

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D 358	<p>Continued From page 4</p> <p>medication used to treat high blood pressure (#6).</p> <p>The findings are:</p> <p>The medication error rate was 4% as evidenced by the observation of 1 error out of 25 opportunities during the 7:00am medication pass on 08/12/21.</p> <p>Review of Resident #6's current FL2 dated 03/10/21 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included Alzheimer's disease, altered mental status, convulsions, kidney failure, hypertension, type 2 diabetes and intellectual disabilities. -There was an order for Hydralazine (a medication used to treat high blood pressure) 100mg three times a day. -There was no order to check blood pressures. <p>Observation of the morning medication pass on 08/12/21 at 7:10am revealed:</p> <ul style="list-style-type: none"> -The medication aide (MA) prepared 10 oral medications for Resident #6. -The Hydralazine in the multidose pack did not match the electronic Medication Administration Record (eMAR) for the Hydralazine. <p>Interview with the MA on 08/12/21 at 7:15am revealed:</p> <ul style="list-style-type: none"> -She did not know the multidose pack contained Hydralazine 50mg instead of the Hydralazine 100mg as indicated on the eMAR. -She administered Hydralazine 50mg seven times during August 2021. -Resident #6 received Hydralazine 50mg three or four times a day since March 2021 because the order changed several times. -The light in the hallway was dim and the writing on the multidose pack was very small and difficult 	D 358		

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D 358	<p>Continued From page 5</p> <p>to read.</p> <p>-She notified the Resident Care Director (RCC) for clarification of the order.</p> <p>Observation of medications on hand for administration for Resident #6 on 08/12/21 revealed:</p> <p>-There was a multidose pack to start on 08/06/21 to 08/12/21 containing Hydralazine 50mg three times a day.</p> <p>-There were 3 of 21 doses of Hydralazine 50mg remaining.</p> <p>Review of Resident #6's hospital records dated 07/14/21 revealed:</p> <p>-He presented to the hospital with vomiting for 2 days.</p> <p>-There was an admission diagnoses included acute kidney injury and dehydration.</p> <p>-The vital signs at admission were as follows; blood pressure 142/81 and heart rate of 91.</p> <p>-His blood pressure fluctuated throughout admission from 142/81 to 147/106 down to 127/81.</p> <p>Review of Resident #6's hospital discharge instructions dated 07/16/21 revealed there was an order for Hydralazine 100mg three times a day.</p> <p>Review of Resident #6's July 2021 eMAR revealed there was an entry for Hydralazine 100mg documented as administered three times a day, 07/01/21 to 07/31/21 at 8:00am, 2:00pm and 8:00pm.</p> <p>Review of Resident #6's August 2021 eMAR revealed there was an entry for Hydralazine 100mg documented as administered three times a day, 08/01/21 to 08/11/21 at 8:00am, 2:00pm</p>	D 358		

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D 358	<p>Continued From page 6</p> <p>and 8:00pm.</p> <p>Review of the facility clarification of orders 07/16/21 for Resident #6 revealed:</p> <ul style="list-style-type: none"> -The clarification was needed because Resident #6 returned from the hospital with new orders and needed reviewed. -There was an order transcribed as Hydralazine 100mg three times a day. -Resident #6's physician continued the Hydralazine 100mg three times a day as transcribed. -The physician signed the clarification orders on 07/21/21. <p>Review of the facility medication cart audit schedule revealed Resident #6 was to have his medications on hand and eMAR checked for accuracy on first shift every Friday.</p> <p>Review of Resident #6's July 2021 medication cart audits revealed there was 1 out of 5 audits completed.</p> <p>Review of Resident #6's August 2021 medication car audits revealed there was 0 out of 1 audit completed.</p> <p>Review of Resident #6 medication cart audit dated 07/09/21 revealed a MA completed the audit and the medications ordered by the physician were on the medication cart.</p> <p>Review of Resident #6's FL2, hospital discharge orders, medication car audits, medications on hand, eMARs for July 2021 and August 2021, Resident #6 did not receive Hydralazine 100mg three times a day as ordered for 127 out of 127 doses.</p>	D 358		

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D 358	<p>Continued From page 7</p> <p>Telephone interview with Resident #6's contracted pharmacy on 08/12/21 at 9:50am revealed:</p> <ul style="list-style-type: none"> -There was a signed physician's order for Hydralazine 50mg three times a day dated 06/02/21. -The was no order in their records for Hydralazine 100mg three times a day dated 07/16/21. -The facility staff could enter a medication on the eMAR and we would print what was in the system but only send the medications according to the orders on hand. -Hydralazine 50mg three times a day was dispensed to the facility, with a quantity of 21 doses on, 06/04/21, 06/11/21, 06/18/21, 06/25/21, 07/02/21, 07/09/21, 07/16/21, 07/23/21, 07/31/21, and 08/06/21. -The facility was responsible for faxing over the hospital discharge orders dated 07/16/21 and or the physician's clarification orders dated 07/21/21. <p>A second interview with the MA on 08/12/21 at 10:26am revealed:</p> <ul style="list-style-type: none"> -On 07/16/21, when Resident #6 arrived at the facility after discharge from the hospital, the MA on duty was to fax all orders to the pharmacy and notify the RCC. -The pharmacy would enter the medications in the eMAR and the RCC would approve the medications prior to the MAs administering the medications to the residents. -Medication cart audit was to be completed each shift, every day by the MA, for the residents per the medication cart audit schedule located in the nurse's station. -During the audits, the MAs were responsible for checking the medications on hand with the eMARs and physician orders for accuracy. -If there were any concerns, the MAs were to 	D 358		

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D 358	<p>Continued From page 8</p> <p>report them to the RCC.</p> <p>-She could not remember the last time she performed a medication cart audit but she did not complete them as scheduled because she was busy with other duties.</p> <p>Interview with the RCC on 08/12/21 at 10:41am revealed:</p> <p>-The MAs were responsible for completion of the medication cart audits on each resident on a weekly basis per the audit schedule.</p> <p>-The MAs were responsible for comparing the medications on hand with the eMAR and physician's orders and report any concerns to her.</p> <p>-She did not receive notification there was a problem with Resident #6's Hydralazine.</p> <p>-She was responsible for ensuring the medication cart audits were completed on a monthly basis.</p> <p>-She did not complete the medication cart audits on a monthly basis because she was only in the facility 2 days a week and those days she was with the physician and completing orders from the physician.</p> <p>-She did not know Resident #6 was not getting his Hydralazine as ordered.</p> <p>-She expected the MAs to complete the medication cart audits as scheduled.</p> <p>Interview with the Administrator on 08/12/21 at 12:06pm revealed:</p> <p>-It was their policy for the MAs to fax the hospital discharge orders to the pharmacy and inform the RCC of the new orders.</p> <p>-She did not know Resident #6's Hydralazine order was not administered as ordered.</p> <p>-The MAs were responsible for medication cart audits but not sure how often.</p> <p>-The medication cart audits were to check the medications on hand against the eMAR and</p>	D 358		

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D 358	<p>Continued From page 9</p> <p>physician's orders for accuracy and let the RCC know if there were any issues.</p> <p>-She did not know the medication cart audits were not completed as scheduled.</p> <p>-She expected the medications be administered as ordered.</p> <p>Based on record review it was determined that Resident #6 was not interviewable.</p> <p>Attempted telephone interview with Resident #6's primary care physician on 08/12/21 at 12:20pm, 2:10pm and 3:40pm was unsuccessful.</p>	D 358		