PRINTED: 08/02/2016 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		HAL053027	B. WING		07/2	8/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING	1107 CART SANFORD,	HAGE STREE NC 27350	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	County Department of an annual, follow-up sinvestigation on July 2 complaint investigation	sure Section and the Lee f Social Services conducted survey and a complaint 27 and July 28, 2016. The n was initiated by the Lee f Social Services on July 5,				
D 113	10A NCAC 13F .0311	(d) Other Requirements	D 113			
	provide an adequate kitchen, bathrooms, la closets and soil utility temperature at all fixth be maintained at a mi (38 degrees C) and si	stem shall be of such size to supply of hot water to the aundry, housekeeping				
	reviews, the facility fa temperature of 6 fixtu in the resident bathro- between 100 degrees	ns, interviews and record iled to assure the hot water res (5 sinks and 1 shower) oms were maintained s Fahrenheit (F) and 116 ater temperatures ranging				
	The findings are:					
	on 07/27/16 from 10:5 -The hot water tempe #3 was 126 degrees I	acility during the initial tour 50 am to 11:45 am revealed: rature at the sink of Room F. rature at the sink of Room				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053027	B. WING		07/28/2016
NAME OF PROVIDER OR SUPPLIER ROYAL OAKS ASSISTED LIVIN	1107 CAR	DRESS, CITY, STA THAGE STREE D, NC 27350		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
#5 was 126 degree -The hot water tem #6 was 124 degree -The hot water tem #26 was 128 degree -The hot water tem Room #26 was 120 Interview on 07/27 who resided in Roo -He had not notice being too hotHe had never bee -He had no probled Interview on 07/27 who resided in Roo -She thought the w -She had never be -She said she adjuturning the handle Interviews on 07/2 11:17 am with 3 ac -No problems with -None had been be -"When the water for more cold". Interview on 07/27 of Room #26 reveal -He stated he cannot temperature in his hotHe stated he had water.	perature at the sink of Room as F. perature at the shower of a degrees F. 19 at 10:57 am with a resident am #4 revealed: at the hot water temperature an burned by the hot water. as with the hot water. as with the hot water. at 19 at 11:00 am with a resident at #5 revealed: atter temperatures were good. an burned by the hot water. asted the water temperature by attended to the water temperature by attended to the tot water. 17/16 between 11:13 am and additional residents revealed: attended to the tot water. attended to the hot wat	D 113		

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hop out real quick" because the hot water was too

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DIVISION	n nealth Service Regu	iation			1	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ED
			_			
		HAL053027	B. WING		07/28/	2016
	20,4252 02 0422452	0.7.0.5.7.4.5	DD500 0171/ 074	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	II E, ZIP CODE		
POVAL O	AKS ASSISTED LIVING	1107 CAF	RTHAGE STREE	Т		
NO IAL O	AND ADDID EIVING	SANFOR	D, NC 27350			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	v	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 440		_	D 440			
D 113	Continued From page	2	D 113			
	hot.					
		, there was a temperature				
		there was a temperature				
		ne shower, "Oh, I didn't				
	know that was there".					
	Observation on 07/27	7/16 at 11:45 am of Room				
	#26 revealed:					
	-The hot water tempe	rature in the sink was 114				
	degrees F.					
	•	rature in the shower was				
	•	iature in the shower was				
	also 114 degrees F.					
		7/16 at 11:45 am revealed				
	maintenance staff had	d placed signs that said				
	"Use caution with hot	water" in each bath room.				
	Recheck of hot water	temperatures on 07/27/16				
	at 2:00 pm revealed:	•				
		rature at the sink of Room				
	#3 was 100 degrees I					
	_	rature at the sink of Room				
	#4 was 104 degrees I					
	•					
		rature at the sink of Room				
	#5 was 102 degrees I					
	•	rature at the sink of Room				
	#6 was 110 degrees F					
	-The hot water tempe	rature at the sink of Room				
	#26 was 112 degrees	F.				
	-The hot water tempe	rature at the shower of				
	Room #26 110 degree					
	1.2525 110 dogio					
	Review of the water to	emperature log on 07/28/16				
	at 9:48 am revealed:	cimperature log off 07/20/10				
	-Temperatures were o					
	documented on to the					
	-	ocumented for the month of				
	May 2016 ranged from	m 114 to 120 degrees F.				
		ocumented for the month of				
		m 118 to 120 degrees F.				
		ocumented for the month of				
	- me temperatures do	Cumented for the Infolling	1			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAI 052027	B. WING		07/29/2046
NAME OF P	ROVIDER OR SUPPLIER	HAL053027	RESS, CITY, STA	TE ZIP CODE	07/28/2016
	AKS ASSISTED LIVING		HAGE STREE		
KOTAL O	AND ADDIOTED LIVING	SANFORD	NC 27350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 113	Continued From page	e 3	D 113		
	July 2016 ranged from	m 116 to 122 degrees F.			
	maintenance staff rev-He had worked at the He checked the hot of recorded the results of He thought the accept water temperature water bring too hot. None of the residents water bring too hot. None of the residents burned by the hot water bring too hot. Now that he knew the the hot water temperature would temperature. Interview on 07/28/16 Resident Care Coording The hot water temperature. Interview on 07/28/16 Resident Care Coording He kept a log of the legal None of the residents hot water temperature. Interview on 07/28/16 Administrator reveale The hot water temperature weekly by the facility logged on to the hot was not the hot was not the hot was not the residents.	e facility for 80 days. water temperatures and on the hot water log weekly. ptable high range of the hot as 120 degrees F. s had complained about the s had said they had been ter. e acceptable high range of ature was 116 degrees F, d remain at that s at 10:25 am with the inator (RCC) revealed: veratures were checked nance staff. hot water temperatures. s had complained about the e being elevated. s at 10:45 am with the d: veratures were checked maintenance staff and			
D 307	10A NCAC 13F .0904 Service	l(e)(1) Nutrition And Food	D 307		
	10A NCAC 13F .0904	Nutrition And Food Service			

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	or periornoise		(V0) 1411 7707	CONCEDUCTION	(V2) DATE 3:	IDVEV
	OF DEFICIENCIES OF CORRECTION	DECTION DENTIFICATION NUMBER:				
, and I LANG		.BERTH IOMITON NOWBER	A. BUILDING: _			0
		HAL053027	B. WING		07/2	8/2016
NAME 2= -	DOMBER 02 01/25: :==		DDE06 017:: 5=:	TE 7/D 00DE	· · · · · ·	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ROYAL O	AKS ASSISTED LIVING		THAGE STREE	Т		
		SANFORI	D, NC 27350			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
TAG	REGULATORT OR L	LSC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	NAIE	DATE
D 307	7 Continued From page 4		D 307			
	(e) Theraneutic Diets	s in Adult Care Homes:				
		et orders including thickened				
		ing from the resident's				
	-	plicable, the therapeutic diet				
	order shall be specific	•				
	-	for calorie controlled ADA				
	•	ts or thickened liquids,				
		en orders which include the				
		apeutic diet identified in the				
	facility's therapeutic n					
	registered dietitian.					
	. og.oto. ou u.ot.t.u					
	This Rule is not met	as evidenced by:				
		ns, interviews and record				
		illed to assure there was a				
	_	et order for 1 of 3 sampled				
	residents (Resident #					
	,	•				
	The findings are:					
	Review of Resident #	5's current FL 2 dated				
	1/28/16 revealed:					
	-Diagnoses included /	•				
	, ,	ageal reflux and muscle				
	weakness.					
	-An order for a no add					
	-There was no order f	for thickened liquids.				
						
	Review of Resident #	5's record on 7/27/16				
	revealed:	sisionale distanda 6				
		sician's diet order form				
	_	1/16 for a pureed, NCS diet.				
		cian's order for thickened				
	liquids.					
		nentation that Resident #5				
	had difficulty swallowi					
	=	h therapist documentation				
	for recommending this	ckened liquids.				
	Review of the therape	eutic diet list posted in the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPLI	
	HAL053027	B. WING		07/2	28/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROYAL OAKS ASSISTED LIVING	1107 CARTI SANFORD,	HAGE STREE NC 27350	Т		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
thickened liquidsResident #5 was not o "Diabetic" meal. Review of the kitchen's orders on 7/27/16 at 10 8:00 am revealed: -An order dated 1/06/16 "puree, no concentrated -No order for thickened -No order for NAS. Observation of the lunc revealed: -Resident #5 was serve applesauce, approximately beansResident #5 was serve loose, but did appear stablemate's waterResident #5 had a large juice with ice. It could not a thickener added to it of member reported thicked alreadyResident #5 consumed beverages without any Interview on 7/27/16 at room aide revealed: -"Before Resident #5 ea as directed on the power scoop for a large glass, small glass". She "did not observed"	0:40 am revealed: e served a pureed diet with on the list to be served a s notebook of physician diet 0:40 am and 7/28/16 at 6 for Resident #3 for a d sweets" diet. I liquids. ch meal on 7/27/16 ed approximately 1/2 cup ately 1 cup pureed BBQ by 1/2 cup pureed green ed water that looked very lightly thicker than a ge red glass of sugar-free not be determined if it had or not, although a staff ener had been added d 100 % of his meal and difficulties swallowing. ed 12:15 pm with a dining ats we thicken his liquids dered thickener- a large of and a small scoop for a not know" if it was ordered	D 307			

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STATE FORM 8899 2BIY11 If continuation sheet 6 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		HAL053027	B. WING		07	7/28/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		RTHAGE STREET			
		SANFOR	RD, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 307	Continued From page	e 6	D 307			
	Resident #5's liquids,	nber who told her to thicken but was told to follow the kener powder container.				
	Interview on 7/27/16 at 12:30 pm with Resident #5 revealed he did not need or want his liquids thickened. Interview on 7/28/16 at 7:25 am with the RCC revealed: -Resident #5 was not ordered to be on thickened liquids and did not know why the staff was thickening his beverages at meal timeShe "updated the kitchen staff to not thicken his (Resident #5) liquids yesterday afternoon (7/27/16)""Another resident had thought Resident #5 was choking with liquids so someone thought to try thickening his liquids."					
	to the survey team or revealed: -Resident #5 was to be diet. -Resident #5 was not NCS diet.	d therapeutic diet list given in 7/28/16 at 2:00 pm oe served a pureed, NAS on the list to be served a to be served thickened				
	7:45 am with the cool -She had worked at the monthsSugar-free beverage for quick identification sweet or notShe referred to the the					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
		HAL053027	B. WING		07/2	8/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		HAGE STREE	Т		
		SANFORD,	NC 2/350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 307	Continued From page	÷ 7	D 307			
	Administrator updated list since "we do not he to print it". -She was not responsithe posted therapeutic how often it was updatured -Copies of the physical were sent to the kitchwere placed in a note -"The front staff handle Interview on 7/27/16 are revealed: -Copies of resident dickitchen with any new	Coordinator (RCC) or the difference of the posted therapeutic diet have a computer back here will be for making changes on a diet list and did not know to ted. In diet orders for residents en by the "front staff" and book in the kitchen. ed all the orders." In at 3:30 pm with the RCC et orders were sent to the or changed diet orders. In an ager were to update the				
	send diet order chang -The kitchen staff wer posted therapeutic die -She expected diets to the physician. Interview on 7/28/16 a Supervisor revealed:	d: e Medication Aide should les to the kitchen staff. e responsible to update the				
	when "orders were che resident came in"She did not regularly was accurate.	ted therapeutic diet list langed or when a new check to make sure the list e posted therapeutic diet				

list.

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL053027	B. WING		07/28/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE. ZIP CODE	
			THAGE STREE	,	
ROYAL O	AKS ASSISTED LIVING		, NC 27350	•	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 309	10A NCAC 13F .0904 Service	4(e)(3) Nutrition and Food	D 309		
	(e) Therapeutic Diets (3) The facility shall in current listing of resid	Nutrition and Food Service is in Adult Care Homes: maintain an accurate and lents with physician-ordered guidance of food service			
	This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to maintain an accurate and current listing of residents with physician ordered therapeutic diets [mechanical soft, No Concentrated Sweets (NCS), and pureed with NCS] for 3 of 3 sampled residents (Residents #2, #3 and #5).				
	The findings are:				
	Observation on 7/27/16 at 10:40 am of the kitchen revealed: -A posted therapeutic diet list that included residents to be served No Added Salt (NAS), mechanical soft, pureed, thickened liquids, double portions and "Diabetics".				
	3/15/16 revealed: -Diagnoses included hallucinations, chroni hypertensionThere was no diet or -An order for nutritiou	c constipation and			
	revealed a facility prin	2's record on 7/27/16 nted physician's diet order d 7/01/16 for a regular diet;			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		HAL053027	B. WING		07	7/28/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		RTHAGE STREET			
	T		RD, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 309	Continued From page	9	D 309			
	no texture modificatio supplements were or	n was specified and no dered.				
	kitchen on 7/27/16 at	eutic diet list posted in the 10:40 am revealed Resident a mechanical soft diet; no dered.				
	orders on 7/27/16 at 2 8:00 am revealed a fa order form signed and #2 for a regular diet; r	's notebook of physician diet 10:40 am and 7/28/16 at acility printed physician's diet d dated 3/21/16 for Resident no texture modification was blements were ordered.				
	BBQ beef on a bun, a french fries, approxim approximately 1/2 cup -Resident #2 consum and fruit cocktail, and	ved approximately 1/2 cup approximately 1 cup baked attely 3/4 cup fruit cocktail, o coleslaw, water and juice. ed 100% of her coleslaw approximately 75% of the rench fries and beverages				
	•	s therapeutic diet menu for a evealed Resident #2 was e meal.				
	form for Resident #2 9 7/28/16 at 7:30 am re dated 7/01/16 for a m	inted physician's diet order given to the survey team on vealed an order signed and echanical soft diet. No diet o nutritional supplements				
	Review of the update to the survey team or revealed Resident #2					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		HAL053027	B. WING		07/28/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
ROYAL O	AKS ASSISTED LIVING		THAGE STREET	Г	
		SANFOR	D, NC 27350		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETE
D 309	Continued From page	e 10	D 309		
	mechanical soft diet.				
		at 1:20 pm with Resident #2 ved a "cut up meal so she			
	Refer to interviews on 7/27/16 at 10:40 am and 7/28/16 at 7:45 am with the cook.				
	Refer to interview on RCC.	7/27/16 at 3:30 pm with the			
	Refer to interview on 7/28/16 at 11:00 am with the Administrator.				
	Refer to interview on Kitchen Supervisor.	7/28/16 at 11:10 am with a			
	B. Review of Residen 6/30/16 revealed: -Diagnoses included hypertensionAn order for a regula	• •			
		3's record on 7/27/16 nted physician's diet order d 7/01/16 for a regular diet.			
		eutic diet list posted in the 10:40 am revealed Resident a Diabetic diet.			
	orders on 7/27/16 at	's notebook of physician diet 10:40 am and 7/28/16 at diet order for Resident #3.			
		nch meal on 7/27/16 ved approximately 1/2 cup proximately 1 cup baked			

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NAME OF PROVIDER OR SUPPLIER ROYAL OAKS ASSISTED LIVING THE TOTAL CONTROL AND ASSISTED LIVING TOTAL CONTROL AND ASSIST		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
CALL DATE CALL			HAL053027	B. WING		07/2	8/2016
PREFIX TAG CACH DEPICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REPERENCED TO THE APPROPRIATE DATE			1107 CAR	THAGE STREE	*		
french fries, approximately 3/4 cup fruit cocktail, approximately 1/2 cup coleslaw, water and sugar-free juice. -Resident #3 gave 1/2 of his fries to another resident at his table, but consumed 100% of his meals and beverages without difficulty. Review of the facility's therapeutic diet menu revealed: -The facility's diabetic meal category was listed as No Concentrated Sweets (NCS). -Resident #3 was served an appropriate NCS meal at lunch 7/27/16. Review of a facility printed physician's diet order form for Resident #3 given to the survey team on 7/28/16 at 7:30 am revealed an order signed and dated 7/01/16 for a NCS diet. Review of the updated therapeutic diet list given to the survey team on 7/28/16 at 3:00 pm revealed Resident #3 was to be served a NCS diet. Interview on 7/27/16 at 10:55 am with Resident #3 revealed: -He was a diabetic controlled by medications and diet. -He was served a diabetic diet. -He was served sugar-free beverages, and did not usually eat desserts. Refer to interviews on 7/27/16 at 10:40 am and 7/28/16 at 7:45 am with the cook. Refer to interview on 7/27/16 at 3:30 pm with the	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETE
Refer to interview on 7/28/16 at 11:00 am with the	D 309	french fries, approximapproximately 1/2 cupsugar-free juiceResident #3 gave 1/2 resident at his table, he meals and beverages. Review of the facility's revealed: -The facility's diabetic No Concentrated Swe-Resident #3 was sermeal at lunch 7/27/16. Review of a facility proform for Resident #3 of 7/28/16 at 7:30 am redated 7/01/16 for a Norevealed Resident #3 diet. Interview on 7/27/16 af #3 revealed: -He was a diabetic codietHe was to be served of the was served sugain not usually eat desserved refer to interviews on 7/28/16 at 7:45 am with Refer to interview on RCC.	ately 3/4 cup fruit cocktail, o coleslaw, water and 2 of his fries to another out consumed 100% of his without difficulty. Is therapeutic diet menu are meal category was listed as eets (NCS). Inted physician's diet order given to the survey team on vealed an order signed and CS diet. Id therapeutic diet list given a 7/28/16 at 2:00 pm awas to be served a NCS Intelled by medications and a diabetic diet. In r-free beverages, and did rts. In 7/27/16 at 10:40 am and ith the cook.	D 309			

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Administrator.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL053027	B. WING		07/28/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRE				TE, ZIP CODE		
ROYAL OA	AKS ASSISTED LIVING		THAGE STREE	т		
			, NC 27350			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 309	Continued From page	÷ 12	D 309			
	Refer to interview on 7/28/16 at 11:10 am with a Kitchen Supervisor.					
	C. Review of Resident #5's current FL 2 dated 1/28/16 revealed:					
	-Diagnoses included Atrial Fibrillation, hypertension, esophageal reflux and muscle weakness.					
	-An order for a no add -There was no order f					
	Review of Resident #5's record on 7/27/16 revealed: -A facility printed physician's diet order form signed and dated 7/01/16 for a pureed, NCS diet. -There was no physician's order for thickened liquids. -There was no documentation that Resident #5 had difficulty swallowing liquids. -There was no speech therapist documentation for recommending thickened liquids.					
	kitchen on 7/27/16 at -Resident #5 was to be thickened liquids.	eutic diet list posted in the 10:40 am revealed: be served a pureed diet with on the list to be served a				
	orders on 7/27/16 at 68:00 am revealed:	ed liquids.				

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revealed:

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		1141.052027	B. WING		07/0	0/0040	
		HAL053027	D. WIIVO		07/2	8/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE			
		1107 CA	RTHAGE STREE	T .			
ROYAL O	AKS ASSISTED LIVING	SANFOR	D, NC 27350				
040.15	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	NI.	0/5)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE	
				DEFICIENCY)			
D 309	Continued From page	12	D 309				
ט 309	Continued From page	÷ 13	D 309				
	-Resident #5 was ser	ved approximately 1/2 cup					
	applesauce, approxin	nately 1 cup pureed BBQ			ļ		
	beef, and approximat	ely 1/2 cup pureed green					
	beans.	, , , ,					
	-Resident #5 was ser	ved water that looked very					
		slightly thicker than a					
	tablemate's water.	enginay amenter aran a					
		irge red glass of sugar-free					
		not be determined if it had					
		it or not, although a staff					
		kener had been added					
	already.	kener nad been added					
	•	and 100 % of his most and					
	-Resident #5 consumed 100 % of his meal and beverages without any difficulties swallowing.						
	beverages without an	iy diπiculties swallowing.					
	Interview on 7/27/16	at 12:15 pm with a dining					
	room aide revealed:	at 12:15 pm with a dining					
		and the Alabama late Devotals					
		eats we thicken his liquids					
		wdered thickener- a large					
		ss, and a small scoop for a					
		I not know" if it was ordered					
	nectar or honey thick						
		ed Resident #5 having					
	•	, but "just did what she was					
	told to do."						
		nber who told her to thicken					
	· · · · · · · · · · · · · · · · · · ·	but was told to follow the					
	directions on the thick	kener powder container.					
		at 12:30 pm with Resident					
		ot need or want his liquids					
	thickened.						
		at 7:25 am with the RCC					
	revealed:						
		ordered to be on thickened					
	liquids.				ľ		
	-She "updated the kit	chen staff to not thicken his					
	(Resident #5) liquids	vesterday afternoon			ľ		

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(7/27/16)".

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DIVISION	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			D WING			
		HAL053027	B. WING		07/2	8/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
		1107 CAR	THAGE STREE	т		
ROYAL O	AKS ASSISTED LIVING		D, NC 27350	•		
			J, NC 27350			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
IAO		,	IAG	DEFICIENCY)		
D 309	Continued From page	e 14	D 309			
	-"∆nother resident ha	d thought Resident #5 was				
		o someone thought to try				
	-					
	thickening his liquids.					
	Deview of the undate	d therapeutic diet list given				
	to the survey team or	•				
	revealed:	17720/10 at 2:00 pm				
		no convod a nurood MAC				
		pe served a pureed, NAS				
	diet.	on the list to be served a				
		on the list to be served a				
	NCS diet.	to be consed thickened				
		to be served thickened				
	liquids.					
	D ()	7/07/40 1/40/40				
		n 7/27/16 at 10:40 am and				
	7/28/16 at 7:45 am w	ith the cook.				
	D ()	7/07/40 1 0 00 ::!! !!				
		7/27/16 at 3:30 pm with the				
	RCC.					
	Refer to interview on 7/28/16 at 11:00 am with the Administrator.					
	5	7/00/40 4 44 40 311				
	Refer to interview on 7/28/16 at 11:10 am with a					
	Kitchen Supervisor.					
		17/00/40				
		at 10:40 am and 7/28/16 at				
	7:45 am with the cool					
	-She had worked at the	ne facility for about 6				
	months.					
		es were served in red cups				
	•	n whether beverages were				
	sweet or not.					
		herapeutic diet list posted				
		ea for a guidance for which				
	diets the residents were to be served.					
		Coordinator (RCC) or the				
Administrator updated the posted therapeutic diet						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
HAL053027		B. WING		07/28/2016		
NAME OF PROVIDER OR SUPPLIER STREET ADDR			RESS, CITY, STA	TE, ZIP CODE		
ROYAL O	AKS ASSISTED LIVING		HAGE STREE	Т		
	OLIMANDY OT			DROWNERIO DI ANI OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 309	Continued From page	: 15	D 309			
	SANFORD, N SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 list since "we do not have a computer back here to print it". -She was not responsible for making changes on the posted therapeutic diet list and did not know how often it was updated. -Copies of the physician diet orders for residents were sent to the kitchen by the "front staff" and were placed in a notebook in the kitchen. -"The front staff handled all the orders." Interview on 7/27/16 at 3:30 pm with the RCC revealed: -Copies of resident diet orders were sent to the kitchen with any new or changed diet orders. -The kitchen staff or manager were to update the posted therapeutic diet list. Interview on 7/28/16 at 11:00 am with the Administrator revealed: -Either the RCC or the Medication Aide should send diet order changes to the kitchen staff. -The kitchen staff were responsible to update the posted therapeutic diet list -She expected diets to be served as ordered by the physician. Interview on 7/28/16 at 11:10 am with a Kitchen Supervisor revealed: -The "front staff" sent the kitchen resident diet orders. -She updated the posted therapeutic diet list when "orders were changed or when a new resident came in". -She did not regularly check to make sure the list was accurate. -She would update the posted therapeutic diet list was accurate.					
	Supervisor revealed: -The "front staff" sent ordersShe updated the poswhen "orders were chresident came in"She did not regularly was accurate.	the kitchen resident diet ted therapeutic diet list anged or when a new check to make sure the list				

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