STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(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 a follow-up survey and complaint investigation on September 7 through September 9, 2016.	{D 000}		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to have foods that are appropriate to residents' diets offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menus as snacks. The findings are: Observation at 11:30am on 09/07/2016 of the regular and therapeutic spreadsheet menus in the facility kitchen revealed: -The facility offered the following diets: Regular/No Added Salt, Regular Ground texture, Dysphagia II/ Mechanical Soft, Low Concentrated Sweets, Renal, Low fat, Low Cholesterol Cardiac, Finger Foods, Pureed, Pesco-Vegetarian, Small Portions, Large Portions, and Reduced Sodium. Review of the facility's daily menu posted in the kitchen on 4/7/15 revealed: -The menu developed by the Registered Dietitian listed three meals and one snack daily to be	D 298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 298	Continued From page 1	D 298		

served to the residents.
-The snack was listed as "HS Snack (Hour of Sleep snack)", but no specific snack food or beverage was planned for all the available diets.
-There were no snack menus available for the dietary staff to follow. "X" was documented for each planned diet snack. The spreadsheet menu noted "X" indicated the diet was to be served the same recipe and portion as was provided to the Regular/NAS diet.

Interview with the Cook at 12:30pm on 09/07/16 revealed:
-The facility always had snack items available in the dining rooms for facility residents.
-The facility always kept snack items available on the 2-tier counter in the assisted living dining room.
-The dietary staff did not offer snacks to residents at any time.
-She did not know if other facility staff helped residents to obtain snacks.
-The residents could help themselves to a snack any time they wanted.

Observation at 1:00pm on 0907/16 of the Assisted Living dining room counter where snacks were kept available revealed:
-The lower tier of the counter was table-height, estimated at 28 inches high and 18 inches deep. The upper tier of the counter was estimated to be 40 inches high and 36 inches deep in the Assisted Living dining room.
-The facility kept a beverage in a large container on the upper level countertop plus individually wrapped apples or other fresh fruit to be eaten out-of-hand for the convenience of the residents.
-The facility kept a basket of individual packages of snack crackers, animal crackers, and cookies available on the lower, seating level countertop in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 298	Continued From page 2 the dining room for the convenience of the residents. Observation of the Assisted Living dining room at 10:15am on 09/08/16 revealed: -A large glass beverage dispenser (estimated size of three gallons) with a spigot on the upper level of the two-tier counter contained a dark purple beverage. It was not labeled as to contents. -A sleeve of Styrofoam cups was lying on the counter next to the glass dispenser. -A chrome C-shaped stand held six individual apples wrapped in plastic wrap. One small apple was at the base of the stand, four apples were at the top of the stand, and were blocked from descending down the C-shaped trough by a large apple. The stand was approximately 24 inches in height. Continued observation in the Assisted Living dining room on 09/08/16 at 3:00pm revealed: -The beverage container and the C-shaped fruit stand could not be reached by five residents standing in front of the two-tier counter. -Three residents utilized walkers, and could not reach the beverage dispenser or the fruit stand without letting go of their walker. -Two residents requested assistance from a staff member, and got a beverage poured for them. Confidential interviews with six residents on 09/08/16 from 2:30 - 3:30pm revealed: -Two residents utilized wheelchairs, and could not reach the beverage dispenser or fruit "because it was too high". Three residents stated they only got a snack if staff was available to obtain their preferred snack items and place the snacks and beverages on a table for them.	D 298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(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 298	Continued From page 3	D 298		

-One resident declined help, stating she was diabetic and she did not know if the beverage was sweetened with sugar or was sugar-free. She stated the fruit stand was useless for her, because she could never reach it.
- None of the residents took any of the pre-packaged cookies or crackers.

Interviews with Assisted Living residents on 09/08/16 revealed:
-The staff did not offer snacks to the residents in their rooms.
- One resident stated she had never asked for a snack, and staff did not offer snacks. "No one asks if I would like a snack."
- None of the twelve residents were aware the facility was required to provide or offer snacks 3 times a day.
-Two residents stated they kept a variety of snack items in their rooms, because the facility snacks offerings were monotonous.
-Two residents stated they came to the dining room for snacks when one resident baked cookies or muffins, as the snack was fresh, smelled good, and brought people together to socialize and enjoy the food.
-Two residents requested snacks other than store-bought packets of crackers, pretzels, and cookies.
-Fresh fruit, especially bananas, ice cream, and fresh desserts were favorites here.
-Beverages needed to be offered with snacks.
-Three residents stated the facility-provided snacks were boring and more suited to young children than adults.
-Three residents stated they never knew snacks were available at the facility, as they stayed in their rooms all the time.
-Three residents would like to have a beverage offered to them in the middle of the morning.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(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 298	Continued From page 4	D 298		

One resident was usually very thirsty at his lunch meal, and drank his luncheon fluids right away "because I get thirsty between breakfast and lunch."

Observation of the Seasons Dementia Community on 09/09/16 at 3:00pm revealed:
-18 residents were in the common activity and dining areas of the community.
-Residents wandered about the unit or sat quietly, watching TV or dozing in chairs.
-Staff offered beverages and snacks to residents in the common areas.
-Beverages were accepted more often than pre-packaged snack items.

Interview with a Seasons Dementia Community Medication Aide (MA) at 3:30pm on 09/09/16 revealed:
-The kitchen staff stocked a large tray or basket with an assortment of cookies and crackers.
-The large tray basket was stored behind the two-tier counter, not directly accessible to residents unless by request.
-Non-ambulatory residents could use a call bell to summon a staff member to their room so they could ask the staff member to bring them a snack.
-The MA stated she did was not sure what an appropriate snack was for a resident on a therapeutic diet. "The resident could eat whatever they wanted."

Based on observations, record reviews, and interviews, residents were not interviewable.

Interview with the Dietary Manager at 4:00pm on 09/09/16 revealed:
-She was not aware that snacks appropriate to therapeutic diets were to be offered to those

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(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 298	Continued From page 5	D 298		

residents who followed a physician-prescribed therapeutic diet.
-She was unaware all residents were to be offered three snacks daily.
-There was currently no system in place for monitoring to ensure snacks were being served three times daily.
- She would review the facility menus to ensure three snacks were planned each day for all regular, modified texture, and therapeutic diets
-The facility's Registered Dietitian Consultant would be notified that the snack menu had to be changed from two to three snacks per day.
- The Registered Dietitian Consultant for the facility would need to sign off on revised therapeutic menus to ensure snack offers met health and safety standards for therapeutic diets.
-She or another member of the Dietary Department could go up and down the hallways to offer beverages and snack items to residents who stayed in their rooms.
-The Personal Care Aides (PCAs) sometimes took meal trays to the rooms of residents who were too ill to attend meals in the dining room, but the PCAs did not go room-to-room to offer snacks between meals.

Interview with the Executive Director at 4:45pm on 09/09/16 revealed:
-She was unaware that three snacks were to be offered to all residents each day.
-She thought making snacks available for residents in the dining rooms met the regulation requirements.
-She thought the current menus were in compliance with state regulations.
-The Registered Dietitian Consultant would be contacted to develop a snack menu appropriate for therapeutic diets.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(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 307	Continued From page 6	D 307		
D 307	10A NCAC 13F .0904(e)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (e) Therapeutic Diets in Adult Care Homes: (1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram or consistency, such as for calorie controlled ADA diets, low sodium diets or thickened liquids, unless there are written orders which include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a registered dietitian. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure therapeutic diet orders were clarified in writing from the resident's physician by altering the consistency of the regular diet prescribed by the physician without an order for two of eight residents sampled for adherence to diet orders (#s 6, 7). The findings are: Review of the therapeutic diet list posted in the kitchen of the Seasons Dementia Community on 09/07/16 revealed Residents #6 and #7 were to receive a Regular diet, with food consistency documented as "cut meat". In the comment section of the dietary list, "No Seafood/Cut meat" was documented for Resident #6 and "Cut up Meats was documented for Resident #7. Observation at 11:30am on 09/07/2016 of the regular and therapeutic spreadsheet menus in the kitchen revealed:	D 307		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(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 307	Continued From page 7	D 307		

-The facility offered the following diets: Regular/No Added Salt, Regular Ground texture, Dysphagia II/ Mechanical Soft, Low Concentrated Sweets, Renal, Low fat, Low Cholesterol Cardiac, Finger Foods, Pureed, Pesco-Vegetarian, Small Portions, Large Portions, and Reduced Sodium.
-The spreadsheet menu developed by the Registered Dietitian listed three meals and one snack daily to be served to the residents.

Interview with the Cook on 09/07/16 at 1:00pm revealed:
-The Executive Director told her to cut the meat off the bone for Residents #6 and #7, and then cut the meat into smaller strips.
-She was not directed to cut the meat into smaller pieces, such as ½-inch or 1/4th inch dice.
-She used a gravy or sauce to keep the meat moist and hold it together for ease in chewing.
-She was told Residents #6 and #7 had difficulty chewing and swallowing meats when it was a larger, denser piece.
-She prepared several pounds of cooked meat by cutting it or pulling it into strips 1/4th inch thick, 3-4 inches long, and ½ inch wide, and would take the rest of the meat and further puree or grind it for other residents with therapeutic diet orders for modified textures.
-She used a ½ cup scoop to place the meat on the plate, to assure portion control.

1. Review of the Resident Register for Resident #6 revealed:
-Resident #6 was admitted to the Seasons Dementia Community on 01/19/16.
-Her Power of Attorney documented Resident #6 required feeding assistance, described as "needs help getting started".

Review of the current FL-2 dated 01/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(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 307	Continued From page 8	D 307		

revealed:
-Diagnoses of Alzheimer's disease, Parkinson's disease, ischemic cardiomyopathy, peripheral neuropathy, hyperlipidemia, and history of hypertension.
-There was an order for a regular diet.
-Resident #6 needed personal care assistance for feeding.

Review of the physician diet order sheet dated 01/14/16 for Resident #6 revealed the physician selected a Regular diet, described as a diet for people who require no dietary modifications.

Review of the resident's record revealed no further diet orders or clarification of the "regular diet" checked on the FL-2.

Observation of the lunch meal on 09/08/16 revealed:
-Resident #6 received ½ cup of white meat chicken cut off the bone into strips 1/4th inch thick, ½ inch wide, and 3 to 4 inches in length. The chicken had a brown sauce holding it together. The meat was scooped onto the middle of the plate. She also received ½ cup of mixed vegetables, ½ cup Parmesan noodles, 1 dinner roll, ½ cup mango chunks, 8 ounces of cranberry juice cocktail, 8 ounces milk, and 8 ounces of water.

Interview with a personal care assistant (PCA) at 12:15pm on 09/08/16 revealed:
-Resident #6 did not want to be in the dining room or eat any of her meal.
-Resident #6 sat in her chair with the chair back against the dining table.
-The PCA redirected her back into her chair when she stood up to leave.
-She poked at the chicken with her fingers,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(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 307	Continued From page 9	D 307		

picked a few strips of the chicken off the top of it, and then picked up the entire ball of chicken and dropped it back on the plate several times. The PCA stated "This was typical behavior."
-The PCA tried to feed Resident #6 the meal, but the resident preferred to feed herself.

Continued observation of Resident #6 on 09/08/16 at 12:20pm revealed:
-She drank half of the beverages served to her, ate a few bites of the noodles, tore her roll into smaller pieces, and ate 3 bites of mango chunks.
-She refused to eat the chicken.
-She picked up the scoop of chicken with her fingers and repeatedly dropped it onto the plate or table.

2. Review of the Resident Register for Resident #7 revealed:
-Resident #7 was admitted to the Seasons Dementia Community on 10/02/15.
-Her Power of Attorney documented she no assistance for feeding.
-He noted the resident has diverticulitis special diet requirements, "no nuts or tiny seeds".

Review of the FL-2 dated 09/16/15 revealed:
-Diagnoses of Alzheimer's disease, hypertension, osteoarthritis, and psychosis.
-There was an order for a regular diet.
-Resident #7 did not need personal care assistance for feeding.

Review of the physician diet order sheets for Resident #7 revealed:
-On 01/14/16, a general diet was selected.
-On 07/28/16, a Regular diet was selected, "cut up meats" was written on the diet sheet.
-On 08/16/16, a Regular diet was selected.
-Both the General and the Regular diets were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(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 307	Continued From page 10	D 307		

described as a diet for people who require no dietary modifications.

Review of the resident's record revealed no further diet orders or clarification of the "regular diet" checked on the FL-2.

Observation of the evening meal at 5:30pm on 09/08/16 revealed:
-Resident #7 received ½ cup of roast beef cut off the bone into strips 1/4th inch thick, ½ inch wide, and 3 to 4 inches in length. The beef had gravy mixed into the strips. The meat was scooped onto the middle of the plate.
-Resident #7 also received ½ cup of cooked carrots, ½ cup baked potato wedges, 1 biscuit, 1 slice of chocolate cake with whip topping, 8 ounces of water, 8 ounces of iced tea, and 8 ounces of milk.

A Personal Care Assistant (PCA) stood next to her as she ate her meal.

Observation of Resident #7 from 5:30pm to 6:15pm during the evening meal on 09/09/16 revealed:
-Resident #7 had no trouble feeding herself the potatoes, carrots, biscuit, cake, and the beverages.
-Resident #7 placed a piece of meat in her mouth, and could not chew it. She kept her head down, and after 30 seconds, the strip of meat started to come out of her mouth.
-Resident #7 pushed it back into her mouth with her fingers, and the meat again started to fall out. The meat was still in one strip, and saliva started to come out with the meat.
-The PCA asked her to spit the meat out into a napkin, the PCA had to assist Resident #7 to pull it out of her mouth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(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 307	Continued From page 11	D 307		

-The PCA removed the plate and napkin from the table.
-The PCA returned to the table with a fresh plate of food within 5 minutes.
-The fresh plate of food contained mashed potatoes, cooked carrots, another biscuit, and ½ cup of plain chicken, shredded into small pieces of 1/2 inch long, ¼ inch thick, and ½ inch wide. There was no gravy on the chicken.
-Resident #7 ate the majority of the meal with her fork, but finished eating the chicken by picking the small pieces with her fingers, placing it in her mouth, and chewing and swallowing the chicken successfully.

Interview with the PCA at 6:00pm on 09/08/16 revealed:
-Resident #7 enjoyed her food at mealtimes, and she had a good appetite.
-Resident #7 was a better feeder with smaller pieces of food and smaller bites of food.
-Resident #7 can't seem to chew large pieces successfully.
-Resident #7 can't hold large pieces of food in her mouth. The food fell out of her mouth when she lowered her head to swallow or to get another bite of food.

Observation of Resident #7 on 09/09/16 from 5:30 - 6:15pm revealed:
-Resident #7 did not talk during the meal.
-Resident #7 responded well to the PCA's directions while consuming her meal.

Based on record review and observations, Resident #7 was not interviewable, due to diagnosis of Alzheimer's dementia.

Review of the facility's therapeutic menus revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(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 307	Continued From page 12 -The Registered Dietitian Consultant did not offer a "Cut Meat" diet option. -There was no documentation the physician had been contacted to clarify the diet orders. The physician had the responsibility and authority for ordering therapeutic diets. Interviews with the Executive Director, the Resident Care Coordinator and the Dietary Manager on 09/09/16 at 6:15pm revealed they were unaware of the need to clarify incomplete therapeutic diet orders that the physician had signed, or for any multiple diet orders that did not match a facility menu for the guidance of kitchen staff.	D 307		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 13	D 344		

Based on observation, record review and interview, the facility failed to verify medication orders for 1 of 5 residents (#2) sampled who was admitted 6 days after the date of the FL-2 with medication orders and failed to ensure clarification of discrepancies identified between the medication orders on the FL-2 and physician order sheets for 10 medications, which included medications for treatment of certain stomach and esophagus problems, prevention of angina attacks (chest pains), treatment of high blood pressure, prevention and control of seizures as well as to relieve nerve pain, relief of moderate to moderately severe pain and treatment of airway narrowing (bronchospasm). The findings are:

Review of Resident #2's current FL-2 dated 07/07/2016 received upon admission of the resident on 07/13/2016 from the hospital revealed:
-Diagnoses to include Anemia, Hypertension, Heart Failure, Gastroesophageal Reflux Disease.
-Medication orders included the following medications: Protonix, Imdur, Catapres, Senna, Neurontin, Norco, Vitamin B-12, Macrodantin, Zyrtec and Duoneb

Interview with Resident Care Coordinator (RCC) on 09/09/2016 at 1:50 p.m. revealed the facility did not have a discharge summary from the hospital.

Review of staff notes for Resident #2 revealed:
-Resident #2 was sent out to the Emergency Room on 06/11/2016 with complaint of pain in stomach.
-Resident returned to facility on 07/13/2016 from the hospital.

Review of the Resident #2's record and interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 344	Continued From page 14	D 344		

with Resident Care Coordinator (RCC)revealed there was no contact with the physician regarding verification of the resident's medication orders dated 07/07/2016 when the resident was admitted to the facility 6 days later, on 07/13/2016.

Review of subsequent medication orders in the resident's record revealed the computerized physician's order sheets was documented as reviewed by the RCC on 08/29/2016 and signed by the physician on 09/01/2016.

Review of the computerized physician's orders dated 09/01/2016, FL-2 dated 07/07/2016 and the July, August and September medication administration records revealed discrepancies between the medication orders for 10 medications.

Review of resident's record revealed no documentation of any contact with the physician or physician's assistant regarding the following discrepancies of the medication orders between the September 2016 physician's order sheet and the FL-2 dated 07/07/2016.

A. Review of Resident #2's FL-2 dated 07/07/2016 revealed a medication order for Protonix 40 mg twice per day. (Protonix is prescribed for the treatment of certain stomach and esophagus problems).

Review of Resident #2's physician order sheet dated 09/01/2016 revealed an entry for Protonix 40 mg every day.

Review of Resident #2's record revealed no subsequent orders for Protonix between FL-2 dated 07/07/2016 and the physician order sheet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 15 dated 09/01/2016. Review of Resident #2's July 2016, August 2016 and September 2016 Medication Administration Record (MAR) revealed Protonix 40 mg was documented as administered every day at 7:30 a.m. from 07/14/2016 to 09/09/2016. Observation of medications on hand at 1:00 p.m. on 09/09/2016 revealed there was one bubble pack of Protonix 40 mg with instructions to be administered once per day. Refer to interview with Medication Aides (MA) on 09/09/2016 at 1:10 p.m. and 6:52 p.m. Refer to interview with Resident #2 on 09/09/2016 at 1:30 p.m. Refer to interview with Resident Care Coordinator on 09/09/2016 at 1:50 p.m. Refer to interview with pharmacy staff on 09/09/2016 at 2:10 p.m., 2:50 p.m. and 2:52 p.m. Refer to interview with Physician on 09/09/2016 at 2:32 p.m. Refer to interview with Administrator on 09/09/2016 at 6:55 p.m. B. Review of Resident #2's FL-2 dated 07/07/2016 revealed a medication order for Imdur 30 mg every day. (Imdur is prescribed for preventing angina attacks (chest pains). Review of Resident #2's physician order sheet dated 09/01/2016 revealed an entry for Imdur 60 mg every day.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 16	D 344		

Review of Resident #2's records revealed no subsequent orders for Imdur between FL-2 dated 07/07/2016 and the physician order sheet dated 09/01/2016.

Review of Resident #2's July 2016, August 2016 and September 2016 MAR revealed Imdur 60 mg was documented as administered every day at 8:00 a.m. from 07/14/2016 to 09/09/2016.

Observation of medications on hand at 1:00 p.m. on 9/9/16 revealed there was one bubble pack of Imdur 60 mg with instructions to be administered once per day.

Refer to interview with Medication Aides (MA) on 09/09/2016 at 1:10 p.m. and 6:52 p.m.

Refer to interview with Resident #2 on 09/09/2016 at 1:30 p.m.

Refer to interview with Resident Care Coordinator on 09/09/2016 at 1:50 p.m.

Refer to interview with pharmacy staff on 09/09/2016 at 2:10 p.m., 2:50 p.m. and 2:52 p.m.

Refer to interview with Physician on 09/09/2016 at 2:32 p.m.

Refer to interview with Administrator on 09/09/2016 at 6:55 p.m.

C. Review of Resident #2's FL-2 dated 07/07/2016 revealed a medication order for Catapres 0.1 mg to be administered twice daily. (Catapres is prescribed for treatment of high blood pressure).

Review of Resident #2's physician order sheet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

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GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 17	D 344		

dated 09/01/2016 revealed:
-An entry for Catapres 0.1 mg by mouth twice daily.
-Another entry for Catapres 0.2 mg daily at 8:00 p.m.

Review of Resident #2's records revealed no subsequent orders for Catapres between FL-2 dated 07/07/2016 and the physician order sheet dated 09/01/2016.

Review of Resident #2's July 2016, August 2016 and September 2016 MAR revealed:
-Catapres 0.1 mg was documented as administered every day at 8:00 a.m. and 2:00 p.m. from 07/14/2016 to 09/09/2016.
-There was also documentation that Catapres 0.2 mg was also administered every day at 8:00 p.m. from 07/14/2016 to 09/09/2016.

Observation of medications on hand at 1:00 p.m. on 09/09/2016 revealed:
-A bubble pack of medication labeled Catapres 0.1 mg with instructions to be administered twice per day.
-A bubble pack of medication labeled Catapres 0.2 mg with instructions to be administered at 8:00 p.m. daily.

Refer to interview with Medication Aides (MA) on 09/09/2016 at 1:10 p.m. and 6:52 p.m.

Refer to interview with Resident #2 on 09/09/2016 at 1:30 p.m.

Refer to interview with Resident Care Coordinator on 09/09/2016 at 1:50 p.m.

Refer to interview with pharmacy staff on 09/09/2016 at 2:10 p.m., 2:50 p.m. and 2:52 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 18 Refer to interview with Physician on 09/09/2016 at 2:32 p.m. Refer to interview with Administrator on 09/09/2016 at 6:55 p.m. D. Review of Resident #2's FL-2 dated 07/07/2016 revealed a medication order for Senna 8.6 mg was ordered to be administered every day. (Senna is prescribed for treatment of constipation). Review of Resident #2's physician order sheet dated 09/01/2016 revealed entry for Senna plus 8.6mg- 50 mg, take two tablets by mouth twice daily. (Senna plus 8.6 mg- 50 mg is prescribed for Senna. Senna plus 8.6 mg- 50 mg has senna and docusate which is a stool softener). Review of Resident #2's records revealed no subsequent orders for Senna or Senna plus between FL-2 dated 07/07/2016 and the physician order sheet dated 09/01/2016. Review of Resident #2's July 2016, August 2016 and September 2016 MAR revealed Senna plus 8.6 mg-50 mg, two tablets were documented as administered every day at 8:00 a.m. and 8:00 p.m. from 07/14/2016 to 09/09/2016. Observation of medications on hand at 1:00 p.m. on 09/09/2016 revealed there was a bubble pack of Senna plus 8.6 mg-50 mg, with instructions for two tablets to be administered twice per day. Refer to interview with Medication Aides (MA) on 09/09/2016 at 1:10 p.m. and 6:52 p.m. Refer to interview with Resident #2 on 09/09/2016	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 19	D 344		

at 1:30 p.m.

Refer to interview with Resident Care Coordinator on 09/09/2016 at 1:50 p.m.

Refer to interview with pharmacy staff on 09/09/2016 at 2:10 p.m., 2:50 p.m. and 2:52 p.m.

Refer to interview with Physician on 09/09/2016 at 2:32 p.m.

Refer to interview with Administrator on 09/09/2016 at 6:55 p.m.

E. Review of Resident #2's FL-2 dated 07/07/2016 revealed medication order for Neurontin 100 mg to be administered three times daily. (Neurontin is prescribed with other medications to prevent and control seizures as well as used to relieve nerve pain).

Review of Resident #2's physician order sheet dated 09/01/2016 revealed entry for Neurontin 300 mg, take one capsule by mouth three times daily.

Review of Resident #2's records revealed no subsequent orders for Neurontin between FL-2 dated 07/07/2016 and the physician order sheet dated 09/01/2016.

Review of Resident #2's July 2016, August 2016 and September 2016 Medication Administration Record (MAR) revealed Neurontin 300 mg was documented as administered every day at 8:00 a.m., 2:00 p.m. and 8:00 p.m. from 07/14/2016 to 09/09/2016.

Observation of medications on hand on 09/09/2016 revealed that there was a bubble

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 20	D 344		

pack of Neurontin 300 mg with instructionsto be administered three times per day.

Refer to interview with Medication Aides (MA) on 09/09/2016 at 1:10 p.m. and 6:52 p.m.

Refer to interview with Resident #2 on 09/09/2016 at 1:30 p.m.

Refer to interview with Resident Care Coordinator on 09/09/2016 at 1:50 p.m.

Refer to interview with pharmacy staff on 09/09/2016 at 2:10 p.m., 2:50 p.m. and 2:52 p.m.

Refer to interview with Physician on 09/09/2016 at 2:32 p.m.

Refer to interview with Administrator on 09/09/2016 at 6:55 p.m.

F. Review of Resident #2's FL-2 dated 07/07/2016 revealed medication order for Norco 5 mg- 325 mg to be administered every six hours as needed. (Norco is prescribed for relief of moderate to moderately severe pain).

Review of Resident #2's physician order sheet dated 09/01/2016 revealed entry for Norco 5 mg-325 mg, take one tablet routinely four times daily.

Review of Resident #2's July 2016 Medication Administration Record (MAR) revealed Norco 5 mg-325 mg was documented as administered four times daily from 07/14/2016 to 07/31/2016.

Review of Resident #2's August 2016 Medication Administration Record (MAR) revealed Norco 5 mg-325 mg was documented as administered four times daily from 08/4/2016 to 08/31/2016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 21	D 344		

Review of Resident #2's September 2016 Medication Administration Record (MAR) revealed Norco 5 mg-325 mg was documented as administered four times daily from 09/01/2016 to 09/09/2016.

Observation of medications on hand at 1:00 p.m. on 09/09/2016 revealed that there was a bubble pack of Norco 5 mg-325 mg with instructions for one tablet to be administered four times per day.

Refer to interview with Medication Aides (MA) on 09/09/2016 at 1:10 p.m. and 6:52 p.m.

Refer to interview with Resident #2 on 09/09/2016 at 1:30 p.m.

Refer to interview with Resident Care Coordinator on 09/09/2016 at 1:50 p.m.

Refer to interview with pharmacy staff on 09/09/2016 at 2:10 p.m., 2:50 p.m. and 2:52 p.m.

Refer to interview with Physician on 09/09/2016 at 2:32 p.m.

Refer to interview with Administrator on 09/09/2016 at 6:55 p.m.

G. Review of Resident #2's FL-2 dated 07/07/2016 revealed that Vitamin B-12 was not listed among the medications. (Vitamin B-12 is a supplement).

Review of Resident #2's physician order sheet dated 09/01/2016 revealed an entry for Vitamin B-12 1,000 mcg by mouth every day.

Review of Resident #2's records revealed no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 22	D 344		

subsequent orders for Vitamin B-12 between FL-2 dated 07/07/2016 and the physician order sheet dated 09/01/2016.

Review of Resident #2 ' s July 2016, August 2016 and September 2016 Medication Administration Record (MAR) revealed Vitamin B-12 was documented as administered every day from 07/14/2016 to 09/09/2016.

Observation of medications on hand at 1:00 p.m. on 09/09/2016 revealed that there was a bottle of Vitamin B-12 1,000 mcg with instructions to be administered once per day.

Refer to interview with Medication Aides (MA) on 09/09/2016 at 1:10 p.m. and 6:52 p.m.

Refer to interview with Resident #2 on 09/09/2016 at 1:30 p.m.

Refer to interview with Resident Care Coordinator on 09/09/2016 at 1:50 p.m.

Refer to interview with pharmacy staff on 09/09/2016 at 2:10 p.m., 2:50 p.m. and 2:52 p.m.

Refer to interview with Physician on 09/09/2016 at 2:32 p.m.

Refer to interview with Administrator on 09/09/2016 at 6:55 p.m.

H. Review of Resident #2's FL-2 dated 07/07/2016 revealed that Macrodantin 100 mg capsule was not listed among the medications. (Macrodantin is prescribed for treatment of specific urinary tract infections).

Review of Resident #2's physician order sheet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 23	D 344		

dated 09/01/2016 revealed an hand written entry for Nitrofurantoin (Macrodantin) 100 mg at bedtime.

Review of Resident #2's record revealed no subsequent orders for Macrodantin between FL-2 dated 07/07/2016 and the physician order sheet dated 09/01/2016.

Review of Resident #2 ' s July 2016, August 2016 Medication Administration Record (MAR) revealed Macrodantin 100 mg capsule was documented as administered every day at 8:00 p.m. from 07/14/2016 to 08/29/2016.

Observation of medications on hand at 1:00 p.m. on 09/09/2016 revealed that there was no Macrodantin available for administration.

Refer to interview with Medication Aides (MA) on 09/09/2016 at 1:10 p.m. and 6:52 p.m.

Refer to interview with Resident #2 on 09/09/2016 at 1:30 p.m.

Refer to interview with Resident Care Coordinator on 09/09/2016 at 1:50 p.m.

Refer to interview with pharmacy staff on 09/09/2016 at 2:10 p.m., 2:50 p.m. and 2:52 p.m.

Refer to interview with Physician on 09/09/2016 at 2:32 p.m.

Refer to interview with Administrator on 09/09/2016 at 6:55 p.m.

I. Review of Resident #2's FL-2 dated 07/07/2016 revealed an order for Zyrtec 5 mg daily. (Zyrtec is prescribed for treatment of cold or allergy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 24 symptoms). Review of Resident #2's physician order sheet dated 09/01/2016 revealed that there was no entry for Zyrtec. Review of Resident #2's records revealed no subsequent orders for Zyrtec between FL-2 dated 07/07/2016 and the physician order sheet dated 09/01/2016. Review of Resident #2's July 2016, August 2016 and September 2016 MAR revealed that Zyrtec (Certirizine) 5 mg was not listed for administration on the MARs. Observation of medications on hand at 1:00 p.m. on 09/09/2016 revealed that there was no Zyrtec available for administration. Refer to interview with Medication Aides (MA) on 09/09/2016 at 1:10 p.m. and 6:52 p.m. Refer to interview with Resident #2 on 09/09/2016 at 1:30 p.m. Refer to interview with Resident Care Coordinator on 09/09/2016 at 1:50 p.m. Refer to interview with pharmacy staff on 09/09/2016 at 2:10 p.m., 2:50 p.m. and 2:52 p.m. Refer to interview with Physician on 09/09/2016 at 2:32 p.m. Refer to interview with Administrator on 09/09/2016 at 6:55 p.m. J. Review of Resident #2's FL-2 dated 07/07/2016 revealed an order for Duoneb 1	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 25	D 344		

premix solution via nebulizer every six hours as needed. (Duoneb is prescribed for treatment of airway narrowing (bronchospasm)).

Review of Resident #2's physician order sheet dated 09/01/2016 revealed that there was no entry for Duoneb.

Review of Resident #2's records revealed no subsequent orders for Duoneb between FL-2 dated 07/07/2016 and the physician order sheet dated 09/01/2016.

Review of Resident #2's July 2016, August 2016 and September 2016 MAR revealed that Duoneb was not listed for administration on the MARs.

Observation of medications on hand at 1:00 p.m. on 9/9/16 revealed that there was no Duoneb available for administration.

Refer to interview with Medication Aides (MA) on 09/09/2016 at 1:10 p.m. and 6:52 p.m.

Refer to interview with Resident #2 on 09/09/2016 at 1:30 p.m.

Refer to interview with Resident Care Coordinator on 09/09/2016 at 1:50 p.m.

Refer to interview with pharmacy staff on 09/09/2016 at 2:10 p.m., 2:50 p.m. and 2:52 p.m.

Refer to interview with Physician on 09/09/2016 at 2:32 p.m.

Refer to interview with Administrator on 09/09/2016 at 6:55 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051048	A. BUILDING: _____ B. WING _____	R-C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GABRIEL MANOR ASSISTED LIVING CENTER	84 JOHNSON ESTATE RD CLAYTON, NC 27520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 26 Interview with a Medication Aide (MA) on 9/9/16 at 1:10 p.m. revealed: -Resident #2 was out of facility with stomach issues. -After the hospital " she went to a rehab for a while " . -When a resident comes back to facility with a new FL-2 the facility takes the old FL-2 and the Medication Administration Record (MAR) to compare the new FL-2 against. -If there are any changes, these changes need to be clarified with the physician. -There should be a hard script in resident's record for any changes. -If there were no hard script, then there should have been a clarification order in the resident's record. -All FL-2s are faxed to the pharmacy. Interview with Resident #2 on 9/9/16 at 1:30 p.m. revealed: -She was in the hospital the July for heart failure. -She stayed in the hospital around a week. -She stayed in rehab for three weeks. -Resident complained of pain in stomach, pointing to the right and left upper quadrant of stomach. -The pain is right at the top of her stomach. -The pain is not new, that she has been having it since before she went into the hospital. -Her stomach did not bother her as much when she was in the rehab. -Her stomach is bothering her more now since she has been back to the facility. -She does not know if she is on anything for her stomach since returning to facility. -She does not know if she was on anything for her stomach while she was out of facility. -The facility gives her pain medication that keeps	D 344		

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D 344	Continued From page 27	D 344		

it from hurting so bad.

Interview with another MA on 9/9/16 at 6:52 p.m. revealed:
-When residents come back from being away from facility, their paperwork is checked to make sure there are no medication changes.
-After checking for changes, if there are none then the paperwork is faxed to the pharmacy.
-If there are changes, the paperwork is faxed to the physician for clarification of changes.
-After clarification the paperwork is then faxed to the pharmacy.
-The pharmacy then sends any new medications to the facility.
-The MA on duty or the Resident Care Coordinator is responsible to check orders.

Interview with Resident Care Coordinator (RCC) on 9/9/16 at 1:50 p.m. revealed:
-All new FL-2s are supposed to be faxed to the pharmacy.
-Once the FL-2 is faxed to the pharmacy, a copy of FL-2 should go to the Hot Box for the MA and RCC to review.
-The RCC should do a check to make sure everything has been transcribed to the MAR.
-The resident ' s FL-2 did not get to where it needed to get to.
-"Going forward, before anything is filed I want the original paperwork left for me with an order tracking form attached."
-"I hope to prevent any orders from falling through the cracks by putting this procedure in place."

Telephone interview with Pharmacist on 9/9/16 at 2:10 p.m. revealed:
-The FL-2 is kept on file in the resident ' s record after it is faxed to us from the facility.
-The resident ' s record is updated and FL-2 is

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D 344	Continued From page 28 kept as a current medication list before it is filed. Telephone interview with Physician on 9/9/16 at 2:32 p.m. revealed: -Resident #2 was seen by me on 7/14/16. -She did not see in her records where new FL-2 was reviewed by her. -Resident #2 was in the hospital and then rehab for aspiration pneumonia and congestive heart failure exacerbation. -Usually if there is a new FL-2, the facility usually puts it in my box. -If there are any changes from the old MAR, the facility would make me aware and have clarified. -If facility did not put new changes on MAR and make me aware that would be concerning. Telephone interview with Pharmacist on 9/9/16 at 2:50 p.m. revealed that she could not find any record of a FL-2 from July 2016 for Resident #2. Telephone interview with Pharmacy Manager on 9/9/16 at 2:52 p.m. revealed: -If facility had a new FL-2, they would fax it into us. -If there are any changes to be made we make those changes. -If there are clarifications needed we make the facility aware of these clarifications. Interview with Administrator on 9/9/16 at 6:55 p.m. revealed: -The MA gathers all the information and the supervisor checks off on it. -Going forward we will have a new tracking form that will be added to each piece of paperwork that comes back with the resident from outside of facility. -Physician should review the new FL-2 that	D 344		

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D 344	Continued From page 29 comes back to facility. _____ Plan of Protection received from facility on 9/9/16 revealed: -This resident ' s old and new orders were faxed to physician for clarification. -The orders upon receipt will be corrected on MAR. -Any resident who was re-admitted from July 2016 to current will have a chart review to make sure no orders have been overlooked. -Business Officer Manager will initiate notification of re-admission using the midnight census. -All re-admitted resident paperwork will be flagged for Resident Care Coordinator, Executive Director or designee review. - Resident Care Coordinator, Executive Director or designee will complete full chart review within 24 hours on a weekly basis for eight weeks then monthly. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 24, 2016	D 344		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure that every resident had the right	{D912}		

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{D912}	Continued From page 30 to receive care and services which are adequate, appropriate and in compliance with rules and regulations as related to verification and clarification of medication orders. The findings are: Based on observation, record review and interview, the facility failed to verify medication orders for 1 of 5 residents (#2) sampled who was admitted 6 days after the date of the FL-2 with medication orders and failed to ensure clarification of discrepancies identified between the medication orders on the FL-2 and physician order sheets for 10 medications, which included medications for treatment of certain stomach and esophagus problems, prevention of angina attacks (chest pains), treatment of high blood pressure, prevention and control of seizures as well as to relieve nerve pain, relief of moderate to moderately severe pain and treatment of airway narrowing (bronchospasm). [Refer to Tag 344, 10A NCAC 13F .1002 Medication Orders (Type B violation).]	{D912}		