Division of Health Service Regulation

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 06/20/2016

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

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow-up survey and compliant investigation on June 15-17, 2016 and June 20, 2016.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the memory care unit short hall and long hall exit doors were equipped with a sounding device that activated when the doors were open resulting in 2 of 2 residents (#3,and #6) exited the memory care unit without staff awareness. The findings are: 1. Review of Resident #3's current FL-2 dated	D 067		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laurie J. Minard — TITLE: Executive Director — (X6) DATE

Laurie J. Minard 7/26/16

acknowledged 7/26/16

Facility Name: Gabriel Manor Assisted Living License # HAL-051-048

Rule Violation Cited: 10A NCAC 13F.0305 (h)(4) Physical Environment

D 067 Page 1: 10A NCAC 13F.0305 Physical Environment (h) the requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.

The facility will assure the Memory Care Unit, Short Hall and Long Hall, doors are equipped with a sounding device that activates when doors are opened.

Door hinges adjustment was completed on June 16, 2016. Door alarms were installed on Memory Care exit doors on June 17, 2016.

Door codes were changed on June 16, 2016 to ensure entrance and exit of the Memory Care Unit with Supervision.

Doors and alarms will be checked daily by the Administrator/Maintenance Director or designee for proper operation until July 31, 2016 then weekly thereafter.

Correction date July 20, 2016.

Rule Violation Cited: 10A NCAC 13F .0904(e)(4) Nutrition and Food Service

D 067 Page 7: 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.

The Facility will ensure that all therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

Page 26 & 27: The Area Director of Clinical services immediately in-serviced staff on new procedure. One staff to look at posted diet spread sheet and the other staff to ensure that resident receives proper diet/liquids.

In Service conducted on July 15, 2016 by Judith Bailey, MS, RD, LD regarding therapeutic diets and texture modifications.

Dining Service Manager received 1:1 training on July 18, 2016 by Judith Bailey, MS, RD, LD, to ensure understanding of diets and texture modifications. DSM to monitor meals daily. The Administrator will monitor meals daily to ensure proper diets and texture modifications are being followed until July 31, 2016 then weekly thereafter.

Correction date July 20, 2016.

Page 29: 10A NCAC 13F .1004(a) Medication Administration

The recording of administration of medication shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication.

The Facility will ensure that the staff person recording of administration of medication shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication.

Medication observations will be conducted by the RCD or designee on each Medication Aide. Random observations will be conducted weekly thereafter.

Correction date July 31, 2016.

Page 29: 10A NCAC 13F .1005(a) Self-Administration of Medications

An adult care home shall permit residents who are competent and physically able to self-administer their medications.

The facility will ensure residents who are competent and physically able to self-administer their medications are permitted as ordered by a physician to self-administer medications.

RCD or designee will conduct an audit of all residents to: a) determine which are currently self-administering medications; and 2) ensure all such residents have appropriate physician orders for the same.

RCD to ensure and monitor quarterly. Medications observed in rooms will be removed until an order is obtained by Primary Care Provider.

Facility staff informed all residents and responsible parties that zero (0) medications are allowed in rooms unless ordered by Primary Care Provider.

Correction date July 31, 2016.

Page 34: 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.

The Facility will ensure that the each 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.

Residents' Rights in-service was conducted on July 19, 2016 by Carolyn Pennington, Ombudsman.

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Correction date July 31, 2016

Laura J. Mura 7/26/16

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5/12/16 revealed:
-Diagnoses included Dementia, memory loss, agitation, gait postural instability, asthma, hypertension, depressive disorder and Type II diabetes.
-The resident was constantly disoriented and was a wander.
-The level of care was special care unit.

Review of facility documentation in the nurse's notes revealed:
-On 3/3/16 at 8:15 pm, "the resident was trying to open doors, ramping wheelchair into the doors. The resident was administered Ativan 1 mg at 6:30 pm with it helped some no other complaints will continue to monitor" .
-On 3/4/16 at 6:15pm, the resident was noticed by the medication aide and the nurse outside at 6:15pm. The medication aide and the nurse brought the resident back inside the building. As needed medication was administered and the resident was monitored.

Interview with the medication aide on 6/16/16 at 3:07 pm revealed:
-On the 3/4/16, "I do not know how [Resident #3 name] got out the building".
-We did not hear any alarms sound.
- "We think he went out the door near the baby area" (long hall exit door)
- The Registered Nurse (RN) was in the front office and saw [Resident #3 name] walking down the side walk in front of the building, heading towards the front door.
- The RN escorted the resident back to the memory care unit.
-None of the staff knew [Resident #3 name] was off the unit, until we notice him being escorted by the RN back to the unit.
-The resident was known to push on the doors at

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times.
-The resident had been monitored by staff around 6:00pm on 3/4/16, the resident had finish dinner and was in the common area.

Interview with Maintenance Director on 6/16/16 revealed [Resident #3's name] was out of the building but he did not go off the property. "He didn't leave, he was still here".

Attempted telephone interview with the RN on 6/20/16 at 3:22pm was unsuccessful.

Refer to observation on 6/16/16.

Refer to interview with Maintenance Director on 6/16/16.

Refer to interview with Executive Director on 6/20/16.

2. Review of Resident #6's current FL-2 dated 12/21/15 revealed:
-Diagnoses included memory impairment, hypothyroidism, hypertension, chronic obstructive pulmonary disease, pernicious anemia, and B12 deficiency.
-The resident was intermittently disoriented.

According to the resident registry Resident #6 was admitted to the facility 12/21/15.

Review of Resident #6's resident information sheet revealed Resident #6 was transferred to the facility from home due to Dementia and Alzheimer's.

Review of the facility resident services level of care program review dated 3/14/16 revealed:
-"The resident wandered inside the community,

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may enter other residents' apartments, required continuous redirection and supervision".
-The resident is had moderate confusion and may have some unpredictable behaviors or require moderate emotional support.

Review of Resident #6's facility progress notes a late entry dated 6/16/16 a 4:00pm revealed:
-On 6/15/16 around 7:30 pm [Resident #6's name] was reported being outside of the building by another staff. The staff stated she was smoking during her 30 minute break when she saw the resident and brought her back in with no complications. The second medication aide was informed and all exits were checked three times.

Interview with the personal care aide (PCA) on 6/20/16 at 4:55 pm revealed:
-The PCA had exited the memory care unit using the numerical pad by the double doors that lead to the employee break room.
-The PCA was finishing her thirty minute break and had gone outside to the smoking area to smoke a cigarette.
-The PCA was getting ready to extinguish her cigarette and notice Resident #6 walking on the concrete pad between the dumpsters and the building.
-The PCA did not hear any alarms sound.
-The PCA did not see the resident come out of a door.
-The PCA thought because of were the resident was seen the resident came out of the short hall exit door of the memory care unit.
-No one knew the resident was out of the building until I brought [Resident #6's name] back to the memory care unit.

Interview with a second medication aide on 6/16/16 at 7:45am revealed:

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D 067	Continued From page 4 -Another medication aide reported that [Resident #6's name] had gotten out of the building after dinner on 6/15/16. Interview with the medication aide on 6/16/16 at 7:45 am revealed: -The PCA reported that she was outside smoking and [Resident #6's name] was walking outside the building. -Staff did not hear any alarms sound. -"I immediately called the maintenance director and executive director". Interview with the Executive Director(ED) on 6/20/16 at 4:15pm revealed she had just left the building and received a telephone call from staff stating Resident #6 had gotten out of the memory care unit. Attempted interview with Resident #6 and facility staff on 6/20/16 at 5:10pm revealed: - "I went out this door, so many do, I see them come in and go, I don't know how but they do" (The resident pointed to the short hall exit door) - "you can go out but I am confused" Refer to observation on 6/16/16. Refer to Interview with Maintenance Director on 6/16/16. Refer to Interview with Executive Director on 6/20/16. _____ Observation of the short hall exit door on 6/16/16 at 5:08 pm with Maintenance Director revealed: -A black numerical pad located on the right side of the wall near the exit door leading outside of the facility by the dumpsters. A code was needed to exit door. After the code had been entered the	D 067		

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exit door would open and no sound was heard.
-A red switch in an upward position with a clear plastic cover labeled "override" adjacent to the numerical pad.
-When the clear plastic cover was lifted up a sound would be heard.
-When the plastic cover closed the sound would stop.
-When the red switch had been flipped down the exit door could be opened.
-The short hall exit door on the memory care unit did not latch/close after being open by staff.
-There was no sound heard each time the door was open afterwards.

Interview with the Maintenance Director on 6/16/16 at 5:05 pm revealed:
- "I am not aware of any residents getting out of the facility since I have been working here". "I started working in November 2015" .
- "I would be aware if any residents did get out so I could check for faulty doors or whatever".

-On 6/15/16 "the executive director called me and I returned to the facility to reset the codes about 8:30pm because someone got out the building".
-Only the maintenance director and executive director had the codes for the short hall and long hall exit door on the memory care unit since 6/15/16 incident.
- During the observation of the short hall exit door on the memory care unit, the maintenance director reported that the door hinge needed to be adjusted so that it would close properly.

Interview with the Executive Director(ED) on 6/20/16 at 4:15pm revealed:
-The ED thought that the she and the maintenance director were the only staff that had the code to the short hall and long hall exit doors

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D 067	Continued From page 6 for the memory care unit. - The ED thought staff may have propped the exit door. _____ Review of the Plan of Protection provided by the facility on 6/16/16 revealed: -The maintenance director will assessed door hinges on the Memory care unit short hall exit door needed to be adjusted. -Door hinges adjustment was completed on 6/16/16. -Door alarms were purchased and would be installed on four memory care exit doors (short hall, long hall, patio door and side door to laundry by the end of the day on 6/17/16. -Thirty minute checks will be done until alarms are installed and working. -ED will talk with staff regarding thirty minute checks were completed and documented. -Door checks on all memory care exit doors will be done daily by the Maintenance Director or designee on going. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 20, 2016.	D 067		
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:	D 310		

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D 310	Continued From page 7 TYPE A1 VIOLATION Based on observations, interviews and record review, the facility failed to serve mechanical soft diets for 4 of 4 residents (#4,#5,#7,#8) which included one resident (#5) who choked and later died, 2 of 2 residents with orders for puree diets (#9, #10) and 3 of 3 residents with orders for nectar thick liquids (#7,#8 and #9). The findings are: 1. Review of Resident #5's FL2 dated 6/11/15 revealed; -Diagnoses included Ortho static Hypotension, Parkinson's, Supine High Blood Pressure, History of Urinary Tract Infections, Mood Disorder, Constipation, Transient Ischemic Attacks. -There was no diet listed. Review of the facility standard diet list dated 8/11/15 for Resident #5 revealed: - Mechanical soft was circled and in parenthesis the following was noted (ground meat, no raw fruit or vegetables, bread is allowed. This is a general diet with ground meat). -General diet was circled ("General" diet was noted as a diet designed for people who require no dietary modifications). Review of Incident Report dated 3/29/16 at 5:13 p.m. for Resident #5 revealed the resident was in the dining room eating and began to choke. Review of the Nurses' Notes for Resident #5 revealed: -On 3/29/16 at 5:13 p.m.,the resident was in the dining room and had begun to choke. 911 was called and resident was sent to the hospital. -On 3/30/16, resident was still at the hospital. No	D 310		

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new information
at this time.

Review of the Emergency Medical Services (EMS) report for Resident #5 revealed:
-On 3/29/16 at 5:40 p.m.,EMS personnel were already on the site at the facility performing CPR.
-Resident was on the floor in the hallway of the facility by dining room.
-According to facility staff, the resident was eating and began to indicate that he was choking.
-Facility staff attempted the Heimlich but were unsuccessful.
-Resident was assisted to the floor by facility staff.
-Foreign body airway obstruction (FBAO) was identified and removed with forceps by EMS and CPR was continued.
-Resident was taken to the hospital by EMS.

Review of the Death Certificate for Resident #5 revealed:
-The date of injury was 3/29/16 at the facility.
-Immediate cause of death was listed as "occlusion of airway by food bolus/ choking on food bolus".
-The time of death for the resident was noted at approximately "12:17" on 04/01/16.

Interview with the first EMS worker on 6/20/16 at 3:40 p.m. revealed:
-Resident #5 was found on floor by dining room at the facility with staff performing chest compressions.
-EMS began working on Resident #5 and were able to get the food out of his mouth.
-He said it was "some type of meat, a big piece of meat, either chicken or pork".

Interview with the second EMS worker on 6/20/16 at 3:50 p.m. revealed:

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D 310	Continued From page 9 -Resident #5 was found on the floor near the dining room of the facility with staff performing CPR. -Another EMS worker had used forceps to remove "some beef lodged in him". -The meat was "maybe a quarter of an inch or more in size; a fairly deceit size". -He said "even a quarter of an inch is too much; it was a pretty nice size of meat". Interview with the third EMS worker on 6/20/16 at 4:00 p.m. revealed: -While Resident #5 was on the floor by the dining room of the facility, he witnessed "a pretty big piece of meat" being pulled out of Resident #5's mouth. -EMS were able to ventilate Resident #5 after the meat was removed and they were able to get a pulse for the resident. Interview with the fourth EMS worker on 6/20/16 at 4:08 p.m. revealed: -The first EMS crew had begun CPR on Resident #5. -After hooking up the defibrillator, EMS were able removed "a big piece of meat". -He said the meat was "about four inches long and four inches wide and was wadded up like". -The meat looked like it had been swallowed whole and had not been chewed by the resident, but he was not sure. Interview with the fifth EMS worker on 6/20/16 at 4:25 p.m. revealed: -He was told by facility staff that the resident had choked. -He looked in the back of Resident #5's throat and used forceps to get the meat out.	D 310		

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-It was a fairly "sizeable portion of meat".
-He said he "could not tell what kind of meat it was but it was three inches long and large enough to block Resident #5's airway".

Review of menu provided by the facility on 6/16/16 revealed:
-On 3/29/16, mechanical soft diets were to receive a 6 ounce ladle of "cream of tomato soup, no packet of saltine crackers, 1 pureed grilled cheese sandwich, and ½ cup of green beans, ½ cup cinnamon scalloped peaches, 4 ounces milk, and 8 ounces beverage of choice".

Interview with the Second Cook on 6/16/16 at 8:35 a.m. revealed:
-She had cooked the day the resident had choked during the supper meal.
-She was told by the Dietary Manager to "give every resident the chopped barbecue except for the pureed diets'.
-The resident was served "chopped barbecue" which was not on the menu.
-The resident was served green string beans as well which were on the menu.
-The different Dietary Managers had instructed her to prepare mechanical soft diets in different ways. She prepared the food for all residents as she was told to do so verbally by the Dietary Managers.
-She was aware of the menu book but did not follow the menu book for mechanical soft diets as written.
-The Dietary Manager orders all of the food for the residents.
-There was no substitution list available to note this substitution.
-She was not sure if the resident had choked on both the "chopped barbecue and green string beans" because she had witnessed EMS pulling

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both food items out of his mouth.
-She started using the menu book after Resident #5's choking incident and since the new Executive Director started at the facility about a month ago.

Interview with the first Cook on 06/15/16 at 3:15 p.m. revealed:
-He was verbally told what to cook by the Dietary Manager.
-Mechanical soft diet preparations were shared verbally by the other cook and Dietary Manager.
-He was not aware of where the menu book was located and cooked "what he was told to cook".
-He was not the cook the day Resident #5 choked.
-He was working the day of the incident with Resident #5 and was told the resident had choked on "green beans" but was not sure.
-He was told green beans "do not need to go in the blender for mechanical soft diet textures" by the Dietary Manager.
-He puts all "green beans" for mechanical soft diets in the blender since the choking incident involving Resident #5.
-He does not purchase the food for the residents.
-The Dietary Manager orders all of the food.
-There had been three different dietary managers at the facility since March 2016.
-He could not locate a substitution list and said to ask the other cook.

Telephone interview with the previous Dietary Manager on 6/20/16 at 4:15 p.m. revealed:
-He was off duty the day Resident #5 had choked.
-The corporate office for the facility had prepared the menu book they went by which was in the facility kitchen.
-All mechanical soft and regular diets could

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receive the "roasted pulled pork which was chopped meat".
-The "roasted pulled pork" was on the Winter/Fall menu and was not a substitution the day of the incident.
-He ordered the food for the facility when he was there and made "sure the food ordered matched the menus".

Interview with the Dietary Manager on 06/20/16 at 10:13 a.m. revealed:
-She started working at the facility four weeks ago.
-The handwritten menu sheets on the clipboard for the cooks were written by her.
-She had written down lists of food items for the cooks to prepare each day while she was on vacation.
-Her "dietician friend" suggested she "get rid of the excess food she had so she made the lists to get rid of the extra food".
-Most of the food items listed on the "handwritten sheets" were in the menu book.
-The handwritten menu sheets without dates were from her first week working at the facility.
-The menu book was there in the kitchen for staff to use if they needed it.
-The menu book was there at the facility before she had gotten there and staff should have known to follow it.
-She understood that the handwritten food lists and menus book were not the same for each day because she had not specified food textures or modifications for any of the residents or listed what was noted in the menu book for each day.
-She "shadowed" the kitchen staff prior to leaving for vacation to ensure proper preparation of food according to the menu book for all residents.

Interview with the Speech Pathologist on 6/15/16

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D 310	Continued From page 13 at 12:55 p.m. revealed: -Resident #5 had orders for a pureed diet when admitted to the facility. -The resident "worked his way up to a mechanical soft diet". -Resident #5 was "cognitively able to manage a mechanical soft diet". Interview with the Medication Aide (MA) on 6/16/16 at 3:00 p.m. revealed: -She was working on the date Resident #5 ' s incident had occurred. -She was asked by the Executive Director to come over to the dining room area to assist as needed with the incident when the resident was choking. -She witnessed the food being removed from [Resident #5's name] airway. -She did not perform CPR but was asked to be there for "back up". Interview with the Resident Care Coordinator (RCC) on 6/16/16 at 11:10 a.m. revealed: -She sent all therapeutic diet order modifications and changes to the doctor for review. -All staff were expected to follow the diet orders for all residents. -Staff had access to the resident charts and bulletin boards in the kitchen which had pictures, names, and diet textures for all residents at the facility. -She put a sheet in the cabinet facing the bar area of the dining room with all resident names and current diet orders listed. -She informed staff of any diet changes at the beginning of each daily shift. -She was not involved with the food ordering and preparation. -She expected staff in the kitchen to ensure proper diet consistency and communicate with	D 310		

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D 310	Continued From page 14 the floor staff as food was being served. Interview with the Executive Director on 6/16/16 at 11:33 a.m. revealed: -She had no role in the therapeutic diet process to include ordering of food. -Once a diet order was received, it was placed in the residents' record and a copy posted for staff to access. -A seating chart was also available to all staff that included residents ' names and diet textures. -She expected all diets to be followed as prescribed in the menu book. 2. Review of Resident #4's FL2 dated 3/31/16 revealed diagnoses of Polymyalgia Rheumatic, High Blood Pressure, Hyperlipidemia, Gout, Drossiness/Giddiness, Anemia, Cancer external ear canal. Review of the facility standard diet list dated 4/18/16 for Resident #4 revealed: -" NAS" diet was circled and was noted in parenthesis as (no added salt) -"Mechanical soft"was circled around and in parenthesis (ground meat, no raw fruit or vegetables, bread is allowed. This is a general diet with ground meat). Observation of the lunch meal for Resident #4 on 6/15/16 at 12:20 p.m. revealed: -The resident received chicken pastry. -The chicken pastry was not modified. -There were chunks of chicken in the pastry. Review of the Facility menu on 6/15/16 revealed: -mechanical soft diets, were supposed to receive "#8 scoop ground pot roast with #8 scoop pureed oven browned potatoes, ½ cup baby carrots, #20	D 310		

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D 310	Continued From page 15 scoop pureed dinner roll or bread, 1 packet margarine, 2 x 3 square red velvet cake moistened with 2-4 tablespoons milk, coffee, juice, and allow time to absorb, 4 fluid ounces of milk, and 8 fluid ounces of beverage of choice". Review of the facility menu on 6/15/16 revealed: -mechanical soft diets were supposed to received "no packet of saltine crackers, #8 scoop ground egg salad or ½ scoop tuna salad with no raw vegetables, #20 scoop pureed bread, ½ cup green and wax beans, 1 sugar cookie, 4 fluid ounces of milk, and 8 fluid ounces of beverage of choice." Observation of the dinner meal for Resident #4 on 6/15/16 at 6:15 p.m. revealed: -The resident received egg salad. -The egg salad was not modified. -There were chunks of egg whites in the salad. Interview with the Resident Care Coordinator (RCC) on 6/16/16 at 11:10 a.m. revealed: -She sent all therapeutic diet order modifications and changes to the doctor for review. -All staff were expected to follow the diet orders for all residents. -Staff had access to the resident charts and bulletin boards in the kitchen which had pictures, names, and diet textures for all residents at the facility. -She put a sheet in the cabinet facing the bar area of the dining room with all resident names and current diet orders listed. -She informed staff of any diet changes at the beginning of each daily shift. -She was not involved with the food ordering and preparation. -She expected staff in the kitchen to ensure proper diet consistency and communicate with	D 310		

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D 310	Continued From page 16 the floor staff as food was being served. Interview with the Executive Director on 6/16/16 at 11:33 a.m. revealed: -She had no role in the therapeutic diet process to include ordering of food. -Once a diet order was received, it was placed in the residents' record and a copy posted for staff to access. -A seating chart was also available to all staff that included residents ' names and diet textures. -She expected all diets to be followed as prescribed in the menu book. 3. Review of Resident #7's FL2 dated 03/09/16 revealed diagnoses of Dementia, Right hip fracture, Diastolic heart failure, Hypotension, Acute Kidney failure, Urinary Tract Infection. Review of the facility standard diet list dated 4/21/16 for Resident #7 revealed: -"General" diet (general diet was designed for people who require no dietary modifications). -"Mechanical soft" (ground meat, no raw fruit or vegetables, bread is allowed. This is a general diet with ground meat). Review of the Facility menu on 6/15/16 revealed: -mechanical soft diets, were supposed to receive "#8 scoop ground pot roast with #8 scoop pureed oven browned potatoes, ½ cup baby carrots, #20 scoop pureed dinner roll or bread, 1 packet margarine, 2 x 3 square red velvet cake moistened with 2-4 tablespoons milk, coffee, juice, and allow time to absorb, 4 fluid ounces of milk, and 8 fluid ounces of beverage of choice." Observation of the lunch meal for Resident #4 on 6/15/16 at 12:20 p.m. revealed: -The resident received chicken pastry.	D 310		

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D 310	Continued From page 17 -The chicken pastry was not modified. -There were chunks of chicken in the pastry. Review of the facility menu on 6/15/16 revealed: -mechanical soft diets were supposed to received "no packet of saltine crackers, #8 scoop ground egg salad or ½ scoop tuna salad with no raw vegetables, #20 scoop pureed bread, ½ cup green and wax beans, 1 sugar cookie, 4 fluid ounces of milk, and 8 fluid ounces of beverage of choice". Observation of the dinner meal for Resident #7 on 6/15/16 at 6:15 p.m. revealed: -The resident received egg salad. -The egg salad was not modified. -There were chunks of egg whites in the salad. Interview with the Resident Care Coordinator (RCC) on 6/16/16 at 11:10 a.m. revealed: -She sent all therapeutic diet order modifications and changes to the doctor for review. -All staff were expected to follow the diet orders for all residents. -Staff had access to the resident charts and bulletin boards in the kitchen which had pictures, names, and diet textures for all residents at the facility. -She put a sheet in the cabinet facing the bar area of the dining room with all resident names and current diet orders listed. -She informed staff of any diet changes at the beginning of each daily shift. -She was not involved with the food ordering and preparation. -She expected staff in the kitchen to ensure proper diet consistency and communicate with the floor staff as food was being served. Interview with the Executive Director on 6/16/16	D 310		

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D 310	Continued From page 18 at 11:33 a.m. revealed: -She had no role in the therapeutic diet process to include ordering of food. -Once a diet order was received, it was placed in the residents' record and a copy posted for staff to access. -A seating chart was also available to all staff that included residents ' names and diet textures. -She expected all diets to be followed as prescribed in the menu book. 4. Review of Resident #8's FL2 dated 04/21/16 revealed a diagnosis of Dementia with behavior disturb, Mental Disorder, Hypo-molality, High Blood Pressure, Acute Kidney failure, oropharyngeal, History of Urinary Tract Infection. . Review of the facility standard diet list dated 4/21/15 for Resident #8 revealed: - "General" diet was noted as a diet designed for people who require no dietary modifications. -"Mechanical soft" was noted and in parenthesis (ground meat, no raw fruit or vegetables, bread is allowed. This is a general diet with ground meat). Review of the facility menu on 6/15/16 revealed: -mechanical soft diets, were supposed to receive "#8 scoop ground pot roast with #8 scoop pureed oven browned potatoes, ½ cup baby carrots, #20 scoop pureed dinner roll or bread, 1 packet margarine, 2 x 3 square red velvet cake moistened with 2-4 tablespoons milk, coffee, juice, and allow time to absorb, 4 fluid ounces of milk, and 8 fluid ounces of beverage of choice." Observation of the lunch meal for Resident #4 on 6/15/16 at 12:20 p.m. revealed: -The resident received chicken pastry. -The chicken pastry was not modified. -There were chunks of chicken in the pastry.	D 310		

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D 310	Continued From page 19 Review of the facility menu on 6/15/16 revealed: -mechanical soft diets were supposed to received "no packet of saltine crackers, #8 scoop ground egg salad or ½ scoop tuna salad with no raw vegetables, #20 scoop pureed bread, ½ cup green and wax beans, 1 sugar cookie, 4 fluid ounces of milk, and 8 fluid ounces of beverage of choice." Observation of the dinner meal for Resident #8 on 6/15/16 at 6:15 p.m. revealed: -The resident received egg salad. -The egg salad was not modified. -There were chunks of egg whites in the salad. Interview with the Resident Care Coordinator (RCC) on 6/16/16 at 11:10 a.m. revealed: -She sent all therapeutic diet order modifications and changes to the doctor for review. -All staff were expected to follow the diet orders for all residents. -Staff had access to the resident charts and bulletin boards in the kitchen which had pictures, names, and diet textures for all residents at the facility. -She put a sheet in the cabinet facing the bar area of the dining room with all resident names and current diet orders listed. -She informed staff of any diet changes at the beginning of each daily shift. -She was not involved with the food ordering and preparation. -She expected staff in the kitchen to ensure proper diet consistency and communicate with the floor staff as food was being served. Interview with the Executive Director on 6/16/16 at 11:33 a.m. revealed: -She had no role in the therapeutic diet process	D 310		

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to include ordering of food.
-Once a diet order was received, it was placed in the residents' record and a copy posted for staff to access.
-A seating chart was also available to all staff that included residents ' names and diet textures.
-She expected all diets to be followed as prescribed in the menu book.

5. Review of Resident #9's FL2 dated 6/18/15 revealed diagnoses of seizures, asthma, urinary tract infections recurrent, Hypercalcemia, history of constipation.

Review of the facility standard diet list dated 8/11/15 for Resident #9 revealed:
-"general" diet was noted for people who require no dietary modifications.
-"Puree" was noted (whole plate is pureed).

Review of the facility menu on 6/16/16 revealed:
-The menu called for "pureed" diets to receive "½ cup pureed hot cereal and #16 scoop pureed egg.

Observation of the breakfast meal for Resident #9 on 6/16/16 at 8:30 a.m. revealed:
-Regular oatmeal and eggs were served to all diet textures.
-The oatmeal and eggs were not modified.

Interview with the Resident Care Coordinator (RCC) on 6/16/16 at 11:10 a.m. revealed:
-She sent all therapeutic diet order modifications and changes to the doctor for review.
-All staff were expected to follow the diet orders for all residents.
-Staff had access to the resident charts and bulletin boards in the kitchen which had pictures, names, and diet textures for all residents at the

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facility.
-She put a sheet in the cabinet facing the bar area of the dining room with all resident names and current diet orders listed.
-She informed staff of any diet changes at the beginning of each daily shift.
-She was not involved with the food ordering and preparation.
-She expected staff in the kitchen to ensure proper diet consistency and communicate with the floor staff as food was being served.

Interview with the Executive Director on 6/16/16 at 11:33 a.m. revealed:
-She had no role in the therapeutic diet process to include ordering of food.
-Once a diet order was received, it was placed in the residents' record and a copy posted for staff to access.
-A seating chart was also available to all staff that included residents ' names and diet textures.
-She expected all diets to be followed as prescribed in the menu book.

6. Review of Resident #10's FL2 dated 7/28/15 revealed diagnoses of altered mental status, atrial fib, history of falls, anxiety, hyperlipidemia, high blood pressure, coronary artery disease, hypothyroidism.

Review of the facility standard diet list dated 4/21/16 for Resident #10 revealed:
- "General" diet was noted and designed for people who require no dietary modifications.
-"Puree" was noted (whole plate is pureed).

Review of the facility menu on 6/16/16 revealed:
-The menu called for "pureed" diets to receive "½ cup pureed hot cereal and #16 scoop pureed egg.

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D 310	Continued From page 22 Observation of the breakfast meal for Resident #10 on 6/16/16 at 8:30 a.m. revealed: -Regular oatmeal and eggs were served to all diet textures. -The oatmeal and eggs were not modified. Interview with the Resident Care Coordinator (RCC) on 6/16/16 at 11:10 a.m. revealed: -She sent all therapeutic diet order modifications and changes to the doctor for review. -All staff were expected to follow the diet orders for all residents. -Staff had access to the resident charts and bulletin boards in the kitchen which had pictures, names, and diet textures for all residents at the facility. -She put a sheet in the cabinet facing the bar area of the dining room with all resident names and current diet orders listed. -She informed staff of any diet changes at the beginning of each daily shift. -She was not involved with the food ordering and preparation. -She expected staff in the kitchen to ensure proper diet consistency and communicate with the floor staff as food was being served. Interview with the Executive Director on 6/16/16 at 11:33 a.m. revealed: -She had no role in the therapeutic diet process to include ordering of food. -Once a diet order was received, it was placed in the residents' record and a copy posted for staff to access. -A seating chart was also available to all staff that included residents ' names and diet textures. -She expected all diets to be followed as prescribed in the menu book.	D 310		

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D 310	Continued From page 23 7. Observations of the facility storage room on 6/15/16 at 10:25 a.m. revealed no nectar thickened milk was in the facility. Observation of the Cook on 6/15/16 at 12:20 p.m. revealed the cook had prepared a small 8 ounce clear plastic cup with a " watered milk like liquid in it. Review of facility food vendor receipts dated 6/05/16 and 6/15/16 revealed: - One case containing 27 nectar thickened milk was ordered on each date. According to the menu, milk was supposed to be served three meals a day. Review of facility diet lists used for diet orders revealed the following 3 residents had orders for thickened Liquids: -Resident #7 had an order dated 04/21/16 for Nectar Thickened Liquids. -Resident #8 had an order dated 04/21/16 for Nectar Thickened Liquids. -Resident #9 had an order dated 04/18/16 for Nectar Thickened Liquids Interview with Resident #9 ' s guardian on 6/15/16 at 12:40 p.m. revealed: -The resident was supposed to receive nectar thickened milk " but the facility was out. " -The cook had tried to " fix her some by adding water to the honey kind of milk but it wasn ' t right. " -He said the facility ran out of her nectar thickened milk " often " but that it was " okay. " -He tried to come for at least one meal each day to make sure she was eating and drinking well. -He said she coughs at times when she gets the " made milk " instead of the nectar thickened	D 310		

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D 310	Continued From page 24 milk. Interview with the Cook on 06/15/16 at 3:15 p.m. revealed: -He does not purchase the thickened liquids for the residents. -The Dietary Manager orders all of the thickened liquids. -There had been three different dietary managers at the facility since March 2016. -The facility has been out of the nectar thickened milk for "almost two weeks now." -He said the facility "does not order enough of the nectar thickened milk to last between orders because the residents get the nectar thickened milk three times a day, 7 days a week." -The Medication Aides (MAs) usually prepared the "nectar thickened liquids when the facility was out of them." -He added water to "honey thickened milk" in an attempt to make the nuclear thickened milk for the residents. -He tried to "gauge" or "eye ball" the water added to the honey thickened milk to get it as close as possible to the nectar thickened milk consistency. -This was not a "common practice" of his but the facility "was out of the nectar thickened milk and he knew the resident needed it. " -The dietary manager was on vacation and he would let her know she needed to order more of the nectar thickened milk when she returned. Interview with the Dietary Manager on 06/20/16 at 10:13 a.m. revealed: -She started working at the facility four weeks ago. -She ordered all of the thickened liquids for the residents at the facility. Interview with the Resident Care Coordinator	D 310		

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D 310	Continued From page 25 (RCC) on 6/16/16 at 11:10 a.m. revealed: -All staff were expected to follow the diet orders which include thickened liquid modifications for all residents. -Staff had access to the resident charts and bulletin boards in the kitchen which had pictures, names, diet textures, and thickened liquids as prescribed for all residents at the facility. -She was not involved with the thickened liquid ordering and preparation if needed. -The MAs prepared the thickened liquids when needed but the liquids were usually ordered already prepared by the dietary manager. -She expected staff in the kitchen to ensure proper thickened liquid consistency and to communicate with the floor staff any changes. Interview with the Executive Director on 6/16/16 at 11:33 a.m. revealed: -She had no role in the therapeutic diet process to include ordering of thickened liquids for the residents. -She expected all diets including thickened liquid modifications to be followed as prescribed in the menu book. -She was unaware there was not enough nectar thickened milk to last between the two week ordering periods. -She would speak with the dietary manager and cook to order 2 more cases of the nectar thickened milk to ensure it lasts beyond the two week ordering cycle. ---------- The facility provided a Plan of Protection on 6/16/16 as follows: -The Area Director of Clinical services immediately in-serviced staff on new procedure. One staff to look at posted diet spread sheet and the other staff to ensure that resident receives proper diet/liquids.	D 310		

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D 310	Continued From page 26 -Dietary staff/cook to follow diet consistency recipes and indicated provided. -Contract Nurse will in-service Medication Aides on mixing of powder thickener of proper consistency with return demonstration. -A copy of the food service spreadsheet has been provided with diets offered and highlighted for easy reference for staff. CORRECTION DATE FOR THEY TYPE A1 VIOLATION SHALL NOT EXCEED JULY 20,2016.	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: Based on observations, interviews and record reviews the facility failed to assure medication were administered as ordered, and facility's policy and procedures for administration 1 of 6 sampled residents (#11) related to the medication aide mixing crushed medications into the resident's food and another resident (#5)ate a portion of the residents's food. The finding are: Review of Resident #11 ' s current FL-2 dated	D 358		

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D 358	Continued From page 27 3/22/16 revealed Diagnoses included Alzheimer's Dementia, coronary artery disease, osteoarthritis, and rhabdomyolysis. Review of physician orders for Resident #11 revealed: -Cogentin 0.5mg (Cogentin treat the symptoms of Parkinson's disease and tremors caused by other medical problems or drugs) -Prolixin 1.25 mg (Prolixin is used to treat schizophrenia) -Lamictal 100 mg (Lamictal in used to treat certain types of seizures in patients who have epilepsy) -Melatonin 9 mg (Melatonin is used to induce sleep) - Ambien 10 mg (Ambien is used to treat insomnia). -Physician order dated 6/9/16 for Norco 5/325mg once a day (Norco is used to relieve moderate-to-severe pain) -There was no documentation that Resident #11's evening medications had been administered as ordered on 5/27/16. Review of Resident #5's record revealed: -On 5/27/16 at 7:40pm, "[Resident #11 name] was eating their medication mixed in, per power of attorney request, when the family member turned away from the plate, [Resident #5 name] ate Resident #11 ' s dinner with approximately 10% of the medications still in it." Telephone Interview with Resident #5 ' s family member on 6/16/16 revealed: -"I received a telephone call that he ate someone else meal that had medication in the food ". -The caller stated it had a mild medication for agitation and pain killer in the food.	D 358		

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D 358	Continued From page 28 Interview with medication aide (MA) on 6/20/16 at 4:15pm revealed: - "I was administering medication on 5/27/16". -[Resident #11's name] night time medications were crushed and placed in mashed potatoes during the dinner meal. The resident's daughter was present. -The MA was called away to assist another resident. -"When I returned the resident's family member stated [Resident #5 name] ate [Resident #11's name] that had medication in it". -The medication aide notified the physician and Executive Director. Interview with the Executive Director on 6/20/16 at 4:15 pm revealed: -The medication aides are supposed to remain with the resident until the medication had been administered. Review of the facility medication management plan section I (medication administration) revealed: -The recording of administration of medication shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents	D 375		

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D 375	Continued From page 29 who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 1 sampled residents (#1), who self-administered medications, had physician orders to self-administer medications. The findings are: Review of Resident #1's FL2 dated 3/07/16 revealed : -Diagnoses included Hyperlipidemia, Cough, Gastro-esophageal, Pain in limb, Reflux disease without esophagus, Coronary Artery Disease and Pain unspecified. -There were no orders to self-administer medications. Review of Resident Register dated 5/05/16 revealed the resident was admitted to the facility on 11/01/15. Observation of the Resident #1's room open shelving area in bathroom on 6/15/16 at 10:35 a.m. revealed: -Ten over-the-counter (OTC) medications were on the open shelf in the resident's bathroom.	D 375		

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D 375	Continued From page 30 -The OTC medications were heartburn relief chews for heartburn, Ranitidine (2 bottles) for stomach acid, Advil PM for minor aches and pains, Centrum multivitamins for a nutritional supplement, Stool softener to treat or prevent constipation, Dulcolax to treat or prevent constipation, Anti-diarrhea medication (2 bottles) to prevent diarrhea, and Bayer low dose aspirin for to prevent heart issues. Interview with Resident #1 on 6/16/16 at 3:45 p.m. revealed: -The ten over-the-counter medications were his and "it was his right to have them." -Resident said the doctor was not aware he had the medications in his room. -He took the medications when he felt he needed them because he knew how to take medications. Interview with the Medication Aide (MA) for Resident #1 on 6/16/16 at 4:05 p.m. revealed: -She was not aware the resident had over-the-counter medications in his room. -No one had informed her the resident had OTC medications. -She would ask the resident about the OTC medications observed in his room. Interview with the Resident Care Coordinator (RCC) for Resident #1 on 6/16/16 at 4:20 p.m. revealed: -She was unaware the resident had OTC medications in his room until the MA had informed her a few minutes ago. -Residents were not allowed to have OTC medications in their rooms unless approved by the doctor to self-administer. -The resident was not approved by the doctor to self-administer the OTC medications observed in his room.	D 375		

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D 375	Continued From page 31	D 375		

-She would speak with the resident about having the doctor to approve him administering the OTC medications.
-She informed the resident she was going to contact his family regarding him having OTC medications in his room without the doctor's assessment and approval.
-The resident agreed to have the doctor talk with him and assess his ability to administer his medications.
-She was not aware of a facility self-administration of medications policy.

Interview with the Nurse Practitioner (NP) for Resident #1 on 6/17/16 at 12:00 p.m. revealed:
-She was not aware the resident had OTC medications in his room until the RCC had informed her.
-She said the resident was not taking those OTC medications but felt better having them just in case he needed them.
-The residents OTC medications were locked on the medication cart until the doctor talked with the resident.
-She said the resident's family had talked with him on last night and he gave his OTC medications to the MA to keep on her cart until the doctor could talk with him.
-She thought the resident had the cognitive ability to self-administer his medications.
-A list of all of the resident's OTC medications were faxed that morning to the doctor for assessment and approval for the resident to self-administer medications.

Interview with the Regional Representative for the facility on 6/17/16 at 12:30 p.m. revealed:
-She was not aware of any resident in the facility who was self-administrating their own mediations.
-Resident #1 had not been assessed or approved

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D 375	Continued From page 32	D 375		

by the doctor to self-administer his medications.
-There was no facility policy on self-administering medications or on having OTC medications in their rooms.
-She was working with the executive director to develop a facility policy for self-administering medications.
-Routine room checks were not performed at the facility.
-A fax requesting the doctor's approval for Resident #1 to self-administer medications had been sent that morning.

Interview with the Executive Director for Resident #1 on 6/17/16 at 12:45 p.m. revealed:
-She was not aware the resident had and was self-administering OTC medications without a doctor's approval.
-There was not a facility policy on self-administering medications.
-She was informed that a fax was sent to the doctor of the resident's OTC medications for approval to self-administer.
-The resident's OTC medications were on the medication chart until the doctor could approve him self-administering them.
-She had spoken with the resident and he understood the doctor would talk with him to determine if he was able to self-administer his medications.

Interview with the Doctor for Resident #1 on 6/20/16 at 4:56 p.m. revealed:
-He was made aware the resident was self-administering OTC medications during his visit to the facility on today.
-The fax from the facility nurse practitioner may have went to the shared office area for the resident.
-The doctor approved the resident to

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D 375	Continued From page 33 self-administer medications and had talked with the resident. -The resident had the capacity and was competent to administer his own medications. -The doctor discontinued medications at the facility that were doubled for the resident to self-administer to include Aspirin, Ranitidine, and Vitamin D3 Supplement.	D 375		
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 observations, interviews and record review, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to physical environment. The findings are: Based on observations, interviews and record reviews, the facility failed to assure the memory care unit short hall and long hall exit doors were equipped with a sounding device that activated when the doors were open resulting in 2 of 2 residents (#3,and #6) exiting the memory care unit without staff awareness[Refer to Tag D067. 10A NCAC 13F .0305(h)(4) (Type A2 Violation)].	D912		

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D914	Continued From page 34	D914		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility neglected to serve therapeutic diets as ordered. The findings are: Based on observations, interviews and record review, the facility failed to serve mechanical soft diets for 4 of 4 residents (#4,#5,#7,#8) which included one resident (#5) who choked and later died, 2 of 2 residents with orders for puree diets (#9, #10) and 3 of 3 residents with orders for nectar thick liquids (#7,#8 and #9). [Refer to tag D 310, 10A NCAC .0904(e)(4)(Type A1 Violation)].	D914		