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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINT HILL SENIOR LIVING	10830 LAWYERS ROAD CHARLOTTE, NC 28227

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual, follow-up and complaint investigation survey on October 17 - 18, 2018. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on September 27, 2018.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the facility was hazard free as evidenced by eleven oxygen cylinders being stored in a free-standing, unsecured manner without stands or storage racks. Observation of a oxygen storage room located on the right side of the hall near the reception desk on 10/17/18 at 10:30am revealed: -There was no staff in the room. -There were five unsecured, free-standing, full oxygen cylinders sitting upright along the counter of the rear wall with a gauge on them. -The storage room contained fifteen other full oxygen cylinders in storage racks.	D 079		

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D 079	Continued From page 1 Observation of resident room 115 on 10/17/18 at 9:57am revealed: -The door was open. -There was no sign on the resident's room door indicating of warning that oxygen was in use. -There were two unsecured, fully charged, home-fill type C-oxygen cylinders sitting on the floor along the rear wall of the room, in front of the entrance to the resident's wardrobe. Observation of resident room 212 on 10/17/18 at 11:00am revealed: -The door was open. -There was an oxygen in use warning sign on the resident's door. -There were two unsecured, free-standing, full oxygen cylinders sitting on the floor along the resident's dresser on the entrance wall of the room. -There were two unsecured home-fill type C-oxygen cylinders sitting on the floor beside the resident's oxygen compressor. Interview with the medication aide (MA) on 10/17/18 at 10:15am revealed: -The "oxygen man" must have dropped off the oxygen cylinders and left them in room 115 and 213, during third shift yesterday. -She did not know how long the oxygen cylinders had been stored unsecured, and why they had not been moved to the oxygen storage room. -She had not seen the oxygen cylinders in the resident's room. -She knew they were to be stored in a stand or storage rack. Interview with the Resident Care Manager (RCM) on 10/17/18 at 3:45pm revealed: -The oxygen company had delivered the oxygen	D 079		

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cylinders to room 115 and 213 for emergency back up if the facility lost power.
-Staff had signed for the delivery and had not moved the oxygen cylinders to the oxygen storage room and secured them in a rack.
-The oxygen cylinders were not supposed to be unsecured; the cylinders were supposed to be stored in the locked oxygen storage room in a rack with a base.
-She did not know how long the oxygen cylinders had been freestanding and unsecured.

Telephone interview with the oxygen supply representative on 10/22/18 at 2:00pm revealed:
-Oxygen and supplies were delivered to each resident's room when orders or requests were received from the facility.
-When oxygen and supplies were delivered the resident or facility staff signed for the delivery.
-Education on usage and set up of the equipment was provided to the staff member receiving the delivery.
-The person receiving oxygen and supplies was educated about the importance of securing stand alone cylinders, and c-tanks used for home fill systems to prevent them from damage and combustion.
-If an oxygen cylinder was left unsecured and fell over it could explode or become a missile type object.
-The facility was suppose to contact them and request excess cylinders that had no rack for securing them to be returned.

Interview with the Administrator on 10/18/18 at 9:00am revealed:
-She acknowledged the free standing oxygen cylinders were a safety concern.
-The oxygen cylinders were supposed to be stored in racks.

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D 079	Continued From page 3 -All staff knew how the oxygen was supposed to be stored, and the oxygen cylinders should not have had been left unsecured. -She routinely rounded the facility daily, but she had not visited the resident's rooms with oxygen, and the oxygen storage room.	D 079		
D 288	10A NCAC 13F .0904(b)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (3) Hot foods shall be served hot and cold foods shall be served cold. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to assure hot foods were maintained hot until served to the residents in the special care unit. The findings are: Observation of the kitchen on 10/17/18 from 11:40am-11:55am revealed: -The Dietary Manager (DM) was arranging the food on plates for the residents in the special care unit (SCU). -The food was covered with a silver tin cover by the DM. -The first resident plate was completed and placed onto the cart at 11:45am. -The last plate was put into the cart at 11:55am. -The prepared plates were not kept warm prior to being served to the residents in the SCU. -There was a food warmer present, but was not used by the DM.	D 288		

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D 288	Continued From page 4 Observation of the lunch meal in the SCU on 10/17/18 between 11:55am and 12:55pm revealed: -A multi-tiered cart was transported from the kitchen to the SCU at 11:55am. -The multi-tiered cart was uncovered and had no insulation. -At 12:00pm the staff began seating residents at the dining room table. -At 12:07pm the staff began serving the residents. -At 12:15pm a resident was served a plate and requested that staff warm her food in the microwave. -Staff warmed the resident's plate in the microwave for 30 seconds. -Staff did not ask other residents about the temperature of their food. -A resident who required feeding assistance received her meal at 12:30pm. -The last plate was served at 12:40pm. -Staff did not check the temperature of any of the residents food. Observation of the kitchen on 10/18/18 from 11:45am-12:00pm revealed: -The DM was arranging the food on plates for the residents in the SCU. -The food was covered with a silver cover by the kitchen manager. -The first resident plate was completed and placed into the cart at 11:50am. -The last plate was put into the cart at 11:59am. -The prepared plates were not kept warm prior to being served to the residents in the SCU. -There was a food warmer present but was not used by the kitchen manager. Observation of the lunch meal in the SCU on 10/18/18 between 12:00pm and 1:00pm revealed:	D 288		

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-The food cart arrived on the SCU at 12:05pm.
-The first plate served to a resident was at 12:15pm.
-At 12:25pm a personal care aide (PCA) served a plate that was cool to touch to a resident from the food cart.
-At 12:25pm the residents' food temperature was taken with a digital thermometer provided by the Dietary Manager (DM), it was 87.6 degrees Fahrenheit (F).
-At 12:26pm the PCA was notified of the temperature of the food, she placed food in the microwave and warmed it for 30 seconds.

Interview with a resident who resided in the SCU on 10/18/18 at 9:17am revealed:
-Her food was "sometimes" cold when served by staff.
-She usually asked staff to place her food in the microwave to warm it up.
-She did not like cold food," I want it to be hot".

Interview with a second resident who resided in the SCU on 10/18/18 at 5:26pm revealed that sometimes the food cold, "I would like for it to always be hot".

Interview with the DM on 10/18/18 at 11:45am revealed:
-He usually started plating the SCU plates at around 11:45am.
-He did not have an insulated food cart to keep the food warm.
-The electric warmer in the kitchen was no longer working and it have been broken for "several weeks".
-He used the silver plate covers to keep the food warm.
-He plated the food as fast as he could to keep the food warm.

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-He used a thermometer to check the temperature of the food before it was plated, and it was always at 140 degrees F. or above.
-He served SCU food first so that it could be available to serve to the residents by 12:00pm.
-He did not know how long it took staff to served food to the residents in the SCU.
-He mentioned the need for a food warmer to the Administrator and he was told that he could get a new warmer next year.

Interview with a personal care aide (PCA) on 10/17/18 at 12:36pm revealed:
-The residents in the SCU were served first.
-The food was not always served hot because of the time between preparation and transport to the SCU.
-There was only her and another PCA and the SCU Manager available to seat and serve residents.
-"We try our best to serve as quickly as possible".
-The silver plate covers were the only way to keep food warm.
-The microwave was available and was used if the resident asked for their food to be warmed.

Interview with the SCU Manager on 10/17/18 at 12:40pm revealed:
-She assisted staff with serving plates to the residents in the SCU.
-She tried to have everyone served timely, but sometimes it was difficult getting everyone seated.
-She relied on the DM to ensure that food was at the proper temperature.
-She did not have any residents complain to her about the food temperature.
-If a plate was cold to touch, staff should request another plate of the food to be warmed in the kitchen.

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D 288	Continued From page 7 Interview with the Administrator on 10/18/18 at 2:49pm revealed: -She expected food to be served to the SCU first. -She expected the food to be served hot to the residents, within proper temperature. -She did not know the food warmer was not working.	D 288		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 sampled residents (Resident #6) with physician orders for a mechanical soft diet with nectar thickened liquids. The findings are: Review of Resident #6's current FL2 dated 05/01/18 revealed diagnoses included unspecified dementia without behavior disturbances, malaise, encephalopathy, generalized osteoarthritis, and hypertension.	D 310		

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D 310	Continued From page 8 Review of Resident Register revealed Resident #6 was admitted to the facility on 05/09/18. 1. Review of Resident #6's physician's diet order revealed an order dated 05/15/18 for a mechanical soft diet. Review of the therapeutic diet list posted in the kitchen on 10/17/18 revealed Resident #6 was to be served a mechanical soft diet. Review of the therapeutic diet menu for lunch on 10/17/18 revealed residents on a mechanical soft diet were to be served ground oven roasted pork with gravy, mashed potatoes, collard greens with no bacon, beverage choice at ordered thickness, and apple pie. Observation of the kitchen on 10/17/18 at 11:40am revealed: -The Dietary Manager (DM) used a food processor to prepare ground chicken. -The DM did not have gravy prepared in the kitchen for residents ordered a mechanical soft diet. -The DM prepared Resident #6's plate for lunch. Observation of lunch meal on 10/17/18 at 12:36pm revealed: -Resident #6 was served ground chicken on a bun without gravy, sliced cheese, green beans, and mashed potatoes. -Resident #6 was assisted with her meal by a personal care aide (PCA). -Resident #6 consumed 50% of the meal without difficulty. Interview with a PCA on 10/17/18 at 12:20pm revealed:	D 310		

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-She knew Resident #6's diet was mechanical soft.
-She assisted Resident #6 with her meals and she did not have any complications.
-She got all meals from dietary already prepared.
-She could not remember if residents who received mechanical soft were served gravy.
-The Dietary Manager (DM) was responsible for preparing all meals.

Interview with Resident #6's Primary Care Provider (PCP) on 10/18/18 at 11:26am revealed:
-Resident #6 was ordered a mechanical soft diet because that was the order from the previous physician at another facility.
-She had no knowledge of Resident #6 receiving a swallow study and did not have any medical evaluation to reference for swallowing complications.
-She continued the mechanical soft diet with nectar thickened liquids as a precaution.
-She had not ordered a speech therapy recommendation since Resident #6 was admitted.
-She expected Resident #6 to continue to receive mechanical soft diet with nectar thickened liquids.

Interview with the Special Care Unit (SCU) Manager on 10/17/18 at 12:40pm revealed:
-She was not aware the meal given to Resident #6 was served without gravy.
-She thought the mechanical soft diet was prepared correctly for Resident #6.
-The dietary staff was responsible for preparing the meals for all of the residents.

Interview with the DM on 10/17/18 at 12:50pm revealed:
-He had worked in the facility as the DM for 2 months.

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-He completed online training and the state food service training when he was first hired.
-He had not received training from the contracted food service company regarding the menus.
-He prepared all the meals for the residents.
-He knew Resident #6's diet was listed as being mechanical soft on the therapeutic diet list.
-He prepared Resident #6's chicken by using a food processor.
-The therapeutic diet extension spreadsheet and recipes were available to use in the facility.
-He never used the recipe or therapeutic spreadsheet as a guide to prepare a mechanical soft meal.
-He did not know the mechanical soft spreadsheet listed gravy to be served with the ground meat.
-He used his prior experience to prepare a mechanical soft diet for residents.

Interview with the Registered Dietician (RD) on 10/18/18 at 10:50am revealed:
-She was the RD for the contracted food service company.
-She reviewed and approved the therapeutic diet extension spreadsheet for the facility.
-The diet spreadsheet should be used to prepare a therapeutic diet accurately.
-Residents who received a mechanical soft diet should have received gravy on the ground meat.
-The gravy would make the meat palatable and if a resident had dysphagia, it would prevent choking.
-The gravy should be used to make the food taste better.
-The facility had not had or requested an orientation of menus and recipes since October 2017.
-The contracted food company would complete trainings annually for facilities as requested.

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D 310	Continued From page 11 Interview with the Administrator on 10/18/18 at 2:49pm revealed: -She expected the cooks to refer to the therapeutic spreadsheet and recipe when preparing meals. -The DM was responsible for preparing all diets according to the orders. -She had not scheduled a training with the contracted food service company because it needed to be discussed with the corporate office. -She hired the DM because of his knowledge and thought he had prior food service training to prepare therapeutic diets. -She expected staff to refer to the therapeutic diet spreadsheet and recipes when preparing meals, as diets were ordered by the physicians. Based on observation and record review, Resident #6 was not interviewable. Attempted telephone interview with Resident #6's guardian on 10/18/18 at 10:48am was unsuccessful. 2. Review of Resident #6's physician's diet order revealed an order dated 05/15/18 for nectar thickened liquids. Review of the therapeutic diet list dated 10/12/18 posted in the kitchen on 10/17/18 revealed Resident #6 was to be served nectar thickened liquids. Observation of the kitchen on 10/17/18 at 11:40am revealed: -The DM used laminated index cards to identity/prepare the tray for foods to serve residents in the memory care unit. -The index card for Resident #6 did not include a	D 310		

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consistency for liquids.
-The tray prepared for Resident #6 had a glass of water and a glass of orange fruit drink.

Observation of the lunch meal on 10/17/18 at 12:36pm revealed:
-A PCA removed Resident #6's tray from the food cart and proceeded to serve Resident #6 a regular glass of water and a regular glass of orange fruit drink.
-The PCA did not refer to a diet list to ensure Resident #6 received the correct diet order.
-The PCA did not consult the diet list prior to preparing Resident #6's beverages.
-After redirection, the SCU Manager went to the kitchen to obtain nectar thickened water and cranberry juice for Resident #6.
-Resident #6 was then served nectar thickened water, nectar thickened cranberry juice and frozen yogurt.
-Resident #6 was assisted with her meal by a PCA.
-Resident #6 consumed 50% of the meal without difficulty and 100% of the liquids.

Interview with a PCA on 10/17/18 at 12:36pm revealed:
-There was a diet list in the cabinet in the memory care unit.
-She thought Resident #6 was ordered thin liquids.
-She thought Resident #6's diet order was changed.
-She had not referred to the most recent diet list in the cabinet.
-She referred to the index card on the tray to determine what to serve to Resident #6.
-She was directed by the previous SCU Manager to serve residents what was listed on the index card.

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D 310	Continued From page 13 -She thought the index card was correct for Resident #6. Interview with the SCU Manager on 10/17/18 at 12:45pm revealed: -Resident #6 was listed on the diet list dated 10/02/18 as ordered to receive nectar thickened liquids. -She did not know why Resident #6 was attempted to be served thin liquids. -The Activity Director (AD) was responsible for recording the diet orders onto an index card. -The Resident Care Manager (RCM) was responsible ensuring the diet orders were given to the AD. -She did not know who responsible for ensuring the index cards were accurate. Interview with the AD on 10/17/18 at 1:30pm revealed: -She was responsible for recording resident diet orders on index cards. -She received the diet orders from the RCM. -She last updated index cards "about 2 weeks ago". -She did not know the last time she updated the index card for Resident #6. -She did not know if the index cards were checked for accuracy. Interview with the RCM on 10/17/18 at 3:05pm revealed: -She was responsible for maintaining an updated diet list. -She ensured the SCU and the kitchen had an updated list. -She last updated the list on 10/12/18. -There was no one currently checking the index cards for accuracy. -She thought the AD completed the index cards	D 310		

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	HAL060136	A. BUILDING: _____ B. WING _____	R 10/18/2018

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accurately.

Interview with Resident #6's PCP on 10/18/18 at 11:26am revealed:
-Resident #6 was ordered nectar thickened liquids because that was the order from the previous physician at another facility.
-She had no knowledge of Resident #6 receiving a swallow study and did not have any medical evaluation to reference for swallowing complications.
-She continued nectar thickened liquids as a precaution.
-She had not ordered a speech therapy recommendation since Resident #6 was admitted.
-She expected Resident #6 to continue to receive nectar thickened liquids.

Interview with the Administrator on 10/17/18 at 2:49pm revealed:
-The DM was responsible for preparing all diets according to the orders.
-The RCM was responsible for ensuring the diet order on the spreadsheet and provided to the memory care unit and kitchen.
-The AD was responsible for making sure the index cards were accurate.
-The DM should have checked the diet list and index cards to ensure they were accurate.
-She expected Resident #6 to receive nectar thickened liquids as ordered.

Based on observation and record review, Resident #6 was not interviewable.

Attempted telephone interview with Resident #6's guardian on 10/18/18 at 10:48am was unsuccessful.

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D 371	Continued From page 15	D 371		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 2 medication aides (MAs) observed during the medication passes implemented infection control measures related to failing to properly clean hand-held nebulizer equipment and improper storage of oxygen tubing and a continuous positive airway pressure(CPAP) mask for 2 of 5 residents (Resident #3, and #5) between use and administration of medications. The findings are: 1. Observation of the 10:00am medication pass on the Assisted Living (AL) side on 10/17/18 at 10:22am revealed: -The MA had administered a nebulizer treatment via mask to Resident #3 and left the mask on the floor beside the resident's bed. -Resident #3's continuous positive airway pressure (CPAP) mask and tubing were laying on the floor beside the nebulizer mask. Review of Resident #3's current FL2 dated 08/02/18 revealed: -Diagnoses included chronic obstructive	D 371		

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pulmonary disease, congestive heart failure, anemia, oxygen dependency, severe aortic stenosis and cardiac arrest.
-There were physician orders for Ipratropium-Albuterol (0.5 mg-3mg/3ml) one vial solution for nebulizer three times a day, CPAP every night at bedtime, and oxygen 2 liters per minute via nasal cannula as needed for shortness of breath.

Interview with Resident #3 on 10/17/18 at 10:46am revealed:
-She received her nebulizer treatments three times per day.
-The staff brought her medications to her, set up her nebulizer treatments, and left her room.
-The staff would return to her room and turn off the nebulizer treatments when they were completed, but she could not recall if they had cleaned the equipment.
-The staff had never cleaned her CPAP equipment or machine.

Interview with the MA on 10/17/18 at 10:22am revealed:
-When administering nebulizer treatments she would wash her hands with soap and water or use hand sanitizer, squeeze the medication from the vial into the cup reservoir of the nebulizer, turn the machine and allow completion of the medication in the reservoir.
-When the nebulizer treatment was completed she was supposed to remove the nebulizer, rinse the reservoir and leave it to air dry on a paper towel on the resident's bedside table.
-She had not rinsed the reservoir and let it air dry on a paper towel.
-She had forgotten to clean the resident's nebulizer.
-She did not know why it was on the floor

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because it was routinely stored on the resident's bedside table.

Interview with Resident #3's Nurse Practitioner (NP) on 10/18/18 at 12:00pm revealed:
-Resident #3 was to receive nebulizer treatments using measures to control infectious disease transmission.
-Without taking appropriate measures to prevent infection, the resident could acquire mouth sores, bacterial infections or fungal lung infections.
-The resident had not acquired any of these infections.

Refer to review of the facility's Medication Administration Policy.

Refer to the interview with the Resident Care Manager (RCM) on 10/17/18 at 3:45pm.

Refer to the interview with the Administrator on 10/18/18 at 9:00am.

2. Observation after the 8:00am medication pass on the AL side on 10/18/18 at 8:30am revealed Resident #5 had a hand-held nebulizer and oxygen tubing laying on the floor beside her home-fill oxygen system.

Review of Resident #5's current FL2 dated 08/07/18 revealed:
-Diagnoses included bipolar disorder, post traumatic stress disorder, epilepsy, opioid dependence, insomnia, and chronic back pain.
-Physician orders for oxygen 2.5 liters per minute via nasal cannula as needed for shortness of breath, and Ipratropium-Albuterol (0.5 mg-3mg/3ml) one vial of solution every six hours.

Interview with Resident #5 on 10/18/18 at

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D 371	Continued From page 18 10:00am revealed: -She received hand held nebulizer treatments twice daily. -The staff brought the medication to her, set up the treatments and left her room. -The staff would return to her room and turn off the nebulizer treatments when they were completed, but she could not recall if they had cleaned the equipment. -Sometimes her equipment would lay on the floor when she knocked it off the bedside table onto the floor. Interview with a second MA on 10/18/18 at 8:30am revealed: -When the nebulizer treatment was completed she was supposed to remove the nebulizer, rinse the reservoir and leave it to air dry on a paper towel on the resident's bedside table. -She had not administered a nebulizer treatment to Resident #5 because it was administered by another MA on third shift. -She had not noticed the dirty equipment on the floor in the resident's room. Refer to review of the facility's Medication Administration Policy. Refer to interview with the RCM on 10/17/18 at 3:45pm. Refer to interview with the Administrator on 10/18/18 at 9:00am. _____ Review of the facility's Medication Administration Policy revealed the policy did not address the appropriate measures to administer medications to prevent the development and/or transmission of infection and/or disease and prevent cross	D 371		

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D 371	Continued From page 19 contamination. Interview with the RCM on 10/17/18 at 3:45pm revealed: -She did not know nebulizer treatments had been administered and left without cleaning the nebulizer in the residents' rooms. -All nebulizer treatment equipment should have been rinsed and left to air dry after use on a paper towel, on a clean surface in the residents' rooms. -All of the MAs had received training on infection control measures when they had completed the checklist for medication administration. Interview with the Administrator on 10/18/18 at 9:00am revealed: -She expected all staff to use appropriate infection control measures. -She expected the MAs to follow the medication administration policy and use appropriate infection control measures when administering medication according to their training provided. -The MAs had all been trained on the policy and completed infection control training, and they had failed to do what they had been trained to prevent possible contamination of the nebulizer's.	D 371		