Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053027	A. BUILDING: _____ B. WING _____	07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL OAKS ASSISTED LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(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 and the Lee County Department of Social Services conducted an annual, follow-up survey and a complaint investigation on July 27 and July 28, 2016. The complaint investigation was initiated by the Lee County Department of Social Services on July 5, 2016.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the hot water temperature of 6 fixtures (5 sinks and 1 shower) in the resident bathrooms were maintained between 100 degrees Fahrenheit (F) and 116 degrees F, with hot water temperatures ranging from 124 degrees F to 128 degrees F. The findings are: Observations of the facility during the initial tour on 07/27/16 from 10:50 am to 11:45 am revealed: -The hot water temperature at the sink of Room #3 was 126 degrees F. -The hot water temperature at the sink of Room	D 113	Rule met as evidenced by corrected H20 temps on day of survey. To prevent future occurences maintanance will check H20 temps randomly and weekly and record.Supervisors/designee will monitor monthly and report, Administrator will oversee prn.	08/01/16

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Alfreda Robinson — Administrator — 8/12/2016

Revicwed + Accepted 8/22/16 Karlin Kay Pam

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D 113	Continued From page 1 #4 was 124 degrees F. -The hot water temperature at the sink of Room #5 was 126 degrees F. -The hot water temperature at the sink of Room #6 was 124 degrees F. -The hot water temperature at the sink of Room #26 was 128 degrees F. -The hot water temperature at the shower of Room #26 was 126 degrees F. Interview on 07/27/19 at 10:57 am with a resident who resided in Room #4 revealed: -He had not noticed the hot water temperature being too hot. -He had never been burned by the hot water. -He had no problems with the hot water. Interview on 07/27/19 at 11:00 am with a resident who resided in Room #5 revealed: -She thought the water temperatures were good. -She had never been burned by the hot water. -She said she adjusted the water temperature by turning the handle toward the cold water. Interviews on 07/27/16 between 11:13 am and 11:17 am with 3 additional residents revealed: -No problems with the hot water temperature. -None had been burned by the hot water. -"When the water feels too hot, I just turn on more cold". Interview on 07/27/16 at 11:45 am with a resident of Room #26 revealed: -He stated he cannot(could not) adjust the water temperature in his shower, that the water is too hot. -He stated he had never been burned by the hot water. -He said he would "hop in the shower and then hop out real quick" because the hot water was too	D 113		

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D 113	Continued From page 2 hot. -He said did not know there was a temperature adjusting handle on the shower, "Oh, I didn't know that was there". Observation on 07/27/16 at 11:45 am of Room #26 revealed: -The hot water temperature in the sink was 114 degrees F. -The hot water temperature in the shower was also 114 degrees F. Observation on 07/27/16 at 11:45 am revealed maintenance staff had 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: -The hot water temperature at the sink of Room #3 was 100 degrees F. -The hot water temperature at the sink of Room #4 was 104 degrees F. -The hot water temperature at the sink of Room #5 was 102 degrees F. -The hot water temperature at the sink of Room #6 was 110 degrees F. -The hot water temperature at the sink of Room #26 was 112 degrees F. -The hot water temperature at the shower of Room #26 110 degrees F. Review of the water temperature log on 07/28/16 at 9:48 am revealed: -Temperatures were checked weekly and documented on to the report. -The temperatures documented for the month of May 2016 ranged from 114 to 120 degrees F. -The temperatures documented for the month of June 2016 ranged from 118 to 120 degrees F. -The temperatures documented for the month of	D 113		

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D 113	Continued From page 3 July 2016 ranged from 116 to 122 degrees F. Interview on 07/28/16 at 10:30 am with the facility maintenance staff revealed: -He had worked at the facility for 80 days. -He checked the hot water temperatures and recorded the results on the hot water log weekly. -He thought the acceptable high range of the hot water temperature was 120 degrees F. -None of the residents had complained about the water bring too hot. -None of the residents had said they had been burned by the hot water. -Now that he knew the acceptable high range of the hot water temperature was 116 degrees F, the temperature would remain at that temperature. Interview on 07/28/16 at 10:25 am with the Resident Care Coordinator (RCC) revealed: -The hot water temperatures were checked weekly by the maintenance staff. -He kept a log of the hot water temperatures. -None of the residents had complained about the hot water temperature being elevated. Interview on 07/28/16 at 10:45 am with the Administrator revealed: -The hot water temperatures were checked weekly by the facility maintenance staff and logged on to the hot water log. -None of the residents had complained about the water temperatures, or been burned by the hot water.	D 113		
D 307	10A NCAC 13F .0904(e)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service	D 307	Rule met as evidenced by all therapeutic diet orders including thickened liquids shall be in writing from the residents physician.To ensure future compliance	

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D 307	Continued From page 4 (e) Therapeutic Diets in Adult Care Homes: (1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram or consistency, such as for calorie controlled ADA diets, low sodium diets or thickened liquids, unless there are written orders which include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a registered dietitian. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure there was a written physician's diet order for 1 of 3 sampled residents (Resident #3). The findings are: 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 added salt (NAS) diet. -There was no order for thickened liquids. 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. Review of the therapeutic diet list posted in the	D 307	Medtech will monitor all orders daily, Rcc will monitor weekly and Administrator will monitor PRN.	08/15/16

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D 307	Continued From page 5	D 307		

kitchen on 7/27/16 at 10:40 am revealed:
-Resident #5 was to be served a pureed diet with thickened liquids.
-Resident #5 was not on the list to be served a "Diabetic" meal.

Review of the kitchen's notebook of physician diet orders on 7/27/16 at 10:40 am and 7/28/16 at 8:00 am revealed:
-An order dated 1/06/16 for Resident #3 for a "puree, no concentrated sweets" diet.
-No order for thickened liquids.
-No order for NAS.

Observation of the lunch meal on 7/27/16 revealed:
-Resident #5 was served approximately 1/2 cup applesauce, approximately 1 cup pureed BBQ beef, and approximately 1/2 cup pureed green beans.
-Resident #5 was served water that looked very loose, but did appear slightly thicker than a tablemate's water.
-Resident #5 had a large red glass of sugar-free juice with ice. It could not be determined if it had a thickener added to it or not, although a staff member reported thickener had been added already.
-Resident #5 consumed 100 % of his meal and beverages without any difficulties swallowing.

Interview on 7/27/16 at 12:15 pm with a dining room aide revealed:
-"Before Resident #5 eats we thicken his liquids as directed on the powdered thickener- a large scoop for a large glass, and a small scoop for a small glass". She "did not know" if it was ordered nectar or honey thick.
-She had not observed Resident #5 having difficulties swallowing, but "just did what she was

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D 307	Continued From page 6 told to do." -She could not remember who told her to thicken Resident #5's liquids, but was told to follow the directions on the thickener 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 time. -She "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." Review of the updated therapeutic diet list given to the survey team on 7/28/16 at 2:00 pm revealed: -Resident #5 was to be served a pureed, NAS diet. -Resident #5 was not on the list to be served a NCS diet. -Resident #5 was not to be served thickened liquids. Interviews on 7/27/16 at 10:40 am and 7/28/16 at 7:45 am with the cook revealed: -She had worked at the facility for about 6 months. -Sugar-free beverages were served in red cups for quick identification whether beverages were sweet or not. -She referred to the therapeutic diet list posted next to the serving area for a guidance for which	D 307		

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D 307	Continued From page 7 diets the residents were to be served. -The Resident Care Coordinator (RCC) or the Administrator updated the posted therapeutic diet 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 physican 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.	D 307		

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D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. 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". A. Review of Resident #2's current FL 2 dated 3/15/16 revealed: -Diagnoses included dementia with hallucinations, chronic constipation and hypertension. -There was no diet ordered on the FL 2. -An order for nutritious supplements to each meal was written at the diet order space on the FL 2. Review of Resident #2's record on 7/27/16 revealed a facility printed physician's diet order form signed and dated 7/01/16 for a regular diet;	D 309	Rule met as evidenced by updated dietary list. To prevent further occurence Medtech will monitor all dietary orders daily and pass on to dietary Manager. Dietary manger will update all new dietary list as needed, Rcc will monitor weekly, and Administrator will oversee as needed.	

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no texture modification was specified and no supplements were ordered.

Review of the therapeutic diet list posted in the kitchen on 7/27/16 at 10:40 am revealed Resident #2 was to be served a mechanical soft diet; no supplements were ordered.

Review of the kitchen's notebook of physician diet orders on 7/27/16 at 10:40 am and 7/28/16 at 8:00 am revealed a facility printed physician's diet order form signed and dated 3/21/16 for Resident #2 for a regular diet; no texture modification was specified and no supplements were ordered.

Observation of the lunch meal on 7/27/16 revealed:
-Resident #2 was served approximately 1/2 cup BBQ beef on a bun, approximately 1 cup baked french fries, approximately 3/4 cup fruit cocktail, approximately 1/2 cup coleslaw, water and juice.
-Resident #2 consumed 100% of her coleslaw and fruit cocktail, and approximately 75% of the BBQ beef on a bun, french fries and beverages without difficulty.

Review of the facility's therapeutic diet menu for a mechanical soft diet revealed Resident #2 was served an appropriate meal.

Review of a facility printed physician's diet order form for Resident #2 given to the survey team on 7/28/16 at 7:30 am revealed an order signed and dated 7/01/16 for a mechanical soft diet. No diet was specified, and no nutritional supplements were ordered.?

Review of the updated therapeutic diet list given to the survey team on 7/28/16 at 2:00 pm revealed Resident #2 was to be served a

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D 309	Continued From page 10 mechanical soft diet. Interview on 7/28/16 at 1:20 pm with Resident #2 revealed she was served a "cut up meal so she could eat it better". 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 RCC. Refer to interview on 7/28/16 at 11:00 am with the Administrator. Refer to interview on 7/28/16 at 11:10 am with a Kitchen Supervisor. B. Review of Resident #3's current FL 2 dated 6/30/16 revealed: -Diagnoses included diabetes type 2 and hypertension. -An order for a regular diet. Review of Resident #3's record on 7/27/16 revealed a facility printed physician's diet order form signed and dated 7/01/16 for a regular diet. Review of the therapeutic diet list posted in the kitchen on 7/27/16 at 10:40 am revealed Resident #3 was to be served a Diabetic diet. Review of the kitchen's notebook of physician diet orders on 7/27/16 at 10:40 am and 7/28/16 at 8:00 am revealed no diet order for Resident #3. Observation of the lunch meal on 7/27/16 revealed: -Resident #3 was served approximately 1/2 cup BBQ beef on bun, approximately 1 cup baked	D 309		

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D 309	Continued From page 11 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 2:00 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 to be 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 RCC. Refer to interview on 7/28/16 at 11:00 am with the Administrator.	D 309		

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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 added salt (NAS) diet.
-There was no order for thickened liquids.

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.

Review of the therapeutic diet list posted in the kitchen on 7/27/16 at 10:40 am revealed:
-Resident #5 was to be served a pureed diet with thickened liquids.
-Resident #5 was not on the list to be served a "Diabetic" meal.

Review of the kitchen's notebook of physician diet orders on 7/27/16 at 10:40 am and 7/28/16 at 8:00 am revealed:
-An order dated 1/06/16 for Resident #3 for a "puree, no concentrated sweets" diet.
-No order for thickened liquids.
-No order for NAS.

Observation of the lunch meal on 7/27/16 revealed:

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D 309	Continued From page 13 -Resident #5 was served approximately 1/2 cup applesauce, approximately 1 cup pureed BBQ beef, and approximately 1/2 cup pureed green beans. -Resident #5 was served water that looked very loose, but did appear slightly thicker than a tablemate's water. -Resident #5 had a large red glass of sugar-free juice with ice. It could not be determined if it had a thickener added to it or not, although a staff member reported thickener had been added already. -Resident #5 consumed 100 % of his meal and beverages without any difficulties swallowing. Interview on 7/27/16 at 12:15 pm with a dining room aide revealed: -"Before Resident #5 eats we thicken his liquids as directed on the powdered thickener- a large scoop for a large glass, and a small scoop for a small glass". She "did not know" if it was ordered nectar or honey thick. -She had not observed Resident #5 having difficulties swallowing, but "just did what she was told to do." -She could not remember who told her to thicken Resident #5's liquids, but was told to follow the directions on the thickener 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. -She "updated the kitchen staff to not thicken his (Resident #5) liquids yesterday afternoon (7/27/16)".	D 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053027	A. BUILDING: _____ B. WING _____	07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 309	Continued From page 14 -"Another resident had thought Resident #5 was choking with liquids so someone thought to try thickening his liquids." Review of the updated therapeutic diet list given to the survey team on 7/28/16 at 2:00 pm revealed: -Resident #5 was to be served a pureed, NAS diet. -Resident #5 was not on the list to be served a NCS diet. -Resident #5 was not to be served thickened liquids. 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 RCC. Refer to interview on 7/28/16 at 11:00 am with the Administrator. Refer to interview on 7/28/16 at 11:10 am with a Kitchen Supervisor. _____ Interviews on 7/27/16 at 10:40 am and 7/28/16 at 7:45 am with the cook revealed: -She had worked at the facility for about 6 months. -Sugar-free beverages were served in red cups for quick identification whether beverages were sweet or not. -She referred to the therapeutic diet list posted next to the serving area for a guidance for which diets the residents were to be served. -The Resident Care Coordinator (RCC) or the Administrator updated the posted therapeutic diet	D 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 309	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.	D 309		