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 _____	01/18/2019

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 an annual survey and a complaint investigation on January 15-18, 2019.	D 000		
D 189	10A NCAC 13F .0604 (e)(2)(A-E) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (2) The following describes the nature of the aide's duties, including allowances and limitations: (A) The job responsibility of the aide is to provide the direct personal assistance and supervision needed by the residents. (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. (C) If the home employs more than the minimum number of aides required, any additional hours of aide duty above the required hours of direct service between 7 a.m. and 9 p.m. may involve the performance of housekeeping tasks. (D) An aide may perform housekeeping duties between the hours of 9 p.m. and 7 a.m. as long as such duties do not hinder the aide's care of residents or immediate response to resident calls, do not disrupt the residents' normal lifestyles and sleeping patterns, and do not take	D 189		

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 _____	01/18/2019

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 189	Continued From page 1	D 189		

the aide out of view of where the residents are. The aide shall be prepared to care for the residents since that remains his primary duty.
(E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure housekeeping duties performed by the personal care aides (PCAs) between the hours of 7:00am and 9:00pm were limited to non-routine tasks as evidenced by PCA staff setting the dining room tables in preparation for meal delivery and completing residents' laundry on a scheduled, routine bases between 7:00am and 9:00pm.

The findings are:

Observation in the Special Care Unit (SCU) on 01/15/19 at 5:00pm revealed the personal care aide (PCA) staff were filling cups on the dining room table with milk, tea, and water to residents seated in the dining room.

Observation in the SCU on 01/15/19 at 5:35pm revealed:
-The PCAs removed glasses from the dining room table and replaced the glasses with plastic cups.
-The PCAs filled the plastic cups with tea, water, and milk.

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 _____	01/18/2019

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 189	Continued From page 2 Interview with a PCA on 01/15/19 at 5:45pm revealed instructions came from the kitchen to remove the glasses from the tables and replace them with plastic cups. Random observations on 01/16/19, 01/17/19, and 01/18/19 during meal delivery in the SCU and in the assisted living section revealed personal care staff prepared the dining room tables for meal service delivery by placing utensils and place settings on the tables and filling glasses with beverages at each place setting. Observation of the SCU on 01/18/19 at 08:05am revealed there were residents seated at the dining tables and bar, and the PCA was serving food, refilling beverages, and taking lunch orders. Confidential interviews with three staff revealed: -The PCA's worked in the assisted living section and SCU section of the facility. -Job duties in the assisted living section were described as "overwhelming" and "too much for one aide". -There was usually one PCA and one medication aide scheduled to work in the assisted living section on the 6am-2pm shift and 2pm-10-pm shift. -When working in the assisted living section, the PCAs had to move fast because the PCAs had to get all the residents ready who needed assistance, then had to serve juice, water, and milk on the dining room table at meal times. -The facility did not have laundry staff. -The PCAs were assigned to wash resident personal clothes and linens on the resident scheduled shower days and shift. -The PCAs run back and forth from laundry to the floor doing laundry and providing resident care.	D 189		

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 _____	01/18/2019

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 189	Continued From page 3 -There might be three residents scheduled to have their laundry done during a day shift. -When the PCA finished laundry for a resident she would take the clothes to their room to fold. Confidential interview with a resident revealed: -Staff washed the resident's sheets and towels on Wednesdays and Saturdays during the day shift. -Staff removed the sheets from the bed, washed them, put them in the linen closet, and put clean sheets on the bed. Observations of four PCAs from 01/17/19-01/18/19 at intervals revealed: -A PCA took a basket of laundry to the laundry room. -A PCA took a load of linen out of the dryer, transferred a load of clothes to the dryer, and put a load of clothes in the washer. -A PCA took a basket of laundry to a resident's room. - A PCA walked down the hall with clothes in her arms. Confidential interviews with five staff revealed: -PCA staff did residents' routine laundry and linen on the days the residents were scheduled for showering. -The staff thought it took anywhere from 30 minutes to one hour to do routine laundry for the residents. -The staff thought routine laundry done by the PCAs took away from the care of the residents. -PCAs were responsible for routine laundry in assisted living and special care unit. -There were no laundry assignments for 3rd shift but they would help with the laundry. -The PCAs had to do 2 to 3 loads of laundry a day. -The PCAs started laundry after breakfast.	D 189		

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 _____	01/18/2019

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 189	Continued From page 4 -The PCAs checked the laundry when they brought soiled incontinent briefs to the trash. -Night shift did not have laundry assignments but helped with the laundry. -The PCAs performed routine laundry needs such as washing and drying the residents' clothing and bed linens prior to 9:00 p.m. on second shift. -What laundry 1st shift did not get finished, 2nd shift would finish. -The PCAs did 5 loads of laundry on one shift Interview with the Resident Care Coordinator on 01/16/19 at 10:55am revealed that the residents' laundry was done by the PCA on the days the resident was scheduled for showers. Review of the assignment sheet for the assisted living section dated 01/15/19 revealed: -There were 2 showers, laundry and linens scheduled for Mondays and Thursdays for 1st shift. -There were 5 showers, laundry and linens scheduled for Mondays and Thursdays for 2nd shift. -There were 2 showers, laundry and linens scheduled for Tuesdays and Saturdays for 1st shift. -There were 2 showers, laundry and linens scheduled for Tuesdays and Saturdays for 2nd shift. -There were 5 showers, laundry and linens scheduled for Tuesdays and Fridays for 1st shift. -There were 2 showers, laundry and linens scheduled for Tuesdays and Fridays for 2nd shift. -There were 4 showers, laundry and linens scheduled for Wednesdays and Saturdays for 1st shift. -There were 2 showers, laundry and linens scheduled for Wednesdays and Saturdays for 2nd shift.	D 189		

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 _____	01/18/2019

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 189	Continued From page 5 Review of the special care unit assignment sheet dated 01/17/19 revealed: -There were 8 showers, laundry and linens scheduled for Monday and Tuesday for 1st shift. -There were 7 showers, laundry and linens scheduled for Wednesday for 1st shift. -There were 6 showers, laundry and linens scheduled for Thursday, Friday, and Saturday for 1st shift. -There were 8 showers, laundry and linens scheduled for Monday, Wednesday, and Saturday for 2nd shift. -There were 10 showers, laundry and linens scheduled for Tuesday for 2nd shift. -There were 11 showers, laundry and linens scheduled for Thursday for 2nd shift. -There were 5 showers, laundry and linens scheduled for Friday for 2nd shift. Interview with the Resident Care Coordinator (RCC) on 01/17/19 at 5:00pm revealed: -The Resident Care Director (RCD) made out the staff schedule. -She (the RCC) would complete the assignment sheets for one week at a time. -For first shift on the assisted living (AL) side would be one MA and one PCA; second shift would be one MA and one PCA; and third shift would be "one person" and "could be an aide". -There could be times when third shift on the AL side did not have a MA. -There was no MA on the AL side for third shift because there were no medications due on third shift. Interview with the Executive Director (ED) on 01/18/19 at 11:30am revealed: -The PCAs did laundry usually two days a week on the residents scheduled shower day.	D 189		

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 _____	01/18/2019

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 189	Continued From page 6 -The PCAs did laundry as needed. -There was no specific laundry staff. -Staff on all shifts did laundry. -She did not know residents clothes were being washed on first or second shift. -Staff on third shift would highlight on the assignment sheet which resident needed their laundry done. -She knew the state rule regarding routine laundry being assigned to personal care staff between the hours of 7am to 9pm. -If someone had dirty clothes and was smelly the staff would need to launder them. -She thought the residents towels were being put in the washing machine after their baths on first or second shift. -She had worked on third shift and she knew third shift did laundry.	D 189		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure referral and follow up for the acute health care needs for 1 of 5 sampled residents (Resident #5) as evidenced	D 273		

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 _____	01/18/2019

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 273	Continued From page 7	D 273		

by a two day delay of notifying the primary care provider after an unwitnessed fall followed by documented complaints of pain after the fall resulting in a diagnosis of a right hip fracture three days later.

The findings are:

Review of Resident #5's current FL-2 dated 06/26/18 revealed:
-Diagnoses included severe dementia, syncopal episodes and atrial fibrillation with rapid ventricular rate.
-The resident was intermittently disoriented and semi-ambulatory with the use of a wheelchair.
-The resident's current and recommended level of care was documented as special care unit (SCU).

Review of Resident #5's care plan dated 01/18/18 revealed the resident required assistance of one staff for transferring and ambulation.

Observation in the main lobby of the facility on 01/15/19 at 9:59 a.m. revealed emergency medical services (EMS) were entering the SCU pushing a stretcher.

Interview with the Executive Director (ED) on 01/15/19 at 10:00 a.m. revealed Resident #5 was "sent out" because he had fallen this morning (01/15/19).

Interview with the Special Care Unit Coordinator (SCUC) on 01/15/19 at 12:05 p.m. revealed:
-Resident #5 slid out of his chair in his room on 01/12/19.
-The SCUC thought Resident #5 was attempting to transfer himself from his recliner to his wheelchair when he fell.

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 _____	01/18/2019

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 273	Continued From page 8	D 273		

-Resident #5 did not have any apparent injuries and was not complaining of any pain at the time of the fall until 01/14/19 when the resident started complaining of pain in his knee and lower back.
-Resident #5's Primary Care Provider (PCP) was called 01/14/19 to make a visit and an x-ray was ordered.
-Resident #5's x-ray results were not back when the PCP visited today (01/15/19).
-The PCP ordered for Resident #5 to be evaluated in the emergency room (ER) due to the pain the resident was having.

Review of an Occurrence report for Resident #5 signed by the SCUC and the ED on 01/13/19 revealed:
-The time of the occurrence was at 8:55 p.m.
-There was documentation the resident was found on the floor by three named staff; the resident stated he was trying to transfer himself from the wheelchair to the chair and fell to the floor.
-There was documentation of a right hip injury.
-No was checked under the treatment required section.
-There was documentation the power of attorney (POA) was called on 01/12/19 at 9:10 p.m.
-In the resident status section there was documentation the resident was placed on 30 minute checks for 48 hour checks to monitor any pain or change.
-There was not documentation the PCP was notified.

Review of a second Occurrence Report for Resident #5 signed by the SCM and the ED on 01/15/19 revealed:
-There was documentation the resident was sent to the ER by the PCP to be checked out for back and leg pain.

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 _____	01/18/2019

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 273	Continued From page 9 -The resident fell on 01/12/19, and started complaining of pain on 01/13/19. -The PCP ordered x-rays, normal, the resident continued to complain of pain on 01/15/19, -The PCP evaluated the resident and sent the resident to the ER for extra imaging. Review of Resident #5's Progress Notes revealed: -On 01/12/19 with a time documented as "2-10pm", there was documentation by a medication aide (MA) that the resident had fallen on the floor; the resident was placed on 30 minute checks; and the resident was complaining of slight pain in right leg. -On 01/13/19 at 5:05 a.m. there was documentation by a MA, the resident was given something for pain at 11:00 p.m., the resident went to sleep and there were no problems the rest of the night. -On 01/13/19 with a time documented as "6a-2p" there was documentation by a MA the resident was complaining of leg and hip pain, the resident did not eat meals today. -On 01/13/19 with a time documented as "2-10pm", there was documentation by a MA the resident "did not come out for dinner", complaining of hip and leg pain. -On 01/14/19 at 5:10 a.m., there was documentation by a MA the resident had a good night. -On 01/14/19 at 2:00 p.m. there was documentation by a MA the resident stayed in bed complaining of back and right knee pain, mobile x-ray would come out today and the resident would be seen by the PCP. -On 01/14/19 at 9:00 p.m., there was documentation by a MA the resident had x-rays to his back and both legs; no complaints of pain or discomfort throughout the shift.	D 273		

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 _____	01/18/2019

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 273	Continued From page 10	D 273		

-On 01/15/19 at 5:00 a.m. the resident rested throughout the night, no complaints of pain.

Review of a 24 hour Communication Log for Resident #5 revealed:
-On 01/12/19 on the "2pm-10p shift", there was documentation by a MA the resident was placed on 30 minute checks due to a fall in his bedroom.
-On 01/13/19 on the "10pm-6am" shift, there was documentation by a second MA the resident was complaining of right hip pain and was given an as needed pain medication at 11:00 p.m. and was "okay" the rest of the night.
-On 01/13/19 on the 6am-2pm" shift, there was documentation by a third MA the resident was complaining of hip/leg pain, "didn't come for breakfast or lunch".
-On 01/13/19 on the "2pm-10pm " shift, there was documentation by a 4th MA the resident was still complaining of leg and hip pain, "did not come for dinner".
-On 01/14/19 on the "6a-2p", there was documentation by a fifth MA the resident was having some pain in his back and leg. The resident's PCP and family was notified.

Interview with the medication aide (MA) who documented Resident #5's progress note and 24 hour Communication Log note dated 01/14/19 on 01/17/18 at 11:30 a.m. revealed:
-She did not work on 01/12/19 or 01/13/19.
-Resident #5 was lying in his bed when she returned to work and was complaining of back and leg pain on 01/14/19.
-She called Resident #1's PCP to make an "urgent visit", but there was no provider that could not come out to see Resident #5 until 01/15/19.
-All providers at Resident #5's PCP were "booked" on 01/14/19 and could not come to the facility to see the resident so X-rays 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 _____	01/18/2019

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 273	Continued From page 11	D 273		

ordered.
-The MAs were responsible for contacting a residents' PCP after a witnessed or unwitnessed fall.
-She thought someone had tried to reach Resident #5's PCP the day he fell.
-The resident complained of pain in his knee on 01/14/19 but "not bad" pain and was not eating.
-The resident could not transfer himself as he normally could and laid in bed on 01/14/19.
-She offered Resident #5 his ordered as needed pain medication on 01/14/19 but he refused.
-She did not document that Resident #5 refused the as needed pain medication on 01/14/19 when she offered it.

Interview with the MA who documented Resident #5's progress note and 24 hour Communication Log note dated 01/12/19 on 01/17/18 at 4:10 p.m. revealed:
-She had just walked down the hallway and passed Resident #5's room before Resident #5 fell on 01/12/19 then she heard the resident holler out.
-Resident #5 was found on the floor on his right side with his right hand propping up his head.
-Resident #5 did not complain of any pain so she checked his vital signs and completed a skin assessment to check for injuries.
-She called the SCUC on 01/12/19 and reported Resident #5's fall.
-She did not call or notify Resident #5's PCP on 01/12/19 because he was under the care of a Veteran care provider as well.
-She documented the Progress note for Resident #5 on 01/12/19 that he complained of slight pain in right leg.
-She thought the SCUC sent the faxed notification to Resident #5's PCP and the SCUC thought she had faxed the notification on

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 _____	01/18/2019

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 273	Continued From page 12	D 273		

01/12/19.
-She "only" completed an Occurrence Report for Resident #5 because of the fall and did not complete the facility's Post Fall packet.

Interview with the MA who documented Resident #5's progress note and 24 hour Communication Log note dated on 01/13/19 on the 6am-2pm on 01/18/19 at 10:40 a.m. revealed:
-When she and the PCA assisted the resident to stand, he complained of pain in his right leg.
-She was going to contact Resident #5's PCP about getting an x-ray but she became busy with other tasks so she faxed the request for an x-ray to Resident #5's on 01/14/19.
-She did not offer any pain medication to Resident #5 because she had just administered the resident's routine aspirin (Aspirin 81mg daily).

Attempted telephone interview with a PCA named on the Occurrence report dated 01/12/19 on 01/18/19 at 11:49 a.m. was unsuccessful.

Telephone interview with a PCA on 01/18/19 at 11:50 a.m. revealed:
-She worked second shift on 01/12/19 in the SCU.
-She and other staff found Resident #5 on the floor in his room lying flat on the floor with the right side of his head on the floor and complaining of right hip pain.
-The MA completed an Occurrence report and she thought the resident would be sent out but the MA told staff that she would wait until the SCM arrived for her shift that night (01/12/19).
-Staff kept asking Resident #5 if he was hurting after the fall and he would say yes and then say no but when his leg was moved the resident would complain of pain and would point to his hip.
-The MA was responsible for notifying the PCP

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 _____	01/18/2019

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 273	Continued From page 13 after Resident #5 fell on 01/12/19. Review of Resident #5's "Resident Observation Every 30 Minute Checks" dated 01/12/19 - 01/15/19 revealed there was no documentation related to the resident's pain level and no labeled section to document pain. Review of a Progress Note from Resident #5's PCP's office dated 01/14/18 revealed: -At 9:24 a.m. a telephone call was received from a named MA who reported the resident had fallen over the weekend and refused an ER evaluation. -The MA stated the resident was complaining of right knee swelling and complaints of back pain. -At 1:24 p.m. there was documentation for an x-ray of bilateral knees, cervical, thoracic, and the lumbar sacral spine. The MA was called and advised of the ordered x-rays. Review of Resident #5's PCP's visit note dated 01/15/19 revealed: -The chief complaint included back/hip pain and gait impairment. -The PCP was seeing the resident at the request of staff. -The resident was seen in bed and had extreme pain with internal and external rotation of the right hip, likely a fracture. -Staff had requested a visit on Monday, 01/14/19, however, there was no provider available, and an x-rays of both knees and spine were ordered. -The spine x-rays were negative and the left knee was negative. -The resident could not tolerate an x-ray of the right knee due to pain in his right hip. -There was documentation for the resident to be sent to the ER for evaluation for possible right hip fracture.	D 273		

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 _____	01/18/2019

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 273	Continued From page 14	D 273		

Review of an EMS Incident report for Resident #5 dated 01/15/19 at 9:57 a.m. revealed:
-The chief complaint was pain from a fall and the resident's level of distress was moderate.
-On arrival, staff reported that the resident fell Sunday (01/13/19) out of a recliner and did not want to go to the hospital.
-The resident currently was complaining of a lot of pain in his right hip and wanted to get checked out.
-The resident was assessed, tried to straighten his leg to check for rotation and shortening but the resident was in pain when trying to move it.
-The resident was not in pain unless he was told his extremity was going to be moved and only had pain upon moving him to and from the stretcher.
-The resident was transported to the ER by EMS.

Review of a hospital History and Physical report for Resident #5 dated 01/15/19 revealed:
-The resident was brought to the ER after an unwitnessed fall.
-ER evaluation showed right femur fracture.
-An x-ray of the right hip revealed an acute right hip fracture with mild displacement.
-The resident was admitted to the hospital to a medical floor with a consult to orthopedics and was placed on pain management.
-A sub-acute stroke was questionable and a MRI ordered.

Telephone interview with Resident #5's family member on 01/17/19 at 10:48 a.m. revealed:
-The resident fell and broke his hip Saturday, 01/12/19.
-Staff called the family member on 01/12/19 and reported that the resident was attempting to get from his wheelchair to his lounge chair and fell.
-The family member was told that the resident

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 _____	01/18/2019

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 273	Continued From page 15	D 273		

was complaining of pain in his knees, but not much pain. After the fall the resident went to sleep.
-The family member thought the resident was receiving pain medication for his pain.
-The family member called the facility on 01/13/19 and was told Resident #5 was sleeping.
-The family member went to see the resident on 01/14/19 to see what the x-rays showed but the PCP never received the resident's x-ray reports and was told on 01/15/19 the resident needed to go to the hospital.

Interview with the SCUC on 01/17/19 at 4:00 p.m. revealed:
-She received a call from the MA on duty on 01/12/19 around 8:00 p.m.
-The MA reported that she and two personal care aides (PCAs) were down the hall and observed Resident #5 on the floor in a seated position.
-Resident #5 told the MA and the two PCAs he had slipped on the floor.
-They (MA and the PCAs) checked Resident #5 out and reported that he was sitting on the floor in his room between his wheelchair and his recliner.
-Resident #5 reported that he did not hit his head.
-Resident #5 did not appear to have any injury.
-Resident #5 was placed on 30 minute checks for 48 hours.
-Unwitnessed falls by the residents in the SCU were not always sent to the ER and were sent out only if the resident had pain or injury.
-Resident #5 complained of knee pain during third shift on 01/12/19.
-The SCUC worked 3rd shift on 01/12/19, but did not assess Resident #5.
-She asked Resident #5 did he hit his head when he fell and was he in pain and he told her no.
-The MA/SICs were responsible to notify the Resident Care Coordinator (RCC) or SCUC

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 _____	01/18/2019

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 273	Continued From page 16	D 273		

immediately after a resident fell and notifying the PCP per the facility's Fall Management Program.
-On Monday, 01/14/19 it took four staff to assist Resident #5 to stand, but normally the resident did not require any staff assistance to help him stand.
-An incident and accident report packet (Post Fall packet) should be completed by a MA or supervisor in charge (SIC) when a resident fell.
-In the packet there was a notification that should have been faxed to the PCP after Resident #5's fall.
-She thought the MA sent the faxed notification to Resident #5's PCP and the MA thought she had faxed the notification on 01/12/19.
-The entire incident and accident report packet (Post Fall packet) had not been completed for Resident #5's fall on 01/12/19 but it should have been.
-When she received occurrence reports and Post Fall packets, she usually checked to make sure it had been completed including notifying the PCP but she did not check Resident #5's Post Fall packet
-Staff could reach Resident #5's PCP 24 hours a day, seven days a week.

Interview with Area Director of Clinical Services (ADCS) on 01/17/19 at 4:25 p.m. revealed:
-MA/SICs were responsible for completing an incident report (Occurrence Report) for any resident incidents which included falls.
-Staff were responsible for notifying the residents' PCP when there was a fall which was in the facility's policy.

Telephone interview with the clinical organizer for Resident #5's PCP's office on 01/18/19 at 9:56 a.m. revealed there was no documentation of any calls or notification of a fall or pain received from

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 _____	01/18/2019

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 273	Continued From page 17	D 273		

the facility prior to 01/14/19 for the resident.

Interview with the ED on 01/18/19 at 12:24 p.m. revealed:
-She found out about Resident #5's fall on 01/13/19 when she read the incident report.
-After reading the report she did not see anything "reportable" other than first aid.
-She saw Resident #5 on Sunday, 01/13/19 and the resident did not complain of any pain.
-Resident #5 told her "shug I'm fine" when she asked the resident about his fall.
-Resident #5 was discussed during the stand-up meeting on 01/14/19 when the resident was complaining of pain.

Interview with ADCS on 01/18/19 at 12:24 p.m. revealed:
-She had reviewed the Occurrence report for Resident #5 dated 01/12/19 and there was no documentation the resident's PCP was notified.
-The normal process after a fall would be for staff to assess the resident, check the resident's head, red areas, check range of motion, ask questions how the fall occurred and if there was a difference in pain.
-Resident #5 did not complain of pain.
-Resident #5 would have told staff if he was hurting.
-If there was no visible change in the resident after a fall, the normal process included to increase supervision after a fall.
-Resident #5 had an unwitnessed fall.
-She agreed when a resident in the SCU had an unwitnessed fall "you can't" determine if the resident had a head injury.

Confidential interview with staff revealed:
-The staff observed Resident #5 lying in his bed on 01/13/19 after his fall on 01/12/19 and knew

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 _____	01/18/2019

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 273	Continued From page 18	D 273		

something was wrong with him because the resident never laid in his bed and slept in his chair.
-The staff did not understand why Resident #5 was not sent to the ER for evaluation before 01/15/19.

Telephone interview with Resident #5's PCP on 01/18/19 at 1:10 p.m. revealed:
-She was aware the facility called her office on 01/14/19 concerning Resident #5's fall on 01/12/19, however, there were no providers available to make a visit with the resident that day and x-rays were ordered.
-When she saw Resident #5 on 01/15/19, he was in his bed and showed clinical signs on her assessment that he had a fractured hip.
-She doubted Resident #5 could recall if he hit his head when he fell.
-It was usual protocol for staff at the facility to notify the PCP after a fall.
-It would have been "preferable" to have sent Resident #5 out after the fall on 01/12/19.
-If he was having pain immediately after his fall until the time she saw him on 01/15/19 he would have been more comfortable by receiving more pain control for his pain by being admitted to the hospital.

Review of the facility's Fall Management Program revealed:
-The purpose of the policy included to provide a systemic review of the resident to determine risk for fall and develop appropriate interventions, to provide a program that educated staff in creative, functional strategies while recognizing resident rights and his/her need to maintain the highest level of function.
-In the procedure section of the policy there were instructions for follow-up post falls that included

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 _____	01/18/2019

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 273	Continued From page 19	D 273		

an Incident/Accident report must be completed when a resident falls.
-In the investigation section of the policy there was documentation that all falls would be investigated, reported, and documented.
-All findings would be reported to the resident's primary care provider, supervisor, and family when the incident occurred once the resident was deemed safe; the individual completing the notification would document in the resident's record, all notifications and responses; and all incidents would be reported to the appropriate agencies within the time frame as required by state.

Review of the facility's Post Fall packet revealed:
-There was an a Post Fall Assessment Tool, a fall referral form, a Body, Evaluation, and Observation form, a pre-printed fax cover sheet and an Occurrence Report.
-The fax cover sheet included a pre-printed "To and from section with fax numbers, dates and an additional entry in the middle of the cover sheet: this is to notify you that (blank underlined space) had a fall in our residence on (blank underlined space). If you have any questions related to this incident please contact me at (a telephone number was pre-printed).

The facility failed to notify Resident #5's primary care provider (PCP) after an unwitnessed fall on 01/12/19 with complaints of right hip pain. The facility's failure resulted in a two-day delay in PCP notification and a three day delay in emergent hospital evaluation. The resident was diagnosed with a right hip fracture. The facility's failure to meet the acute health care needs resulted in serious neglect and serious physical harm to the resident which constitutes a Type A1 Violation.

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 _____	01/18/2019

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 273	Continued From page 20 The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/17/19 with an addendum dated 01/23/19 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 17, 2019.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to implement physician orders for 3 of 5 sampled residents (#1, #2, #3) with orders for blood and urine laboratory (lab) tests (Residents #1, #2), and an order to wear a safety helmet daily (Resident #3). The findings are: 1. Review of Resident #2's current FL-2 dated 01/08/19 revealed: -Diagnoses included Alzheimer's dementia, hypertension, and diabetes mellitus type 2.	D 276		

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 _____	01/18/2019

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 276	Continued From page 21 -He was assessed as constantly disoriented. a. Review of the Resident #2's record revealed mental health provider (MHP) visits with laboratory orders revealed: -There were orders dated 11/26/18 for a CBC (complete blood count) with differential (used to provide an overview of a resident's health status), CMP (comprehensive metabolic panel) [provides information about a resident's current metabolism], fasting lipids (measures current levels of cholesterol), hemoglobin A1C (used to monitor blood sugar), and TSH (thyroid stimulating hormone) [monitors thyroid gland function} with Free T4. -There were orders dated 12/20/18 for a CBC with differential, CMP, fasting lipids, hemoglobin A1C, and TSH with Free T4. Review of the MHP's on-site visit encounter notes dated 11/26/18 and 12/20/18 revealed: -Current medications prescribed for Resident #2 included Escitalopram (generic for Lexapro and used to treat anxiety), Xanax (used to treat anxiety), Melatonin (used to treat sleep disorders), Memantine (generic for Namenda and used to treat Alzheimer's dementia), and Donepezil (generic for Aricept used to treat Alzheimer's dementia). -The treatment plan included lab orders for CBC with differential, CMP, fasting lipids, HgbA1C, and TSH with free T4. -There was a notation requesting lab results be faxed [number provided]. -The MHP had been reviewed with community staff. Interview with the primary care physician (PCP) on 01/17/19 between 8:20am and 9:00am revealed the provider name listed on the 11/26/18	D 276		

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 _____	01/18/2019

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 276	Continued From page 22 and 12/20/18 lab orders was the Psychiatrist. Telephone interview with a clinical assistant with the primary care physician (PCP)'s office on 01/18/19 at 8:30am revealed: -There was no documentation of any lab requests sent to primary care physician (PCP) office that were ordered by theMHP on 11/26/18 and 12/20/18. -The last documentation of labs drawn according to the PCP's office record were for 07/2018. Interview with the SCUC on 01/18/19 at 9:00am revealed the MHP probably re-ordered the labs on 12/20/18 because when the phlebotomist came to draw labs on 11/26/18 Resident #2 refused. Telephone interviews with the medical assistant at Resident #2' MHP office on 01/18/19 between 9:40am and 10:40am revealed: -She did not see any lab results in their computer system for Resident #2 resulting from the 11/26/18 or 12/20/18 orders. -The MHP probably rewrote the lab order on 12/20/18 because the labs ordered 11/26/18 had not been done. -When the MHP wrote the 11/26/18 and 12/20/18 orders, they were left at the facility. -The MHP spoke to the resident care director (RCD) [named] at the December MHP visit, about the labs ordered. -The RCD told her she would submit the lab orders through the primary care provider. -The MHP ordered the labs based on the fact that Resident #2 had not had any labs done recently, and the resident was on psychotropic medications which the provider wanted to make sure were not interacting with any of the routine medications Resident #2 was prescribed.	D 276		

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 _____	01/18/2019

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 276	Continued From page 23 Interview with the RCD on 01/18/19 at 11:05am revealed: -She remembered talking to the MHP staff about labs ordered during the December facility visit. -She gave the paperwork to the SCUC when the SCUC came to work so the orders could be faxed to the primary care provider office. Interview with the SCUC on 01/18/19 at 12:15pm revealed she had not been able to locate any new order tracking forms for lab work ordered for Resident #2 for 11/26/18 or 12/20/18. b. Review of Resident's #2's physician orders revealed: -There was a physician's order dated 01/11/19 from the primary provider for collection of a urine specimen via swab from the resident for UA/UC (urinalysis/urine culture to diagnose urinary tract infection). There were instructions provided that included to call (provider group named with telephone number) when ready for pickup. -There was a Physician Visit Form dated 01/15/19 for Resident #2 with a handwritten notation of "agitated, [family member] wants him to be check[ed] for UTI". There was a new order to check UA/UC. Review of documented laboratory results for Resident #2 revealed there were no laboratory reports in Resident #2's record for review dated between 09/22/18 and 01/16/19. Interview with the Special Care Unit Coordinator (SCUC) on 01/16/19 at 3:15pm revealed: -There were labs ordered for Resident #2 that had not been completed. -A urine sample had just been collected on	D 276		

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 _____	01/18/2019

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 276	Continued From page 24 01/16/19 by a MA. Interview with Resident #2's PCP on 01/17/19 between 8:20am and 9:00am revealed: -She thought the PCP saw Resident #2 on 01/08/19, and the resident was having some agitation. -A urine sample was collected on 01/16/19. -The facility contacted the PCP's office on 01/16/19 to notify that the urine specimen was ready for pickup. -"Ideally", the PA would want the UA collected the same day of the order. -There was not really a concern with collecting the UA the same date ordered for Resident #2 because she (PA) could understand the difficulty getting a urine sample back in the special care unit. Telephone interview with a Clinical Assistant with the provider physician's office on 01/18/19 at 8:30am revealed: -There was a physician's order dated 01/11/19 for a urine sample to be collected. -The facility was responsible for collecting the urine sample. -There was no communication from the facility between 01/11/19 and 01/16/19 about collecting the urine sample. -The facility contacted the office on 01/16/19 at 4:22pm that a urine sample was ready for pick up. -The facility or the MHP was responsible to send lab orders to the provider physician's office for processing. -The last documentation of lab results was according to the provider physician's office record were for 07/2018. Interview with the SCUC on 01/18/19 at 9:00am	D 276		

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 _____	01/18/2019

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 276	Continued From page 25	D 276		

revealed:
-If the facility received lab orders from the MHP, the orders were faxed to the provider physician's office for processing.
-The PCP's office would have record of receipt of the lab request.
-The MA's or whoever received the orders were responsible for faxing the orders.
-The facility used a tracking form when lab request or orders were sent.
-The fax confirmation was supposed to be attached to the order/new order tracking form.
-Whoever processed the new order was responsible to fill out the new order tracking form.

Interview with the SCUC on 01/18/19 at 12:15pm revealed she had not been able to locate any new order tracking forms for lab work ordered for Resident #2 for 01/11/19.

Interview with the ED on 01/18/19 at 12:55pm revealed:
-She did not know there had been lab work ordered for Resident #2.
-The facility implemented a new order tracking form and attached the form to the new orders when new orders were processed.
-When ordered lab was not collected, the physician should be notified.
-The RCD or RCC/SCUC were responsible for checking the tracking form daily so they would know if there was something that needed to be done.
-The tracking forms were filed in a box on the unit once the orders were completed.
-She periodically checked the new order tracking forms.

2. Review of the current FL-2 dated 01/03/19 for Resident #1 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 _____	01/18/2019

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 276	Continued From page 26 -Diagnoses included chronic obstructive pulmonary disease (COPD), muscle weakness, hypothyroidism, obesity, and major depressive disorder. -Resident #1 was incontinent of bowel and bladder. Review of the Resident Register for Resident #1 revealed an admission date of 10/01/18. a. Review of a physician visit form for Resident #1 dated 12/20/18 revealed: -There was an order to collect a urine swab for urinalysis and notify Resident #1's Primary Care Provider (PCP) -There was an order for Levaquin 500mg take one tablet daily for seven days. Review of a physician orders form dated 12/27/18 revealed an order to collect a urine specimen via swab for urinalysis/urine culture to diagnose a urinary tract infection (UTI). Review of Resident #1's progress notes revealed there was no documentation that a urinalysis swab was collected for a urinalysis per the 12/20/18 order. Review of a handwritten, undated medication administration record (MAR) revealed: -There was a handwritten entry dated 12/20/18 to collect a urinalysis swab and notify Resident #1's PCP. -The order dated 12/20/18 for a urinalysis swab had not been initialed in the initial blocks as completed. -There was another handwritten entry dated 12/27/18 to collect a urinalysis and call Resident #1's PCP for pickup. -The order dated 12/27/18 for a urinalysis was	D 276		

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 _____	01/18/2019

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 276	Continued From page 27	D 276		

documented as collected and initialed on 12/28/18.

Review of Resident #1's lab results revealed there was a urinalysis report with a collection date of 12/28/18.

Interview with the Physician Assistant (PA) for Resident #1 on 01/16/19 at 9:00 am revealed:
-Urine was collected for a urinalysis by a urine swab process.
-For incontinent residents, the incontinent brief was swabbed to collect the urine; or the urine could be collected in a cup and the swab dipped in the urine.
-Ideally the urine was collected the same day as the order.

Interview with the Area Director of Clinical Services (ADCS) on 01/18/18 at 1:00 pm and 4:00 pm revealed:
- A urinalysis swab was performed on incontinent residents by swabbing their incontinent brief for urine, and then sending the swab for a urinalysis.
-The urinalysis swab on Resident #1 was not collected on 12/20/18 because the resident was incontinent. There was a second urinalysis order on 12/28/18, and that was collected.

Interview with the ED and the ADCS on 01/18/19 at 1:00 pm reveled:
-The facility had a "new order tracking form" that had step by step instructions on how to process orders from start to finish, and was a check list to be certain orders were processed per facility expectation.
-A copy of the order would be attached to the new order tracking form and would be kept at the nurse's station. The original order was filed in the chart.

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 _____	01/18/2019

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 276	Continued From page 28	D 276		

-It was the responsibility of the resident care coordinator (RCC), resident care director (RCD), and memory care manager (MCM) to check every day.
-The medical doctor was notified if labs not collected.
-After the order was completed the tracking form would be filed and the ED would do periodic random audits to be certain the orders were completed. The ADCS would check on facility site visits.

Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 01/18/18 at 1:18pm was unsuccessful.

b. Review of a hospital Emergency Department (ED) after visit summary sheet for Resident #1 dated 12/16/18 revealed Resident #1 was treated for a nosebleed and was to follow up with her Primary Care Provider (PCP) and Ear, Nose, and Throat (ENT) specialist "around" 12/18/18.

Review of a second hospital ED after visit summary sheet for Resident #1 dated 12/17/18 revealed Resident #1 was treated for another nosebleed and was to have a recheck blood count in one to two days.

Review of Resident #1's progress notes dated 12/17/18 at 8:25 pm revealed:
-There was documentation Resident #1 had returned from the hospital and was given discharge follow up instructions.
-There was no documentation that revealed the need for a recheck blood count.

Review of Resident #1's record revealed:
-There was no documentation that the recheck blood count was performed.

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 _____	01/18/2019

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 276	Continued From page 29 -There was no documentation of report to Resident #1's PCP that a recheck blood count was needed per the 12/17/18 ED discharge instructions. -There was no documentation of report to Resident #1's ENT that a recheck blood count was needed per the 12/17/18 ED discharge instructions. Review of the ED follow up office visit with Resident #1's ENT specialist dated 12/21/18 revealed there was no documentation that revealed a recheck blood count was performed. Refer to the interview with the ED and ADCS on 01/18/19 at 11:00 am. Refer to the interview with the ADCS on 01/18/19 at 1:00 pm. Interview with the ED and ADCS on 01/18/19 at 11:00 am revealed: -Emergency Medical Services (EMS) would bring the ED records back to the facility with the residents when the residents were returned to the facility from the ED. -The Medication Aide (MA)/Supervisor for the specific resident would start a "hot box" which was also known as "alert charting" for residents with a change in condition. -The MA/Supervisor would review any orders and send the orders to the pharmacy and the residents PCP -Discharge instructions would be sent to the residents PCP. -Any discharge instructions in question would be documented on the clarification form and sent to the residents PCP. Interview with the ED and the ADCS on 01/18/19	D 276		

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 _____	01/18/2019

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 276	Continued From page 30 at 1:00 pm reveled: -The facility had a "new order tracking form" that had step by step instructions on how to process orders from start to finish, and was a check list to be certain orders were processed per facility expectation. -A copy of the order would be attached to the new order tracking form and would be kept at the nurse's station. The original order was filed in the chart. -It was the responsibility of the resident care coordinator (RCC), resident care director (RCD), and memory care manager (MCM) to check every day. -The medical doctor was notified if labs not collected. -After the order was completed the tracking form would be filed and the ED would do periodic random audits to be certain the orders were completed. The ADCS would check on facility site visits.	D 276		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record review, the facility failed to assure foods were free from contamination related to a wet pink, brown and black build-up substance in the large	D 283		

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 _____	01/18/2019

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 283	Continued From page 31	D 283		

ice machine in the kitchen; a pink, tan and black build-up on the ice and water dispensing unit in the special care unit; open food packages that were not labeled or dated, foods not labeled or marked with an expiration date, soiled food container lids and expired foods stored in the pantry; rodent droppings around foods in the pantry and opened herb containers with tacky and grimy lids in the kitchen.

The findings are:

1. Observation of the ice machine in the kitchen on 01/15/19 at 5:21 p.m. revealed:
-There was a build-up of a wet pink, brown and black colored substance scattered across the lower portion of a white inner shield positioned directly over the bin of ice.
-Water was flowing across the build-up on the white inner shield that was dropping into the bin of ice.
-There was a heavier concentration of a tan and orange colored build-up substance covering a section of the upper wall of the storage bin of ice.
-There were water droplets formed across the upper wall of the storage bin.

Observation in the kitchen and in the residents' dining room on the assisted living (AL) section of the facility on 01/15/19 at 5:18 p.m. revealed beverage glasses were prefilled with ice for the residents' dinner meal.

Interview with a dietary aide (DA) on 01/15/19 at 5:32 p.m. revealed:
-The ice in the beverage glasses came from the ice machine in the kitchen.
-She had not noticed any pink, brown, or black colored build-up in the ice machine.
-The cook and the dietary manager (DM) 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 _____	01/18/2019

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 283	Continued From page 32	D 283		

responsible for cleaning the ice machine in the kitchen.

Interview with the DM on 01/15/19 at 5:20 p.m. revealed:
-The prefilled beverage glasses were prefilled with ice was prepared for the residents' dinner meal.
-The ice in the beverage glasses came from the ice machine in the kitchen.
-She was not aware of any build-up in the ice machine.
-She was responsible for cleaning the ice machine.
-The ice machine was cleaned at least every 2-3 weeks and was last cleaned a few days ago.
-She had a log posted in the kitchen for the days the ice machine was cleaned.
-When she cleaned the ice machine, the ice stored in the bin was protected with a cover.
-She cleaned the ice machine's inner walls and door with a sanitizer used in the kitchen mixed with water using a cloth.
-The maintenance staff assisted the DM to clean the ice machine every 6 months by removing the ice from the bin so the entire bin, walls and grooves could be cleaned.
-She would discard the ice in the beverage glasses and would dispose of the ice in the machine immediately.

Review of the ice machine cleaning log posted in the kitchen revealed there was documentation the ice machine had been cleaned by the DM on 01/01/19, 01/06/19, and 01/11/19.

Observation of the dining room on the AL side of the facility on 01/15/19 at 5:30 p.m. revealed the beverage glasses of ice used to serve the residents had been removed from the dining

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 _____	01/18/2019

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 283	Continued From page 33	D 283		

room by dietary staff and the residents were served beverages out of disposable cups with no ice.

Interview with the Executive Director (ED) on 01/15/19 at 5:45 p.m. revealed:
-The DM was responsible for cleaning the ice machine and the maintenance staff assisted the DM at times.
-Staff had emptied the residents' beverage glasses that were prepared for the supper meal today (01/15/19).
-The ice machine would be emptied by disposing of the ice in the bin immediately.
-She monitored the kitchen for cleanliness but had not seen and did not know about any issues with a build-up in the ice machine.

A second interview with DM on 01/17/19 at 8:45 a.m. revealed:
-She cleaned the inside of the ice machine in the kitchen at least every 7 days and as needed in between by wiping down the inside, the door, door casket and the guard (white inner shield) using water and sanitizer.
-She could not reach to clean behind the white inner shield but the outside vendor came last night (01/16/19) and removed some of the internal parts of the machine and cleaned them.

Interview with the maintenance staff on 01/18/19 at 4:04 p.m. revealed:
-The DM took care of the ice machine in the kitchen and he cleaned the ice and water dispensing unit in the SCU.
-He had never broken the ice machine unit down in the kitchen.
-The outside contractor for the ice machine told him when he came to the facility this week that there were no major concerns and the pink

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 _____	01/18/2019

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 283	Continued From page 34	D 283		

colored build-up was "bad in the south". He thought the pink colored build-up came from chlorine that was in the water.
-He saw a cream colored "moist", build-up removed from the unit that had no smell and was not slimy when the outside contractor cleaned the ice machine this week.

2. Interview with the Executive Director (ED) on 01/15/19 at 5:45 p.m. revealed the facility had an ice and water dispensing unit in the special care unit (SCU) that was not often used.

Observations in the SCU on 01/15/19 at 6:02 p.m. revealed:
-There was a table top ice and water dispensing unit located in the dining room of the SCU.
-There was a brown, black, and pink colored grimy build-up on the inner side of a clear splash guard that surrounded the water and ice dispenser.
-There was a scattered beige, black and pink colored build-up surrounding the base and opening of the vaulted section of the ice dispenser.

Interview with the ED on 01/15/19 at 6:05 p.m. revealed she was not aware of any build-up in the ice and water dispensing unit in the SCU.

Interview with a personal care aide (PCA) in the SCU on 01/16/19 at 8:32 a.m. revealed:
-She had worked at the facility for two months.
-She had never used the ice and water dispenser in the SCU but thought third shift used it to get water that was used on the medication carts.
-She had seen dietary staff clean the outer walls and clean the tray under the bottom of the unit using a red bucket and a cloth "about every day".

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 _____	01/18/2019

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 283	Continued From page 35 Interview with a second PCA in the SCU on 01/16/19 at 8:44 a.m. revealed: -She had not noticed a build-up on the clear splash guard on the ice and water dispensing unit in the SCU -She helped a resident use the ice and water dispenser approximately 2 weeks ago. Interview with a third PCA in the SCU on 01/16/19 at 8:45 a.m. revealed: -She had not noticed any build-up on the clear splash guard on the ice and water dispensing unit in the SCU. -She had never paid attention to the clear splash guard when she used the unit. -She used the ice dispenser today and helped a resident use the ice and water dispenser approximately 1 week ago. Interview with a housekeeper on 01/17/19 at 9:30 a.m. revealed: -She had worked at the facility approximately 7 months. -She cleaned the outer stainless steel parts of the ice and water dispensing unit and wiped the bottom tray out each day when she worked. -She had not noticed any build-up around the clear splash guard. -She had not been instructed to clean around the ice and water dispenser or the clear splash guard. Interview with a second housekeeper on 01/17/19 at 1:10 p.m. revealed she had never cleaned the ice and water dispensing unit in the SCU. Interview with DM on 01/17/19 at 8:45 a.m. revealed: -The ice and water dispenser's drip pan in the SCU was cleaned through the dishwasher by	D 283		

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 _____	01/18/2019

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 283	Continued From page 36	D 283		

dietary staff.
-Housekeeping and the maintenance staff cleaned the ice and water dispenser.

Interview with the maintenance staff on 01/18/19 at 4:04 p.m. revealed:
-The DM took care of the ice machine in the kitchen and he cleaned the ice and water dispensing unit in the SCU.
-He cleaned the ice and water dispensing unit in the SCU by removing all of the removable parts using a sanitizer.
-He last cleaned the ice and water dispensing unit on 01/16/19 using a cloth with half water and half bleach and finished the cleaning with a sanitizer, then rinsed with water.
-He cleaned the ice and water dispensing unit 4 months ago prior to the last cleaning.
-Housekeeping staff were responsible for cleaning only the stainless steel portions of the ice and water dispensing unit because he did not want them to use any chemicals around the dispensing section of the unit.
-He had not received any training since he had been employed at the facility about cleaning the ice machines.

Telephone interview with the contracted vendor for the facility's ice machine on 01/18/19 at 3:06 p.m. revealed:
-He provided services for the facility on an as needed basis.
-He had 25 years of experience working with ice machine units and 5 years of experience with sanitizing ice machines.
-The facility made him aware of the ice and water dispensing unit in the SCU but he did not service that unit.
-The build-up on the splash guard sounded like mildew.

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 _____	01/18/2019

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 283	Continued From page 37 -If there was visible build-up seen on the clear splash guard of the ice and water dispensing unit in the SCU there would have been a much bigger problem going on inside the unit and would only be "the tip of the iceberg" and a good indicator of what was going on the inside of the unit. 3. Observation of the kitchen on 01/15/19 at 4:05 pm revealed: -There were three wire racks containing spices on the corner wall from the stove, and a white ledge shelf on the left adjoining wall. -There were twenty-seven large clear plastic spice containers on the wire rack. -There were at least ten of the spice containers with open lids that were tacky and grimy when touched. -Two seasoning containers had a white, powdery substance on the lids and sides of the containers. -On the white ledge shelf were a mixture of spices, flavored syrups, and food coloring. -There was a bottle of mango sauce with an electronic best before date of 11/06/18. -There was one, 16 ounce (oz) bottle of chocolate colored syrup with syrup on the opening of the pour spout and down the sides. -There was one, 16 oz bottle of cinnamon sauce with rust colored syrup on the opening of the pour spout and down the sides of the spout, around the lid, and down the sides of the container. -There was one, 32 oz bottle approximately 3/4th full of red food coloring with dark debris around and under the lid edges. -There was one, 32 oz bottle of liquid brown seasoning flavor with a residue ring around the top portion of the bottle and dark splattered debris around the top outside of the bottle. Observation of the pantry on 01/15/19 from 4:20 pm - 5:10 pm revealed:	D 283		

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 _____	01/18/2019

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 283	Continued From page 38 -There were wire racks that had four shelves each for storage along the rooms facing wall, and to the left wall. -There were two containers of powdered drink mix on the second shelf from the top. One container lid had an electronic date of 04/22/17, and the other container lid an electronic date of 05/28/18. -There were four, 4 lb cans of caramel topping, and on the top of the cans were black handwritten dates 08/25/16. -There were six, 14 oz cans of whole red pimento without expiration dates. -There were two, 1 gallon plastic containers of molasses with a handwritten date of 02/27/17 on the lids. The containers were sticky and tacky to touch, and had brown colored drippings from the top of the container down the sides in multiple areas. -There was one sealed plastic bag of granola with an electronic date of 06/12/17. -There was one sealed bag of oat cereal with an electronic date of 05/11/18. -There was a twenty-three lb opened container of chocolate fudge icing with a handwritten date of 09/07/18 on the lid. On the edges of the container was dried tan and black colored debris that flaked off when touched. -There was a (named) cardboard box with no less than twenty individual four oz plastic containers of juices. The box had an electronic best by date of 05/22/18. -There was one opened 16 oz bottle of kiwi flavored syrup and two 16 oz bottles of caramel flavored syrups stored on a storage rack with no covering over the opening of the bottles. -There was a large food storage bin used to store sugar with a lid that had scattered loose food particles and was covered in a tacky film.	D 283		

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 _____	01/18/2019

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 283	Continued From page 39 Interview with the Dietary Manager (DM) on 01/15/19 at 4:50 pm reveled: -Stock was rotated as it was restocked. -She checked the rotation of the food stored in the pantry each time food was delivered to the facility to make sure the already stored food on the shelf was moved to the front of the storage shelves and the new food being delivered was placed in the back of the storage shelves. A second interview with the DM on 01/15/19 at 5:15 pm revealed: -The stickers on the bulk boxes were what they ordered by, and the date on the stickers was when the shipment came in. -Some food expiration dates were on the bulk shipment containers, and some were on the individual containers. -The dates on the tops of lids were when the containers were opened. -Most of the time, the expiration dates were preprinted on the containers. -Staff would know a products expiration date if the products were kept in the shipment box because there were expiration dates on the shipment boxes. -She knew after one year food was not good and was not used. -There was no way to know an expiration date if it was not on the bottles or packages. -There was not a policy for labeling containers that were removed from the shipment boxes. Observation of the DM on 01/15/19 at 5:15pm revealed she pointed to the letters and numbers by a universal product code (UPC) as the expiration date for a container of opened molasses. Interview with the Executive Director (ED) on	D 283		

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 _____	01/18/2019

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 283	Continued From page 40 01/15/19 at 5:43 pm revealed she monitored the kitchen for cleanliness. Observation of the pantry on 01/16/19 at 10:01 am revealed: -There were wire racks that had four shelves each for storage along the rooms facing wall, and to the left wall. -There was one sealed plastic bag of granola with an electronic date of 06/12/17. -There was one sealed bag of oat cereal with an electronic date of 05/11/18. -There were eleven, 24 oz foil bags of vanilla pudding and pie filling mix without expiration dates. -There was one, 12 quart plastic container labeled with a named brand flaked cereal that was approximately ½ full. It was not dated, and there was no expiration date. -There was one, 12 quart plastic container labeled rice cereal that was approximately 1/4th full. It was not dated, and there was no expiration date. -There was one, 12 quart plastic container labeled ziti that was approximately 1/4th full that was not dated. -There was one, 6 quart plastic container of labeled egg noodles that was full, and was not dated. The lid was dirty and tacky to touch. -There was one, 6 quart plastic container labeled with a named brand oat cereal that was approximately 3/4th full. It was not dated, and there was no expiration date. -There was one, 6 quart plastic container labeled with a named brand rice cereal that was approximately ½ full. It was not dated, and there was no expiration date. -There was one, 6 quart plastic container labeled bread crumbs that was empty. There was light tan to cream colored debris on the inside walls of	D 283		

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 _____	01/18/2019

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 283	Continued From page 41	D 283		

the container.
-All seven of the containers had lids that were tacky and grimy to touch.
-There were four, 5 lb plastic bags of unopened yellow cake mix without expiration dates.
-There was one, 1 lb bag of unopened mini marshmallows with an expiration date of 03/20/18.
-There were four, 5 lb bags of fudge brownie mix without expiration dates.
-There were four, 2 lb bags of powder sugar without expiration dates.
-There was one, 5 lb bag of gingerbread mix that was opened and the top was rolled down unsecured.
-There were seven, 2 lb bags of brown sugar without expiration dates.

Interview with the facility's contracted dietician on 01/16/19 at 11:15 am revealed:
-She was onsite at the facility one to two times a year, unless needed more; then they would call her in.
-She provided oversight, education, and in-services for the kitchen staff.
-All of the food was consumed within seven days because food was ordered two times a week.
-She expected staff to label food items with the dates they were opened, and when removing items from shipping boxes with the dates they were opened.
-There were some items that had a year shelf life; spices, jellies, anything with sugar, flour.
-Rices and pasta would last unlimited because there was nothing in them to grow.
-Vinegars, syrups, and molasses did not need an expiration date because they would never expire.
-Cereal should be dated the date they were opened.
-Staff could use the shipping labels from the

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 _____	01/18/2019

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 283	Continued From page 42	D 283		

shipping boxes to put on plastic containers when dry goods were poured in them.
-For tacky feeling containers she would expect a rotation of cleaning and there was "probably" no risk for contamination from the tacky containers to the food but it "could happen".

A third interview with the DM on 01/16/19 at 11:20 am revealed she expected staff to label and date any package opened.

Interview with a dietary aide on 01/18/19 at 4:40 pm revealed:
-She did not put the expiration date on opened foods that were removed from the original shipping boxes. She would only put the date opened and what the product was.
-She would not know the expiration date if it was not already on the package when taking it out of the original shipping box.
-Whatever food was already opened was the oldest.

Interview with the ED, dietician, and Area Director of Clinical Services (ADCS) on 01/18/19 at 5:05pm revealed:
-Staff had a rotating process when stocking food to where the new food was in the back and the old food was put in the front.
-The ED expected staff to keep a system where they would know when food was opened and expired.
-The dietary aides should go through the food and look for expiration dates, and anything expired should be thrown away.

4. Observation of the kitchen on 01/15/19 at 4:05 pm revealed:
-There was a long glue fly trap tube hanging from the ceiling in the corner over the spices on the

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 _____	01/18/2019

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 283	Continued From page 43	D 283		

white ledge shelf.
-The glue fly trap tube contained three flies stuck to the inner edge. Below the ledge was a fly swat.

Observation of the pantry on 01/15/19 from 4:20 pm - 5:10 pm revealed:
-There was a rolling rack with 9 shelves that held fifteen, 6 pound (lb) 3 oz cans on the right wall.
-On the bottom frame of the rolling rack just above the casters were rodent droppings.
-There was a twenty-three lb opened container of chocolate fudge icing. On the top of the lid were small rodent droppings.
-There was a cardboard box containing four, 5 oz packages of vanilla pudding pie filling mix with pink to light red powder substance, brown flake cereal like substance, and rodent droppings scattered on the top of the packages and in the cardboard box.
-There was a (named) cardboard box with no less than twenty individual four oz plastic containers of juices. In the box were scattered rodent droppings.
-There were approximately eight, single serving size cans of soup stored on a serving tray on the storage rack with rodent droppings scattered across the tray.
-There was a spring loaded mouse trap with the spring bar deactivated to capture a mouse under the wire shelving to the right of the room.

Interview with the Dietary Manager (DM) on 01/15/19 at 4:50 pm reveled:
-She knew there had been mice problems.
-She did not set the mouse trap.
-Maintenance had told her the mice problem was from a parking lot construction site behind the facility.
-The mice problems had been going on since November 2018, and had seen mostly in the back

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 _____	01/18/2019

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 283	Continued From page 44 hall of the kitchen. -"Rat traps" had been put out and had caught two mice that came through the back kitchen door. -She had not seen mice in the dry food pantry. -She checked the food pantry every other day, and was last checked today (01/15/19). -She would look around boxes, and for any holes in containers. -She would look for rodent droppings twice weekly when the new food shipment was delivered and stock was rotated. -She had not seen any mice droppings. -She was "quiet sure ..." maintenance had reported the mouse problem to the exterminator. -She thought the exterminator came monthly or every other month. -She was supposed to let maintenance know if she saw mice. -The mice droppings in the pantry "...had to happen the last day or so." Interview with maintenance staff on 01/15/19 at 5:05 pm revealed: -The last mouse was caught two weeks ago. -There was a mouse caught under the rack in the storage room, and one in the dietary manager's office. -The mice problems had been going on since November 2018. -The exterminator came monthly and would set baits outside. -If there was a "minor" problem with mice he would handle himself. -A minor problem with mice would be three mice a month. -If there were ten mice a month he would contact the exterminator. -Dietary was responsible for checking the boxes in dry storage. -He was "pretty sure" the mice droppings came	D 283		

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 _____	01/18/2019

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 283	Continued From page 45 from the mice caught two weeks ago. Interview with the Executive Director (ED) on 01/15/19 at 5:43 pm revealed: -She monitored the kitchen for cleanliness. -She did not know about the mice droppings in the kitchen; and she would call the exterminator for outdoor traps. Observation of the pantry on 01/16/19 at 10:01 am revealed: -There was a hole with jagged edges approximately quarter sized towards the end of one, 3 lb foiled bag of croutons with crumbs around the hole on the outside of the bag. -There was a hole with jagged edges approximately dime sized in the side of a plastic bag containing cereal flakes. A second interview with maintenance staff on 01/18/19 at 4:04pm revealed: -The exterminator would set bait traps outside that was a block of poison the rodent would go inside and eat then go back out. -There was currently a glue trap for mice under the ice machine in the kitchen. -He had placed glue traps for mice in the kitchen dry storage, and by the backdoor under the shelves -When he would catch a mouse he would discard it in a bag, and put it in the trash. -Everyone knew to report mice sightings to him. -There was not a pest log. -The last mouse was seen three weeks ago, and he had caught three since April 2018. -He called the exterminator yesterday (01/17/19) because of old rodent droppings in the dry storage. -He knew the droppings were old because they were hard. If the droppings were soft that mean	D 283		

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 _____	01/18/2019

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 283	Continued From page 46	D 283		

they were fresh droppings.
-The exterminator came monthly, and he would call him for more visits if there was anything out of the ordinary, meaning "five or more mice".
-He did not call the exterminator three weeks ago when he first started seeing the mice.
-He had never seen a written policy and/or procedure for rodents.
-When he would set out glue traps he would tell the DM but would not tell the ED.
-He checked the traps every day Monday - Friday, between the hours of 8:30 am - 5:00pm. and the DM checked the traps in the kitchen on the weekends. If the DM wasn't working she would assign someone to check the traps.
-If a mouse was caught on the weekend, he would come to the facility to remove it.
-He did not set live traps in the dry storage room and did not know who would have set the trap.

Interview with the ED, dietician, and Area Director of Clinical Services (ADCS) on 01/18/19 at 5:05pm revealed:
-The maintenance staff or DM called the exterminator.
-The ED expected to be told of any rodents found and she would call the exterminator.

The facility failed to assure foods were free from contamination related to a wet pink, brown and black build-up substance in the large ice machine in the kitchen; a pink, tan and black build-up on the ice and water dispensing unit in the special care unit; open food packages that were not labeled with a date opened, foods not labeled or marked with an expiration date, soiled and tacky food container lids, and expired foods stored in the pantry; rodent droppings around foods in the pantry that had jagged holes in packaging, and in boxes with foods, and opened herb containers

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 _____	01/18/2019

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 283	Continued From page 47 with tacky and grimy lids that were stored under and near a fly trap in the kitchen. The facility's failure resulted in an increased risk for the transmission of disease due to contamination of foods consumed by the residents which was detrimental to the health, safety, and welfare of the residents which constitutes a TYPE B VIOLATION. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/15/19 with an addendum dated 01/23/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 04, 2019	D 283		
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.	D 358		

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 _____	01/18/2019

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 358	Continued From page 48 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered for 4 of 6 sampled residents (#1, #3, #8, #9) including observations during the 8:00am medication pass on 01/16/19 of late administration of an eye drop (#8) and a medication used to treat stomach disorders (#9); and 2 of 6 sampled residents (#1, #3) for record review including errors with a breathing treatment (#1) and synthroid (#3). The findings are: 1. The medication error rate was 6% as evidenced by observations of 2 errors out of 29 opportunities during the 5:00pm medication pass on 01/15/19, and the 8:00am medication pass on 01/16/19. a. Review of Resident #8's current FL-2 dated 07/12/18 revealed diagnoses included traumatic brain injury, hemiplegia, and depression. Review of a physician's order for Resident #8 revealed: -There was a medication clarification physician's order dated 10/01/18 for Prednisolone 1% (used to treat inflammation of the eyes) place one drop into left eye four times a day. -There was a signed physician's order copy dated 11/01/18 which included an order for Prednisolone Acetate 1% instill one drop in left eye four times daily. -There was a prescription from a local eye associates office for Pred Forte (a brand name for Prednisolone Acetate 1%) 1% reduce to one drop three times a day one week then two times a day week, then one time a day one week, then stop.	D 358		

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 _____	01/18/2019

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 358	Continued From page 49 Observation of the 8:00am medication pass on 01/16/19 revealed: -Resident #8's medications were prepared and administered to the resident at 8:00am in the resident's room. -There were no Prednisolone Acetate 1% eye drops administered. Review of Resident #8's January 2019 medication administration records (MARs) revealed: -There was a handwritten entry for Pred Forte 1% instill one drop to left eye three times a day for one week scheduled for administration at 8am, 2pm, and 5pm daily. -There was documentation for administration for the Pred Forte 1% eye drops at 8am on 01/16/19. Interview with the Medication Aide (MA) on 01/16/19 at 10:20am revealed: -She checked her MARs when she finished her medication pass. -She saw that she had missed administering the Pred Forte 1% eye drops to Resident #8, so she administered the Pred Forte 1% eye drop late when she noticed the omission around 10am. -There was a family member in the room when she administered the eye drops to Resident #8. Interview with the MA on 01/16/19 at 5:20pm revealed: -She always double checked the MARs for "holes" when she finished her medication passes. -When she saw a "hole" [medication omission] on the MAR, she would go back to the resident and administer the medication. Observation of the medication on hand for Resident #8 on 01/16/19 at 5:20pm revealed	D 358		

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 _____	01/18/2019

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 358	Continued From page 50 there was an opened bottle of Pred Forte 1% ophthalmic solution dispensed 01/10/19 for Resident #8 from the provider pharmacy that included labeled instructions of one drop to left eye three times a day for 7 days. Interview with Resident #8 on 01/17/19 at 11:05am revealed: -She usually was administered eye drops three times a day. -She remembered having the eye drops administered "at least two times on yesterday", but was not sure. -She did not know the name of the eye drops. -She did not remember if a family member visited on 01/16/19. -She denied having any itching or burning sensation to her eyes. Telephone interview with the family member on 01/17/19 at 11:25am for Resident #8 revealed: -She visited the resident 2 - 3 times a week. -She visited the resident on 01/16/19. -Resident #8 was administered eye drops on 01/16/19 "around 10:00am". Interview with the Provider Pharmacist on 01/17/19 at 12:45pm revealed: -There was a current order for Resident #8 for Pred Forte 1% that included instructions for one drop to left eye three times a day for 7 days. -The times of administration had been spaced out over awake hours. -A small deviation in administering the medication would have no effect to the resident. Refer to interview with Executive Director/Administrator (ED) dated 01/18/19 at 11:15am.	D 358		

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 _____	01/18/2019

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 358	Continued From page 51 b. Review of Resident #9's current FL-2 dated 10/30/18 revealed: -Diagnoses included hypertension, diabetes mellitus type 2, chronic obstructive pulmonary disease, emphysema, chronic kidney disease, and dehydration. -There was a physician's order Omeprazole (used to treat disorders of the stomach) 20mg tablet every day at least 30 minutes prior to meal. Review of a physician's order for Resident #9 revealed there was a medication clarification physician's order dated 12/20/18 for Omeprazole 20mg capsule DR one cap every day at least 30 minutes prior before meal. Observation of Resident #9 on 01/16/19 at 8:32am revealed: -The resident was sitting in a chair next to the bed. -A staff delivered Resident #9's breakfast tray to the room and placed the breakfast tray on the bedside table. -The staff uncovered the breakfast tray and left the resident's room. Observation of the 8:00am medication pass on 01/16/19 revealed the MA prepared and administered Resident #9's medications at 8:35am, mixed in pudding, in the resident's room, including one Omeprazole 20mg capsule. Observation of Resident #9 on 01/16/19 revealed: -At 8:43am the resident took the first bite of the breakfast meal after the administration of the morning medications, which included the Omeprazole. -At 8:43am, the resident drank a sip of coffee. -At 8:45am, the resident drank a sip of juice.	D 358		

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 _____	01/18/2019

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 358	Continued From page 52 Review of Resident #9's January 2019 MARs revealed: -There was a printed entry for Omeprazole 20mg capsule DR take one capsule every day at least 30 minutes prior before meal scheduled for administration at 7:30am daily. -There was documentation for administration of the Omeprazole at 7:30am on 01/16/19. Interview with the MA on 01/17/19 at 12:15pm revealed: -She could administer medication one hour before or one hour after the scheduled medication time. -She saw the instructions on Resident #9's MAR for the Omeprazole to be administered 30 minutes before the meal. -She saw on the MAR that the Omeprazole was scheduled to be administered at 7:30am. -She knew she was administering the Omeprazole late but did not want Resident #9 to not be administered the Omeprazole. -The process followed when a medication was administered outside the timeframe was to contact the physician, and she was getting ready to do that. Interview with the Provider Pharmacist on 01/17/19 at 12:35pm revealed: -The pharmacy was responsible for printing the MARs for the facility residents. -The instructions for Resident #9's Omeprazole included administering the medication 30 minutes before the meal. -The expectation would be for the Omeprazole to be administered before the meal. -Omeprazole was normally given on an empty stomach and was more effective on an empty stomach.	D 358		

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 _____	01/18/2019

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 358	Continued From page 53 Interview with Executive Director/Administrator (ED) on 01/18/19 at 11:15am revealed: -She expected medications to be administered to residents as ordered and documented. -Medications were supposed to be administered within the timeframe of one hour before or after scheduled time. -If a medication was not administered within the timeframe, the MA was supposed to contact the physician for direction. -She expected staff to sign off medications when administered and recheck the MARs after the medication pass was finished, and do a third check of the MARs at end of shift. 2. Review of the current FL-2 dated 01/03/19 for Resident #1 revealed diagnoses of chronic obstructive pulmonary disease (COPD), muscle weakness, hypothyroidism, obesity, and major depressive disorder. Resident #1 was incontinent of bowel and bladder. Review of the Resident Register for Resident #1 revealed an admission date of 10/01/18. a. Review of Resident #1's current FL-2 dated 01/03/19 revealed there was an order for albuterol 0.083% 1 vial by inhalation four times daily as needed. Review of a physician visit form for Resident #1 dated 01/08/19 revealed: -There was a request to discontinue albuterol solution 0.083% by nebulizer four times a day. -There was an order to change albuterol to three times a day scheduled. Review of a subsequent order for Resident #1 dated 01/11/19 revealed an electronic prescription	D 358		

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 _____	01/18/2019

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 358	Continued From page 54	D 358		

for albuterol sulfate 2.5mg/3ml (0.083%) solution for nebulizer use 1 vial by inhalation four times a day as needed.

Review of a medication clarification form for Resident #1 dated 01/15/19 revealed:
-Documentation to discontinue albuterol sulfate 2.5mg/3ml (0.083%) by nebulizer 1 vial four times a day as needed.
-Documentation to administer albuterol sulfate 0.083% by nebulizer one vial three times a day scheduled.

Review of Resident #1's facility chart revealed there was no order to discontinue the current FL-2 order for Resident #1 dated 01/03/19 for albuterol 0.083% 1 vial by inhalation four times daily as needed from 01/03/19 - 01/15/19

Interview with Resident #1 on 01/15/19 at 10:40 am revealed:
-She had COPD, became short of breath on exertion, was on Oxygen 2 liters at bedtime, and used albuterol nebulizers.
-She had been out of albuterol nebulizer for 4 days in a row because there were no refills left on the prescription.
-Two nights ago she had shortness of breath and asked for an albuterol nebulizer treatment.
-She did not have the albuterol breathing treatment because she had run out.
-She had to have an extra pillow to prop up so she could breathe better.
-She had to sit up "for a while" because of shortness of breath.
-Her shortness of breath improved after sitting up "for a while" with the extra pillow.

A second interview with Resident #1 on 01/17/19 at 4:41pm 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 _____	01/18/2019

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 358	Continued From page 55 -On the night she had shortness of breath she had gone to bed and it was sometime after 8:00pm when she needed the albuterol nebulizer treatment. -The person who told her the albuterol was out was PCA. -"She did the best she could. She went looking for the albuterol and could not find it..."I don't want to get anyone in trouble." -She was told the physician did not write a refill for the albuterol nebulizer and they were having trouble getting a hold of the physician. Interview with a MA on 01/17/19 at 12:50pm revealed: -She did not know two nights ago Resident #1 had needed an albuterol nebulizer treatment and did not receive it because there was not any available. -Albuterol nebulizer vials were reordered when there were approximately five vials left. -She did not know if albuterol nebulizer vials were on automatic reorder from the pharmacy. -If the albuterol had five vials remaining she would not wait for the pharmacy to automatically send if they were on automatic refill. -She had never had to reorder albuterol nebulizers for Resident #1 because they were full or had already been reordered. Review of Resident #1's albuterol on 01/17/19 at 3:02pm of Resident #1's albuterol box revealed: -There was an electronic label that read albuterol sul 0.083% 2.5mg/3ml via 75ml refills 3, refill after 01/20/19 use one vial by inhalation route four times per day as need, and was dated 01/14/19. -There were 25 x 3ml unit dose vials to a box, and there were 19 vials remaining. - There was a black, handwritten date on the top of box lid that read "open 1/15/19".	D 358		

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 _____	01/18/2019

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 358	Continued From page 56 Observation of medications on hand for Resident #1 on 01/18/19 at 10:40am revealed: -There was a box of albuterol sulfate inhalation solution 0.083% with an electronic label. -The electronic label read albuterol sul 0.083% 2.5mg/3ml via 75ml, refill after 01/20/19, and three refills, and was dated 01/14/19. -The electronic label had a sticker placed over it that read "directions changed refer to chart". -There were 25 x 3ml unit dose vials to a box, and there were 17 vials remaining with three refills. - There was a black, handwritten date on the top of box lid that read "open 1/15/19". Review of Resident #1's eMAR for 01/03/19 - 01/17/19 revealed: -There was an electronic entry for albuterol solution 0.083% 2.5mg/3ml vial by nebulizer inhalation four times daily as needed. -There were no staff initials documenting that it had been administered. -On the same line as the initial boxes for the electronic entry of albuterol sulfate there was handwritten documentation that read "D/C 1-15-19", and was initialed. -There was documentation on the signature sheet of the back of the same eMAR dated 01/14/19 that read "2pm and 8pm albuterol sulf 0.083% not available". Telephone interview with the facility's contracted pharmacist on 01/16/19 at 5:10pm revealed: -On 10/29/18 there was one box of albuterol solution 0.083% 2.5mg/3ml vials sent to the facility for Resident #1. The orders were to use one vial by inhalation four times a day as needed. -On 01/14/19 there was one box of albuterol solution 0.083% 2.5mg/3ml vials sent to the	D 358		

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 _____	01/18/2019

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 358	Continued From page 57	D 358		

facility for Resident #1. The orders were to use one vial by inhalation four times a day as needed.
-There were 25 vials in each box.
-If the albuterol needed to be administered four times a day, one box would have lasted Resident #1 around six and one-half days.

A follow up telephone interview with another facility contracted pharmacist on 01/25/19 at 1:45pm revealed:
-Albuterol sulfate was only dispensed on 10/29/18 and 01/14/19 for Resident #1.
-On 01/10/19 there were only two vials of albuterol sulfate remaining for Resident #1.
-The pharmacy would automatically refill only routine, oral, solid medications.
-It would be the responsibility of the facility to request refills for the albuterol sulfate.
-There was no guideline on when the facility would need to request refills for as needed medications.
-It would be up to the facility on when they would request the refill for as needed medications.

Interview with the Executive Director (ED) on 01/18/19 at 11:15am revealed she expected medications to be administered to residents as ordered and documented.

Attempted interview with a Medication Aide/Personal Care Aide (MA/PCA) on 01/16/19 at 7:35 am was unsuccessful.

Attempted interview with a MA on 01/18/19 at 10:50 am was unsuccessful.

Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 01/18/18 at 1:18 pm was unsuccessful.

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 _____	01/18/2019

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 358	Continued From page 58 b. Review of Resident #1's current FL-2 dated 01/03/19 revealed there was an order for albuterol 0.083% 1 vial by inhalation four times daily as needed. Review of a physician visit form for Resident #1 dated 01/08/19 revealed: -Under a section titled "purpose of visit, recent concerns" there was documentation of a request to discontinue albuterol solution 0.083% by nebulizer four times a day. -Under a section titled "new orders" there was documentation that read change albuterol to three times a day. Review of a subsequent order for Resident #1 dated 01/11/19 revealed an electronic prescription for albuterol sulfate 2.5mg/3ml (0.083%) solution for nebulizer use 1 vial by inhalation four times a day as needed. Review of a medication clarification form for Resident #1 dated 01/15/19 revealed: -Documentation to discontinue albuterol sulfate 2.5mg/3ml (0.083%) by nebulizer 1 vial four times a day as needed. -Documentation to administer albuterol sulfate 0.083% by nebulizer one vial three times a day. Review of Resident #1's electronic medication administration record (eMAR) for 01/03/19 - 01/17/19 revealed: -There was an electronic entry for Albuterol 0.083% 2.5 milligrams (mg)/3 milliliters (ml) inhale contents of 1 ampule (amp) by nebulizer four times daily. -There were staff initials in the initial box that the albuterol was administered from 01/03/19 - 01/10/19 for a total of 28 doses.	D 358		

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 _____	01/18/2019

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 358	Continued From page 59 Review of Resident #1's facility chart revealed there was no order to administer albuterol 0.083% 2.5mg/3ml inhale 1 amp by nebulizer four times a day scheduled from 01/03/19 - 01/10/19. Interview with the Executive Director (ED) on 01/18/19 at 11:15am revealed she expected medications to be administered to residents as ordered and documented. 3. Review of Resident #3's current FL-2 dated 10/09/18 revealed diagnoses that included vitamin D deficiency, insomnia and vascular dementia. Review of a Physician's Visit Form dated 12/10/18 revealed an order for Synthroid 25 mcg every morning 1 hour before coffee or breakfast. Review of Resident #3's January 2019 medication administration record (MAR) revealed: -There was an electronic entry for Synthroid 25mcg each morning 1 hour before coffee or breakfast. -Synthroid was documented as administered from 01/01/19 through 01/13/19 at 6:00am. -Synthroid was documented as not administrated on 01/14/19, 01/15/19 and 01/16/19 because "out of medicine; waiting on pharmacy." Review of Resident #3's medications on hand on 01/15/19 at 3:50pm revealed: -There was no Synthroid labeled for the resident on the medication cart. -The MA stated the empty Synthroid punch card must have been discarded. Interview with a pharmacy technician at the providing pharmacy on 01/17/19 at 10:41am revealed:	D 358		

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 _____	01/18/2019

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 358	Continued From page 60 -Resident #3 did not have a prescription for refills for Synthroid until 01/16/19. -The medication refill system does not notify the facility when a new prescription is needed. -The medication aide (MA) has to monitor the "anniversary date" on the medication card to see when a new prescription is needed. Interview with Executive Director (ED) and Area Director of Clinical Services (ADCS) on 01/17/18 at 4:50pm revealed: -The facility did not have a medication reorder policy. -The ED and ADCS expected the MA to contact the pharmacy before medications run out. -If the refill was not obtained by the MA, he or she should have contacted the Resident Care Director (RCD). -If the RCD could not resolve the problem with the refill, the ED or the ADCS should be contacted. -The ED nor the ADCS did not know why Resident #3 was out of Synthroid for 3 days. Attempted telephone interview with the prescribing physician on 01/16/19 at 10:19am was unsuccessful.	D 358		
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.	D912		

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 _____	01/18/2019

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
D912	Continued From page 61 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to nutrition and food service. The findings are: Based on observations, interviews, and record review, the facility failed to assure foods were free from contamination related to a wet pink, brown and black build-up substance in the large ice machine in the kitchen; a pink, tan and black build-up on the ice and water dispensing unit in the special care unit; open food packages that were not labeled or dated, foods not labeled or marked with an expiration date, soiled food container lids and expired foods stored in the pantry; rodent droppings around foods in the pantry and opened herb containers with tacky and grimy lids in the kitchen. Refer to Tag 0283, 10A NCAC 13F .0904 (a) (2) Nutrition and Food Service (Type B Violation)].	D912		
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	D914		

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 _____	01/18/2019

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
D914	Continued From page 62 reviews, the facility failed to assure residents are free of neglect and in compliance with federal and state laws and rules and regulations related to related to health care. The findings are: Based on observations, interviews and record reviews, the facility failed to assure referral and follow up for the acute health care needs for 1 of 5 sampled residents (Resident #5) as evidenced by a two day delay of notifying the primary care provider after an unwitnessed fall followed by documented complaints of pain after the fall resulting in a diagnosis of a right hip fracture three days later.[Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].	D914		