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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on September 13, 14, and 15, 2017.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered by the physician for 1 of 1 sampled residents who had an order for chopped meats and nectar thickened liquids (Resident #6). The findings are: Review of Resident #6's current FL-2 dated 12/15/16 revealed: -Diagnoses included gastroesophageal reflux disease (chronic digestive disease in which stomach acid/stomach contents flows back into the esophagus, irritating the lining), history of cerebrovascular accident (stroke), arthritis, and migraine headaches. -The resident's diet order was listed as regular. Review of Resident #6's Resident Register revealed an admission date of 10/11/11. Review of Resident #6's physician's orders dated	D 310		

Reviewed & Accepted [signature] 10/20/17

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D 310	Continued From page 1 6/07/17 revealed a dietary order for regular chopped meats and nectar thickened liquids. Review of the current resident therapeutic diet list posted in the kitchen and revised on 7/21/17, revealed Resident #6 had a diet of regular chopped meat and nectar thickened liquids. Review of the manufacturer's instructions on the thickened liquid product revealed: -Scoop and level off recommended thickener using enclosed spoon. -Slowly add product to the liquid while stirring briskly with a spoon, fork, or whisk until thickener has dissolved. -Let thickened liquid stand 30 seconds to 1 minute to achieve desired consistancy. -For nectar thickened water, coffee, and tea, use 3-1/2 to 4 teapoonspoons per 4 fl. oz. Observation on 9/13/17 between 4:50 pm and 5:40 pm of the dinner meal revealed: -Resident #6 was served a glass of a clear thickened liquid by a Personal Care Aide (PCA). -The PCA prepared Resident #6 a cup of thickened coffee at the dining room table; the regular sized cup was approximately 4 oz. to 6 oz. of coffee. -The PCA used the thickened liquid container teaspoon measuring spoon to place 2 scoops into the coffee. -The PCA slowly stirred the coffee, paused, and added 2 more scoops of the powered thickener to the coffee and said the coffee would not thicken, so she would add more, she did not know why the coffee would not thicken. -The PCA slowly stirred the thickened clear liquid a couple of times and then slowly restirred the coffee, saying the coffee was not thickened, she might need more thickener.	D 310	See Attached	

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-The thickened clear liquid, when stirred, appeared to be pudding thick; the coffee appeared to begin to thicken.
-The PCA had not brought a measuring cup to the table to measure the liquids before adding the thickener.
-The PCA did not refer to the instructions on the thickener container.
-The measuring spoon was not leveled off when the product was scooped to put into the coffee.
-The PCA did not stir briskly when mixing the liquid.
-The resident had not been served nectar thickened liquids at her meal.

Observation of Resident #6 during the dinner meal from 4:50 pm to 5:40 pm revealed:
-Resident #6 stared at the glass of clear thickened liquid, looked up, shook her head and told the PCA "that is too thick."; the resident did not drink the clear thickened liquid, she did not drink the thickened coffee.
-The resident was offered another glass of thickened clear liquid and a cup of thickened coffee prepared by a Medication Aide (MA).
-Both drinks, when stirred, were nectar thickened.
-The resident was observed drinking the thickened liquids prepared by the MA without difficulty swallowing.

Interview on 9/13/17 at 4:55 pm with the PCA revealed:
-Resident #6 was to be served nectar thickened liquids at meals.
-The clear liquid had become thick fast and the coffee would not thicken.
-She stated the ratio of liquid to powder product was 3 teaspoons or 1 tablespoon for the drinks (manufacturer's instructions, 3-1/2 to 4 teapoonspoons per 4 fl. oz., let thickened liquid

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stand 30 seconds to 1 minute to achieve desired consistancy), but put in extra when the coffee did not thicken after stirring .
-She was not sure how many tablespoons she put in the clear liquid to thicken it.
-The PCA had not used a measuring cup, she did not know exactly how many ounces of liquid were in the clear liquid glass or in the coffee mug.
-The PCA had been trained by a MA, but could not remember who trained her or how long ago she had training.

Observation on 9/14/17 between 8:00 am and 8:55 am of the breakfast meal for Resident #6 revealed:
-The resident was served 8 oz. cranberry juice, 8 oz. milk, 8 oz. water.
-The resident was served nectar thickened liquids (eggnog, tomato juice consistency) as per physician's order.
-The resident drank 75% of her cranberry juice, 50% of her milk and water without having difficulty swallowing.

Interview on 9/14/17 at 10:00 am with Resident #6 revealed:
-She had pneumonia last year (did not remember the date); food had gotten into her lungs.
-A swallowing study had been done, but she did not have a problem swallowing then.
-She had 3 strokes (did not remember the dates) and would cough sometimes when drinking liquids that had not been thickened.
-She could swallow the nectar thickened liquids without difficulty.
-She would tell staff if the liquids were too thin or too thick.
-She would cough if too thin, and if too thick, she could not get the drink out of the glass and into her mouth.

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-She had ginger ale at dinner last night, it was not prepared correctly and was too thick to drink; she had pointed to the drink, looked up at the PCA and said "that is too thick".
-Resident #6's family member brought her 4 oz. pre-thickened nectar water and tea in cups for her to sip on during the day; they were kept in her room refrigerator.
-The resident liked the pre-made thickened liquid cups to drink, she could read on the top of the cups that the liquid was nectar thick.

Interview on 9/14/17 at 10:25 am with Resident #6's Sitter revealed:
-Staff was supposed to prepare nectar thickened liquids for Resident #6's meals.
-Different staff would make the resident's thickened liquid drinks.
-Sometimes the resident would get a "tickle" in her throat and would have a little cough when drinking liquids at meals.

Interview on 9/14/17 at 11:50 am with the Dietary Manager revealed:
-Resident #6 had a physician's order for nectar thickened liquids; it was on the posted list in dietary.
-Dietary staff were not trained to prepare thickened liquids for residents and did not make it; the MAs and PCAs prepared the drinks for Resident #6.
-She did not know what training the MAs and PCAs received to make thickened liquid drinks.
-Dietary stored the powdered thickener in their department, staff came to use it to prepare Resident #6's drinks.
-Measuring cups were available for use for the preparation on thickened liquids.

Interview on 9/14/17 at 12:03 pm with the PCA

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revealed:
-The PCA had prepared Resident #6's nectar thickened liquids of cranberry juice, water, ginger ale, and coffee.
-She read the label on the container of the powered thickener product to make Resident #6's nectar thickened liquids.
-There was a measuring cup in the kitchen, but she had not used it to measure the liquid for Resident #6's drinks; she had estimated the ounces in the resident's glass and coffee cup.
-If the MAs were busy passing medications at mealtimes, the PCAs prepared the thickened liquids.
-The Resident Care Director (RCD) told her yesterday, after she prepared Resident #6's nectar thickened liquids at dinner, the MAs were supposed to prepare the thickened liquids.
- She had been a certified nursing assistant since 1999, but did not have specific training on how to make thickened liquids.
- A MA showed her how to make thickened liquids some time ago, but could not remember with whom or when it was.
-The PCA was not aware of any training the MAs received to prepare thickened liquids for residents.

Interview on 9/15/17 at 11:40 am with a MA revealed:
-Resident #6 was the only resident in the facility that had an order for nectar thickened liquids.
-The MA had not been trained on the preparation of thickened liquids; she read the container instructions.
-The RCD wanted the MAs to prepare the thickened liquids, but the PCAs would make the drinks if the MAs were passing medications during meals.

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Interview on 9/15/17 at 11:15 am with a 2nd MA revealed:
-The MA had not made thickened liquids in a long time, she would have to read the instructions on the container.
-The MAs made the thickened liquids after using a measuring cup for liquids and the measuring scoop in the product container.
-The liquids were stirred as directed on the product label.
-The MA did not remember being offered a class on the preparation of thickened liquids and had worked at the facility for many years (did no say how long).

Interview on 9/14/17 at 11:12 am with Resident #6's Power of Attorney (POA) revealed:
-The resident had a history of aspiration pneumonia last year and could not swallow water without coughing; she was started on thickened liquids by Speech Therapy.
-The Speech Therapist evaluated the resident and made a recommendation to the Primary Care Provider (PCP) for nectar thickened liquids on 6/07/17.
-The POA brought pre-made nectar thickened liquid cups for the resident to drink as she wanted, and the facility used a powdered thickening product to make the thickened drinks for meals.
-The MAs and PCAs made the thickened liquid drinks.
-The facility was not consistent with which staff made the nectar thickened liquids for the Resident.
-The POA was not aware of any training for staff for preparing nectar thickened liquids.
-Sometimes the liquids staff prepared were over thickened and "gloppy" like thick pudding.
-When the nectar thickened liquids were made

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correctly, the resident could swallow her drinks easily.

Interview on 9/14/17 at 3:30 pm with Resident #6's Speech Therapist revealed:
-The therapist worked with Resident #6 for about a year after the Resident's stroke.
-The PCAs at the facility made the thickened liquids for Resident #6.
-Resident #6 had not told the therapist her liquids had been prepared too thickly.
-If staff did not make the nectar thickened liquids correctly, it should be redone at the correct consistency.
-The resident would not be able to swallow her drinks if they were prepared too thickly.

Interview on 9/14/17 at 4:38 pm with Resident #6's Primary Care Provider (PCP) revealed:
-Resident #6 had a history of aspiration pneumonia.
-The PCP had not been contacted about Resident #6 having any problems swallowing the nectar thickened liquids.
-The consequences of Resident #6 drinking thickened liquids prepared too thin was aspiration pneumonia; if prepared to thick, she would have dysphasia (difficulty swallowing).
-The PCP had the expectation that the facility staff were trained to properly prepare the ordered nectar thickened liquids correctly.

Interview on 9/15/17 at 12:57 pm with the Resident Care Director (RCD) revealed:
-The facility always used the same brand powered thickener to make thickened liquids for residents, the pre-made brands were expensive.
-The MAs or the PCAs were responsible for preparing the thickened liquid drinks.
-The MAs and PCAs had not had any training on

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the preparation of thickened liquids except what they were shown at the facility by herself or other MAs.
-The RCD learned how to make thickened liquid drinks in certified nursing assistant class 18-19 years ago.
-The facility hired certified nursing assistants (CNA) for the PCA position; she thought making thickened liquids was included in their (CNA) training.
-Resident #6 had a stroke about a year ago, had speech therapy, and was started on thickened liquids.
-The Resident's POA brought in pre-made nectar thick water and tea for the Resident to drink as she wished.
- A measuring cup was purchased for staff to use in preparing the drinks.
-The glasses and coffee mugs were different sizes, staff needed to measure the liquid before mixing in the powder.
-Staff needed to be trained on how to correctly prepare thickened liquids and it was her fault in not providing it.
-The RCD would have a Registered Dietitian give a class for staff on thickened liquids and how to correctly prepare them.

Interview on 9/15/17 at 3:27 pm with the Executive Director (ED) revealed:
-He was new to the facility, having been there for 2 months.
-He knew Resident #6 had a physician's order for nectar thickened liquids.
-The RCD was responsible for handling residents' dietary orders.
-There had been no classes for staff to learn how to correctly prepare thickened liquids.
-The RCD was responsible for having staff training on the correct procedures for preparing

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D 310	Continued From page 9 thickened liquids. -The ED planned to have pre-made thickened liquids available in the future for residents with orders for thickened liquids.	D 310		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration.	D935		

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2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to assure that 2 of 5 Medication Aide Staffs (Staff B, Staff E) completed the 5, 10, 15 hours medication training or previously worked as a medication aide during the previous 24 months prior to performing unsupervised medication aide duties. The findings are:

1. Review of Staff B's personnel record revealed:
-She was hired on 09/04/2017 as a Medication Aide/ Personal Care Aide
-She took and passed the Medication Aide test on 08/01/2016.
-She completed the Medication Clinical Skills checklist on 09/12/2017.
-There was no documentation of the 5 hour, 10 hour or 15 hour medication training.
-There was no verification that Staff B had previously worked as a medication aide during the previous 24 months.

Attempted interview with Staff B on 09/15/2017 was unsuccessful.

Refer to interview with the Resident Care Director (RCD) on 09/15/2017 at 6:20 p.m.

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Refer to interview with the Administrator on 09/15/2017 at 6:45 p.m.

2. Review of Staff E's personnel record revealed:
-She was hired on 07/01/2017 as a Medication Aide/ Personal Care Aide
-She took and passed the Medication Aide test on 11/22/2006.
-She completed the Medication Clinical Skills checklist on 07/21/2017.
-There was no documentation of the 5 hour, 10 hour or 15 hour medication training.
-There was no verification that Staff E had previously worked as a medication aide during the previous 24 months.

Attempted interview with Staff E on 09/15/2017 was unsuccessful.

Refer to interview with the Resident Care Director (RCD) on 09/15/2017 at 6:20 p.m.

Refer to interview with the Administrator on 09/15/2017 at 6:45 p.m.

Interview with the Resident Care Coordinator (RCC) on 09/15/2017 at 4:30 p.m. revealed:
-Our nurse was responsible to do training.
-The RCC called the nurse for new staff training.

Interview with the Resident Care Director (RCD) on 09/15/2017 at 6:20 p.m. revealed:
-The RCD and the RCC was responsible to make sure new hires have all their training.
-The RCD and RCC sent a list of staff to the pharmacy that needed the 5 hour, 10 hour or 15 hour medication training.

Interview with the Administrator on 09/15/2017 at

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D935	Continued From page 12 6:45 p.m. revealed: -It was the responsibility of the department heads (the Resident Care Coordinator and the Resident Care Director) to make sure that all training was done. -The "oversight" comes back through the business office and the Administrator. -MA was not to go on the medication cart until they are checked off on it by our Registered Nurse Consultant. -The verification request was sent off to the staffs' previous jobs.	D935		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or	D992		

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(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
D992	Continued From page 13	D992		

psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to assure examination and screening for the presence of controlled substances was performed for 2 of 6 sampled staff (Staff A & B) that were hired after 10/01/13.

The findings are:

1. Review of Staff A's personnel file revealed:
-Staff A was hired on 8/22/17 as a Personal Care Aide.
-There was no documentation that Staff A had completed a drug screen upon hire.

Attempted interview with Staff A on 9/15/2017 was unsuccessful.

Refer to interview on 9/15/17 at 6:45 p.m. with the Administrator.

2. Review of Staff B's personnel file revealed:
-Staff B was hired on 9/4/17 as a Medication Aide.
-There was no documentation that Staff B had completed a drug screen upon hire.

Attempted interview with Staff B on 9/15/2017

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
	HAL001023	A. BUILDING: ______ B. WING ______	09/15/2017

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D992	Continued From page 14 was unsuccessful. Refer to interview on 9/15/17 at 6:45 p.m. with the Administrator. ________________ Interview with Administrator on 9/15/17 at 6:45 p.m. revealed: -There was no drug screen completed for Staff A and Staff B. -Staff A was going to get the drug screen completed on 9/15/17. -The Business Office Manager was responsible for setting up the drug screening. -The Business Office Manager had been given additional job responsibilities by the previous administrator, which did not allow her time to follow-up on the drug screenings. -The Administrator would make sure that the Business Office Manager would insure all staff who require drug screens would have them completed.	D992		

Annual Survey Completed Sept. 15, 2017
Blakey Hall Assisted Living
HAL 001-023
Alamance Co.

D 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service
Complete Date: 10/25/17

The facility has ordered premixed nectar thick water, tea & juice for Resident #6. The facility has also ordered nectar thicken coffee packets that require 6 oz. of hot water to be added and mixed with one packet of coffee and mix until powder is dissolved. The facility has provided a measuring cup to properly measure the 6 oz. of hot water. This measuring cup is only to be used for the coffee and is to be mixed by the RDC or a Medication Aide. PCAs and CNAs are no longer authorized to mix thickened liquids to ensure consistency. The RCD and Administrator has provided additional training and instruction on the new policy and has also trained Medication Aides how to properly thicken the new products. The facility has also scheduled additional training for the Medication Aides on October 25, 2017 at 2pm to receive additional training in the areas of thickened liquids and special diets. A Registered Nurse will be providing the training on thickening liquids to the proper thickness. Although we are now purchasing pre-thickened items, the facility acknowledges the importance of understanding how to thicken other beverages to offer resident choice for other beverages. The RCD will be responsible for training any new Medication Aides hired after the training. The RCD will be responsible for monitoring the thickened liquids on a weekly basis. The Administrator will provide oversight of the RCD and also the Dietary Director to ensure products are in ample supply and staff training is being conducted correctly and consistently. Although safeguards were put in place immediately and new products were ordered and in place by October 3, 2017, I am documenting the completion date as October 25, 2017 due to the scheduling of the formal staff training with the Registered Nurse.

D 935 G. S. 131D-4.5B(b) ACH Medication Aides; Training and Competency
Complete Date: 10/04/17

Staff B now has a Facility Medication Aide Verification form completed and dated September 18, 2017 in her employee chart. Staff E has completed the 15 hrs. Medication Aide Training on October 4, 2017. I have attached the documentation for both Staff B and Staff E. Following the state survey, a complete employee file audit was conducted by the RCD and the Office/ Admissions Manager to ensure no documentation was missing from any employee file. To prevent the possibility of this happening again, the facility has developed and implemented a new hire checklist that will be completed by the Manager. The employee chart will not be filed away in the filing cabinet until all the proper documentation has been completed and provided. After the checklist will be completed and signed by the Manager, then the chart will be given to the Administrator to confirm the file is complete. The Administrator will then sign the new checklist confirming its completion. This new procedure will provide the proper monitoring oversight needed to ensure this issue will not happen again.

D 992 G. S. 131D-45(a) Examining and Screening
Complete Date: 10/04/17

Staff A's drug screening was completed and documented on September 16, 2017. Staff B's drug screening was completed and documented on September 17, 2017. Following the state survey, a complete employee file audit was conducted by the RCD and the Office/Admissions

Manager to ensure no documentation was missing from any employee file. To prevent the possibility of this happening again, the facility has developed and implemented a new hire checklist that will be completed by the Manager. The employee chart will not be filed away in the filing cabinet until all the proper documentation has been completed and provided. After the checklist will be completed and signed by the Manager, then the chart will be given to the Administrator to confirm the file is complete. The Administrator will then sign the new checklist confirming its completion. This new procedure will provide the proper monitoring oversight needed to ensure this issue will not happen again.

Executive Director: [signature] Print: James E. Weeks

Date: 10-17-17