Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
7442 1 2744	or contraction	BERTH TO ATTOMBER.	A. BUILDING:		R	
		hal002004	B. WING			≺  1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ALEXAN	DER ASSISTED LIVIN	1G	HIGHWAY 10 SVILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	Alexander County I conducted a follow-investigation on Oc County Department	ensure Section and the Department of Social Services up survey and complaint tober 9-11, 2017. Alexander t of Social Services initiated tigation on September 23,				
D 282	10A NCAC 13F .09 Service	04(a)(1) Nutrition and Food	D 282			
	10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.  This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to protect all food being stored, prepared, and served by the facility from contamination.					
	The findings are:					
	revealed: -No staff members -There was a 5 pou wrapped in clear pla submerged in a box -Water was dripping the ground beef. -There was no over	wl of water in the prep sink. g slowly out of the faucet onto flow of water from the bowl.  9/17 at 10:00am of a				

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

TITLE (X6) DATE

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
			D WING		R-	
		hal002004	B. WING		10/1	11/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		3032 N.C.	IIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING		/ILLE, NC 286			
			TELL, 140 200			T
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		DATE
iAO		,	IAG	DEFICIENCY)		
D 282	Continued From page	2 1	D 282			
	chicken salad with "us	se by 11/29/17" stamped on				
	the lid. One serving h	nad been removed from the				
	•	s no date the container was				
	opened.					
	'	ck labeled smoked sliced				
		ar plastic bag. There were				
		tes on the bag, 9/12, 9/17,				
	and 9/27. There was					
		d plastic container labeled				
		y date of 10/1/17" stamped				
		itten date of 10/8 with no				
	year was on the lid.	itteri date or 10/8 with 110				
		d plastic container labeled				
	-	e by date of 4/8/17" stamped				
		itten date of 9/20 with no				
	year was on the lid.	•				
	·	ng like consistency inside				
	the container.					
		5 pound plastic container				
		Two hand written dates of				
		year were on the lid. There				
	was no visible use by	date stamped on the lid.				
		oound plastic container				
	labeled potato salad.	One hand written date of				
	9/29 with no year was	s on the lid. There was no				
	visible use by date sta	amped on the lid.				
		17 at 10:05am of the freezer				
	in the kitchen reveale					
	_	ear open plastic bag with				
	frozen biscuits					
	-There was no date o	pened on the bag.				
	-One third of the bisco	uits were exposed.				
	Davison 40/40/45	Attac Food Fatalist 1				
		of the Food Establishment				
	· ·	ted 8/23/17 revealed a				
		ave a person-in-charge who				
		nerican National Standards				
	Institute (ANSI) appro	oved food safety managers				

course.

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PRINTED: 10/27/2017

Division (	of Health Service Regu	lation			FORM	// APPROVED
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPL	ETED
		hal002004	B. WING		1	11/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 S VILLE, NC 286			
(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 APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 282	Continued From page	2	D 282			
	revealed: -The kitchen staff was lids of prepared saladThe kitchen staff "ge salads for 4 days befor and the frozen biscuit -Frozen meat was puroutTap water from the father meatThe Cook did not knot the water should beHe was not sure who wayThe Cook had been two yearsThe Cook had "no transThe Cook had no foo employment here.  Interview on 10/10/17 Administrator revealeThe Cook had been the Cook had no pring the Cook had no pring the Administrator transThe Administrator was weekThe Administrator mother kitchen".	nerally" would keep the pre throwing them out. In to to throw out the salads so the in a bowl of water to thaw it saucet was left dripping on the work what the temperature of the told him to thaw meat this employed at the facility for saining from the people here". In the service training before his said at 9:40 with the doc.				

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opened.

outside of the facility.

-The Administrator expected items in the refrigerator to be thrown away in 3 to 4 days after

-The Administrator did not know the correct procedure to thaw out frozen meat.

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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
					R-C
		hal002004	B. WING		10/11/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		3032 N C H	IGHWAY 16 SO	DUTH	
ALEXAND	ER ASSISTED LIVING		ILLE, NC 286		
(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 COMPLETE
D 282	Continued From page	3	D 282		
	and Sanitation staff or revealed: -Only seafood should waterOther foods should band kept at 41 degree Review of the person Staff E, who worked c-He was hired on 9/14-There was no document the Food Service Orientee.	be thawed under running the thawed in the refrigerator the ses F while thawing. The record for the Cook, the second 10/9/17 revealed: 14/15. The rentation he had completed the record for the completed that the second se			
D 285	D 285  10A NCAC 13F .0904(a)(4) Nutrition And Food Service  10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets.  This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure at least a three-day supply of perishable food and a five-day supply of non-perishable food was in the		D 285		
	facility based on the r concentrated sweets, diets.	·			
	The findings are:				
		od supply at 9:30am on the facility's menu for Week			

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	Division of Health Service Regul	lation					
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED			
		hal002004	B. WING	R-C <b>10/11/2017</b>			
	NAME OF PROVIDER OR SUPPLIER	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
ı	ALEXANDER ASSISTED LIVING						

ALEXAND	ER ASSISTED LIVING	: HIGHWAY 16 SOU SVILLE, NC 28681	****	
(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 285	Continued From page 4	D 285		
	3 revealed the facility did not have the following			
	perishable and non-perishable items for residents			
	on a no concentrated sweets diet, regular diet,			
	and a resident on a vegetarian diet:			
	A. No Concentrated Sweets Menu:			
	-Breakfast on 10/9/17: seasonal fruit			
	-Lunch on 10/9/17: egg roll			
	-Dinner on 10/9/17: sugar free fruited gelatin			
	-Dinner on 10/10/17: field peas and			
	snaps/crowder			
	-Lunch on 10/11/17: sugar free ice cream			
	-Dinner on 10/11/17: greens, seasonal fruit			
	-Lunch on 10/12/17: sugar free cake			
	-Dinner on 10/12/17: mushrooms, breaded vege			
	sticks, seasonal fruit			
	B. Vegetarian Menu:			
	-Breakfast on 10/9/17: veggie sausage gravy,			
	seasonal fruit			
	-Lunch on 10/9/17: stir fry with tofu, egg roll			
	-Dinner on 10/9/17: black bean burger			
	-Breakfast on 10/10/17: veggie sausage -Dinner on 10/10/17: veggie sausage sloppy joe,			
	field peas and snaps/crowder			
	-Breakfast on 10/11/17: veggie sausage patty			
	-Lunch on 10/11/17: veggie burger			
	-Dinner on 10/11/17: tofu pot pie, seasonal fruit,			
	greens			
	-Breakfast on 10/12/17: veggie sausage			
	-Lunch on 10/12/17: tofu alfredo			
	-Dinner on 10/12/17: veggie patty, mushrooms,			
	breaded vege sticks, seasonal fruit			
	-Breakfast on 10/13/17: veggie sausage			
	-Lunch on 10/13/17: veggie burger, lemon			
	pudding			
	C. Regular Menu:			
	-Breakfast on 10/9/17: seasonal fruit			
	-Lunch on 10/9/17: egg roll			

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Division of Health Service Regulation					AITROVED	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		R-C 10/11/2017	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SO VILLE, NC 286			
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 285	Continued From page	: 5	D 285			
	-Dinner on 10/10/17: snaps/crowder -Dinner on 10/11/17: -Dinner on 10/12/17: sticks, seasonal fruit -Lunch on 10/13/17: Interview on 10/9/17 a revealed: -The Cook had been of two yearsThe Cook had "no tra-The Cook had no foo employment at the factory of the Administrator or kitchenShe was not aware of ruleMost of the time she side items. Interview on 10/10/17 Administrator revealed: -The Administrator, the Care Coordinator would items needed to be on the control of the time she side items.	greens, seasonal fruit mushrooms, breaded vege demon pudding at 10:15am with the Cook employed at the facility for aining from the people here". It deservice training before his cility.  at 9:00am with a second dered the food for the of the three day and five day just gave the vegetarian  at 9:40am with the derect cook, and the Resident and "go over" what food dered. It missed ordering tofu and degetarian diet menu.				
D 310	10A NCAC 13F 0904	(e)(4) Nutrition and Food	D 310			

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Service

10A NCAC 13F .0904 Nutrition and Food Service(e) Therapeutic Diets in Adult Care Homes:(4) All therapeutic diets, including nutritional

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
711101111111			A. BUILDING: _		
		hal002004	B. WING		R-C <b>10/11/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ALEXAND	ER ASSISTED LIVING		IIGHWAY 16 S		
			/ILLE, NC 286		
(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 APPROPE DEFICIENCY)	BE COMPLETE
D 310	Continued From page	e 6	D 310		
		kened liquids, shall be the resident's physician.			
	This Rule is not met a FOLLOW-UP TO TYPE				
	Non-compliance conti severity resulting in so				
	This is a TYPE A2 VI	OLATION.			
	reviews, the facility fa diets for 6 of 6 sample #5, #9, #10, #11, and ordered related to pur	ee, honey thick liquids, no vegetarian, lactose free,			
	The findings are:				
	8/9/17 revealed: -Diagnoses that include chronic obstructive purellitus, obesity, psor osteoarthritis.	t #5's current FL2 dated  ded mental retardation, ulmonary disease, diabetes riasis, gout, and an order for pureed diet and			
		or oxygen at 2L per minute			
	dated 7/28/17 posted	eutic diet list for residents in the kitchen revealed e served a pureed diet with			
	Review of the facility's	s weekly therapeutic diet			

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STATEMENT OF DEPICIENCIES IDENTIFICATION NUMBER: INDEX. OF CORRECTION  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, 2IP CODE 3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28861  PROVIDER'S PLAN OF CORRECTION  NAME OF PROVIDER ASSISTED LIVING  SUMMARY STATEMENT OF DEPICIENCIES (PACIFIC PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEPICIENCIES (PACIFIC PROVIDER OR SUPPLIER)  PREPIX (PACIFIC PROVIDER OR SUPPLIER)  PROVIDER'S PLAN OF CORRECTION (PACIFIC PROVIDER'S PLAN OF CORRECTI	Division	of Health Service Regu	liation				
NAME OF PROVIDER OR SUPPLIER  ALEXANDER ASSISTED LIVING  SIRVANTO SOLUTION TAYLORS SUPPLIER  ALEXANDER ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES 3032 N.C. HIGHWAY 16 SOUTH TAYLORSVILLE, N.C. 28881  TAYLORSVILLE, N.C. 28881  PREPIX (PACH CORRECTIVA CHORNOR SING EMPRICED BY PULL PREPIX TAYLOR OF CROSS REFERENCES TO TITLE APPROPRIATE DAYLORS OF TAYLORS OF			1 ' '	(X2) MULTIPLE	CONSTRUCTION		
NAME OF PROVIDER OR SUPPLIER  ALEXANDER ASSISTED LIVING  TAYLORSVILLE, NC 28881  ID PRETRY  (PAYLID PRETRY TAYLOR PROVIDER SUMMARY STATEMENT OF DEPICIENCIES 100 PRETRY TAYLORSVILLE, NC 28881  ID PRETRY TAYLOR PROVIDER SUMMARY STATEMENT OF DEPICIENCIES 100 PRETRY TAYLORSVILLE, NC 28881  D 310 PROVIDER'S PLAN OF CORRECTION 100 PRETRY TAYLORSVILLE, NC 28881  D 310 PROVIDER'S PLAN OF CORRECTION 100 PRETRY TAYLORS	AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
NAME OF PROVIDER OR SUPPLIER  ALEXANDER ASSISTED LIVING  SUMMANY DISTRIBUTIONS  SUMMANY DIS							0
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3032 N C HIGHWAY 16 SOUTH  TAYLORSVILLE, NC 28881  DYAY, 10  PREFIX TAG  CROSS REFERENCED TO THE APPROPRIATE  D 310  Continued From page 7  menu book on 10/9/17 revealed all pureed food should be a creamy mashed consistency.  Review of a thickening powder instant food and beverage thickener chart on 10/9/17 posted in the kitchen revealed to thicken 8 ounces of tea or coffee to honey consistency add 8-10 teaspoons of the thickener.  Review of the facility menu book on 10/9/17 for the puree difer revealed to thicken 8 ounces of tea or coffee to honey consistency add 8-10 teaspoons of the thickener on 10/9/17 at 12:10pm of the lunch menu was to be one serving of pureed stiff by with cababage, 1/2 cup pureed mandarin oranges, and 1/3 cup pureed roil.  Observation on 10/9/17 at 12:10pm of the lunch meal revealed:  -Resident #5 was served one serving of pureed rice, one serving of applessuce, one serving of pureed chicken, and one serving of ground cabbage, one 16 oz cup of tea with a less than honey consistency, and one 8 oz cup of coffee with a less than honey consistency, and one 8 oz cup of coffee with a less than honey consistency, and one 8 oz cup of coffee with a less than honey consistency, and one 8 oz cup of coffee with a less than honey consistency, and the liquids did not appear honey consistency.  Surveyor entered the kitchen on 10/9/17 for 12:15pm to 11/2 sopm of the lunch meal of Resident #5 revealed:  -Resident #5 was seated in front of meal, coughing forcefully, short of breath, and face was purple in color.			1 1000004	B WING		1	
ALEXANDER ASSISTED LIVING   SUMMARY STATEMENT OF DEFICIENCES   TAYLORSYLLE, NC 28691   PREPRIX   TAYLORSYLLE, NC 28691   TAYLORSYLLE, NC 28691   PREPRIX   TAYLORSYLLE, NC 28691   TAYLORSYLLE, NC 286			nai002004	B. Wille		10/1	1/2017
TAYLORSVILLE, NC 28681  (CA) ID SUMMARY STATEMENT OF DEFICIENCIES   ID PROVIDERS PLAN OF CORRECTION   CACHE CHARGE (ACC) DENTEYING INFORMATION   PREFIX   TAG   PROVIDERS PLAN OF CORRECTION SHOULD BE CHOSS-ARE-PRINCIPLY ACTION SHOULD	NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CAN-10   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG			3032 N C	HIGHWAY 16 S	OUTH		
SUMMER'S STATEMENT OF DEPICIPACIES PREFIX  (REACH SPECIALEN' WIST RE REPORTED BY TILL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 310  Continued From page 7  menu book on 10/9/17 revealed all pureed food should be a creamy mashed consistency.  Review of a thickening powder instant food and beverage thickener chart on 10/9/17 posted in the kitchen revealed to thicken 8 ounces of tea or coffee to honey consistency add 8-10 teaspoons of the thickener.  Review of the facility menu book on 10/9/17 for the pureed diet one serving of pureed stir fry with cabbage, 1/2 cup pureed mandarin oranges, and 1/3 cup pureed roll.  Observation on 10/9/17 at 12:10pm of the lunch meal revealed: -Resident #5 was served one serving of ground cabbage with dime sized visible pieces of cabbage, one 16 oz cup of tea with a less than honey consistency, and one 8 oz cup of coffee with a less than honey consistency.  Surveyor entered the kitchen on 10/9/17 at 12:13pm to inform staff of Resident #5's ground cabbage was not a pureed consistency, and the liquids did not appear honey consistency.  Observation on 10/9/17 from 12:15pm to 12:30pm of the lunch meal of Resident #5 was seated in front of meal, coughing forcefully, short of breath, and face was purple in color.	ALEXAND	ER ASSISTED LIVING	TAYLORS	VILLE. NC 286	81		
PREFIX TAG  REGULATORY OR LSC (IDENTIFYING INFORMATION)  D 310  Continued From page 7  menu book on 10/9/17 revealed all pureed food should be a creamy mashed consistency.  Review of a thickening powder instant food and beverage thickener chart on 10/9/17 posted in the kitchen revealed to thicken 8 ounces of tea or coffee to honey consistency add 8-10 teaspoons of the thickener.  Review of the facility menu book on 10/9/17 for the puree diet revealed the lunch menu was to be one serving of pureed stir fry with cabbage, 1/2 cup pureed mandarin oranges, and 1/3 cup pureed role.  Observation on 10/9/17 at 12:10pm of the lunch meal revealed:  -Resident #5 was served one serving of pureed rice, one serving of applesauce, one serving of pureed chicken, and one serving of ground cabbage, one 16 oz cup of tea with a less than honey consistency, and one 8 oz cup of coffee with a less than honey consistency, and one 8 oz cup of coffee with a less than honey consistency and the liquids did not appear honey consistency.  Surveyor entered the kitchen on 10/9/17 at 12:13pm to inform staff of Resident #5's ground cabbage was not a pureed consistency, and the liquids did not appear honey consistency.  Observation on 10/9/17 from 12:15pm to 12:30pm of the lunch meal of Resident #5 revealed:  -Resident #5 was seated in front of meal, coughing forcefully, short of breath, and face was purple in color.	0/0.15	STIMMADV ST.		<u>,                                      </u>			0/5)
D310 Continued From page 7 menu book on 10/9/17 revealed all pureed food should be a creamy mashed consistency.  Review of a thickening powder instant food and beverage thickener chart on 10/9/17 posted in the kitchen revealed to thicken 8 ounces of tea or coffee to honey consistency add 8-10 teaspoons of the thickener.  Review of the facility menu book on 10/9/17 for the puree diet revealed the lunch menu was to be one serving of pureed stir fry with cabbage, 1/2 cup pureed mandarin oranges, and 1/3 cup pureed mandarin oranges, and 1/3 cup pureed roll.  Observation on 10/9/17 at 12:10pm of the lunch meal revealed: -Resident #5 was served one serving of pureed rice, one serving of applesauce, one serving of pureed cabbage, with dime sized visible pieces of cabbage, one 16 oz cup of tea with a less than honey consistency, and one 8 oz cup of coffee with a less than honey consistency, and one 8 oz cup of toeffee with a less than honey consistency, and one 8 oz cup of the with a less than honey consistency, one serving of pureed the kitchen on 10/9/17 at 12:13pm to inform staff of Resident #5's ground cabbage was not a pureed consistency, and the liquids did not appear honey consistency, and the liquids did not appear honey consistency.  Observation on 10/9/17 from 12:15pm to 12:30pm of the lunch meal of Resident #5's revealed: -Resident #5 was seated in front of meal, coughing forcefully, short of breath, and face was purple in color.							
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Division of Health Service Regulation

-Resident #5 was removed from the dining room

STATE FORM 6899 1KDL11 If continuation sheet 8 of 71

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	hal002004	B. WING	R-C <b>10/11/2017</b>

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

## 3032 N C HIGHWAY 16 SOUTH

ALEXANDER ASSISTED LIVING		HIGHWAY 16 SOUTH			
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		
Continued From page 8	D 310				
at 12:30pm.					
Interview on 10/9/17 at 12:30pm with the cook revealed: -He knew Resident #5 was on a pureed diet with honey thick liquidsHe thought the cabbage was blended enoughHe "made it" like he always didHe thought Resident #5 had put corn bread in her cabbageHe used the chart on the wall for the thickening instructionsHe had put 5 teaspoons in the coffee cup and 9 teaspoons in the tea cupHe thought the coffee cup was about 4 ounces and the tea cup was about 8 ouncesHe used the measuring device from the thickening powder to thicken the liquidsHe thought Resident #5 had added milk to her coffeeHe had no food service trainingHe had "no training from the people here".  Interview on 10/9/17 at 1:30pm with the Resident Care Coordinator (RCC) revealed: -Resident #5 was placed on 2L of oxygen and her oxygen saturation was 90%The doctor had been notified of Resident #5's coughing.					
-Resident #5 had been taken by EMS to the emergency room at 1:15pm.					
Attempted telephone interview on 10/9/17 at 4:15pm and 10/10/17 at 8:37am with Resident #5's guardian was unsuccessful.					
Interview on 10/10/17 at 8:45am with a facility Medication Aide revealed: -She always gave Resident #5 her medications crushed with regular (not thickened) water.					
	Continued From page 8 at 12:30pm.  Interview on 10/9/17 at 12:30pm with the cook revealed: -He knew Resident #5 was on a pureed diet with honey thick liquidsHe thought the cabbage was blended enoughHe "made it" like he always didHe thought Resident #5 had put corn bread in her cabbageHe used the chart on the wall for the thickening instructionsHe ad put 5 teaspoons in the coffee cup and 9 teaspoons in the tea cupHe thought the coffee cup was about 4 ounces and the tea cup was about 8 ouncesHe used the measuring device from the thickening powder to thicken the liquidsHe thought Resident #5 had added milk to her coffeeHe had no food service trainingHe had "no training from the people here".  Interview on 10/9/17 at 1:30pm with the Resident Care Coordinator (RCC) revealed: -Resident #5 was placed on 2L of oxygen and her oxygen saturation was 90%The doctor had been notified of Resident #5's coughingResident #5 had been taken by EMS to the emergency room at 1:15pm.  Attempted telephone interview on 10/9/17 at 4:15pm and 10/10/17 at 8:37am with Resident #5's guardian was unsuccessful.  Interview on 10/10/17 at 8:45am with a facility Medication Aide revealed: -She always gave Resident #5 her medications crushed with regular (not thickened) water.	Continued From page 8 at 12:30pm.  Interview on 10/9/17 at 12:30pm with the cook revealed: -He knew Resident #5 was on a pureed diet with honey thick liquidsHe thought the cabbage was blended enoughHe "made it" like he always didHe thought Resident #5 had put corn bread in her cabbageHe used the chart on the wall for the thickening instructionsHe had put 5 teaspoons in the coffee cup and 9 teaspoons in the tea cupHe thought the coffee cup was about 4 ounces and the tea cup was about 8 ouncesHe used the measuring device from the thickening powder to thicken the liquidsHe had no food service trainingHe had "no training from the people here".  Interview on 10/9/17 at 1:30pm with the Resident Care Coordinator (RCC) revealed: -Resident #5 was placed on 2L of oxygen and her oxygen saturation was 90%The doctor had been notified of Resident #5's coughingResident #5 had been taken by EMS to the emergency room at 1:15pm.  Attempted telephone interview on 10/9/17 at 4:15pm and 10/10/17 at 8:37am with Resident #5's guardian was unsuccessful.  Interview on 10/10/17 at 8:45am with a facility Medication Aide revealed: -She always gave Resident #5 her medications	(EACH OBFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8 at 12:30pm.  Interview on 10/9/17 at 12:30pm with the cook revealed:  - He knew Resident #5 was on a pureed diet with honey thick liquids.  - He thought the cabbage was blended enough.  - He "made it" like he always did.  - He thought Resident #5 had put com bread in her cabbage.  - He used the chart on the wall for the thickening instructions.  - He had put 5 teaspoons in the tea cup.  - He thought the coffee cup was about 4 ounces and the tea cup was about 8 ounces.  - He used the measuring device from the thickening howder to thicken the liquids.  - He thought Resident #5 had added milk to her coffee.  - He had no food service training He had "no training from the people here".  Interview on 10/9/17 at 1:30pm with the Resident Care Coordinator (RCC) revealed: - Resident #5 was placed on 2L of oxygen and her oxygen saturation was 90% The doctor had been notified of Resident #5's coughing Resident #5 had been taken by EMS to the emergency room at 1:15pm.  Attempted telephone interview on 10/9/17 at 4:15pm and 10/10/17 at 8:37am with Resident #5's guardian was unsuccessful.  Interview on 10/10/17 at 8:45am with a facility Medication Aider revealed: - She always gave Resident #5 her medications crushed with regular (not thickened) water.		

Division of Health Service Regulation

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Division of Health Service Regulation

Division	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
				R-	С	
		hal002004	B. WING		1	1/2017
NAME OF D	ROVIDER OR SUPPLIER	QTPEET AP	DRESS, CITY, STA	TE ZIR CODE		
NAME OF T	TOVIDEIT OIT 301 1 EIEIT		HIGHWAY 16 SO	*		
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 310	Continued From page	9	D 310			
	-She was aware Resi liquids. -Resident #5 never ch	dent #5 was on honey thick				
	Medication Aide reversus Aide Resident # broken in half with recursive She was "under the inneeded from the doct thickened waterResident #5 had not	t5 her medications whole or gular (not thickened) water. impression" an order was or to give medications with choked.				
	the facility's Physiciar -Resident #5 had dys food or liquids) and w	phagia (difficulty swallowing as at risk for aspiration. g the wrong diet and wrong				
		at 9:00am with the RCC had been admitted into the				
	revealed: -"EMS reports that the was 83% on room air the facility (on 10/9/17-"The patient's (Resid and cough became al facility) when she cho-Chest x-ray revealed.  Interview with a second	esident #5 on 10/11/17 e patient's oxygen saturation when he initially arrived to				
	9:00am revealed: -The Cook had worke	ed at the facility since April				

2017.
Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION	i Health Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					_	_
			D MANAGO		R-	
		hal002004	B. WING		10/1	1/2017
NAME OF D	ROVIDER OR SUPPLIER	STREET AND	RESS, CITY, STA	TE ZIR CODE		
NAME OF T	TOVIDER OR SOLT LIER					
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 S			
		TAYLORSV	ILLE, NC 286	81		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	JAIE	DATE
				52. 10.2.10.1		
D 310	Continued From page	÷ 10	D 310			
	. •					
		d by two other Cooks.				
		enu book for what to serve				
	the residents and in the	ne back of the book for the				
	servings.					
	-There was a list on the	ne board in the kitchen for				
	the special diet orders	S.				
	-The blender was use	ed to puree the food into				
	pudding like consister	ncy.				
	-There was a measur	ing diagram on the board				
		ow to mix the drinks for				
	honey consistency.					
	,					
	Refer to the interview	on 10/10/17 at 9:40am with				
	the Administrator.					
	Pureed foods should	be ready to swallow, moist,				
		s or visible pieces. The				
		ve a pureed diet increased				
	•	and choking which can				
	•	•				
		going into the windpipe				
		gs and causing aspiration				
	pneumonia. The facili					
	thickened liquids also					
	aspiration pneumonia					
		t #3's current FL2 dated				
	2/9/17 revealed:					
		schizophrenia paranoid type,				
		flux disease, back pain, mild				
	renal insufficiency, ur	inary tract infection, and				
	insulin dependent dia					
	-There was an order f	or no concentrated sweets				
	diet.				ľ	
	Review of the therape	eutic diet list for residents			ľ	
		in the kitchen revealed				
		e served a no concentrated				
	sweets (NCS) diet.					
	2					

Division of Health Service Regulation

Review of the facility weekly therapeutic diet

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Division of Health Service Regulation

DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	=IED
						_
		L - 100000 4	B. WING		R-	
		hal002004	B. WING		10/1	1/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		3032 N C	HIGHWAY 16 SO	OUTH		
ALEXAND	ER ASSISTED LIVING					
		IATLURS	VILLE, NC 286	81		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
D 310	Continued From page	e 11	D 310			
		7 mayo aladi				
	menu book on 10/9/1					
	-	nd calorie controlled diets -				
		milk should be sugar free.				
		for lunch on 10/9/17 should				
		cabbage, 1/2 cup fried rice,				
		1/2 cup mandarin oranges,				
	and 1 roll.					
	-The NCS diet menu t					
		arbecue pork, 1/2 cup field				
		and sour coleslaw, 1/2 cup				
	peach bread pudding	and 1 roll.				
	01 11 10 10 1	47 440 40 50 1				
		17 at 12:10pm of the lunch				
	meal revealed:					
		n served one serving of				
		of rice, one serving of				
	-	of cornbread, and one				
	serving of mandarin o	•				
	-Resident #3 ate 1009	% of her lunch.				
		/17 at 5:00pm of the dinner				
	meal revealed:					
		n served one serving of				
		g of peas, one serving of				
	fruit cocktail, and a ro					
	-Resident #3 ate 1009	% of her dinner.				
		17 and 10/10/17 of the food				
		nly canned fruit available				
	was packed in light sy	/rup.				
		at 1:00pm with the Cook				
	revealed:					
		ow that an NCS diet could				
	not have light syrup.					
		ve any food service training				
	outside of the facility.					

Division of Health Service Regulation

Cook revealed:

Interview on 10/10/17 at 9:00am with a second

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SU COMPLE	
					R-C	
		hal002004	B. WING		10/11	/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STAT	E, ZIP CODE		
ALEXANDER ASSISTED LIVING			HIGHWAY 16 SO SVILLE, NC 2868			
040.45	CLIMMA DV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	NI .	0.450
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 310	Continued From page	: 12	D 310			
D 310	-The Cook had worke 2017The Cook was traine -She looked in the me the residents and in the servingsThere was a list on the special diet ordersThe Administrator was food.  Refer to the interview 10/10/17 at 9:40am.  The facility's failure to Sweets diet increased glucose levels.	d at the facility since April d by two other Cooks. enu book for what to serve ne back of the book for the	D 310			
	sweets (NCS) and ch Review of the therape dated 7/18/17 posted Resident #9 was to be meat diet. Review of the facility menu book on 10/9/1 -There was an entry f	er for no concentrated opped meats.  eutic diet list for residents in the kitchen revealed e served a NCS/chopped  weekly therapeutic diet 7 revealed:				

Division of Health Service Regulation

and 1 roll.

-The NCS diet menu for lunch on 10/9/17 should be 2/3 cup stir fry with cabbage, 1/2 cup fried rice, 1 1/2 ounce egg roll, 1/2 cup mandarin oranges,

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
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		hal002004	B. WING		1	1/2017
		070557.40		TE 7/0 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	•		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SC			
		TAYLORS	VILLE, NC 2868	81		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 310	Continued From page	e 13	D 310			
	-The NCS diet menu	for dinner on 10/10/17				
		parbecue pork, 1/2 cup field				
		and sour coleslaw, 1/2 cup				
	peach bread pudding	, and 1 roll.				
		17 at 12:10pm of the lunch				
	meal revealed:	ved one serving of whole				
		erving of cabbage, one				
		erving of cabbage, one erving of mandarin oranges,				
	and one serving of co					
	-Resident #9 ate 100°					
	difficulty.					
		0/17 at 5:00pm of the dinner				
	meal revealed:	ved one serving of chopped				
		erving of peas, one serving				
	•	one serving of fruit cocktail.				
	-Resident #9 ate 100°	•				
	Observation on 10/9/	17 and 10/10/17 of the food				
	•	nly canned fruit available				
	was packed in light sy	yrup.				
	latamiaith the Ma	disetion Aido on 10/10/17 et				
		dication Aide on 10/10/17 at at Resident #9's blood				
		17 at 4:00pm was 219 and				
		f Novolog sliding scale				
	insulin.	3				
		7 at 4:20pm with Resident #9				
	revealed:					
		iting the meat on his plate.				
	-His meat was usually	y chopped up.				
	Interview with the Co.	ok on 10/9/17 at 1:00pm				
	revealed:	3K 011 10/9/17 at 1:00pi11				
		ware that Resident #9 had a				

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chopped meat diet order.

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ווטופועום	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		hal002004	B. WING		10/11/2017	
NAME OF B		0.775.57.40.5		T. 70.000		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 S			
		IAYLORS	/ILLE, NC 286	81		
(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 APPROPR DEFICIENCY)	BE COMPLE	
D 310	Continued From page	e 14	D 310			
	-The Cook did not kno	ow that an NCS diet could				
	not have light syrup.					
	-The Cook did not have outside of the facility.	ve any food service training				
	Interview with a secon 9:00am revealed:	nd Cook on 10/10/17 at				
		ed at the facility since April				
		ed by two other Cooks.				
		enu book for what to serve				
		he back of the book for the				
	servings.					
		he board in the kitchen for				
	the special diet orders					
	food.	as responsible for ordering				
	Refer to the interview 10/10/17 at 9:40am.	with the Administrator on				
	The facility's failure to	serve a chopped meat diet				
	_	choking and aspiration				
	which can result in foo	od going into the windpipe				
		ngs and causing aspiration				
		ty's failure to serve a No				
		diet increased the risk of				
	higher blood glucose	ieveis.				
		nt #10's current FL2 dated				
	12/30/16 revealed:	moderate mental				
	-Diagnoses included i	moderate mental pression, speech/language				
		rder, B12 deficiency, history				
	of deep vein thrombos					
	embolism.					
	-There was an order f	for lactose free diet.				
	Review of the therape	eutic diet list for residents				

Division of Health Service Regulation

dated 7/18/17 posted in the kitchen revealed

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Division of Health Service Regulation

STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER				(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		hal002004	B. WING		R-C 10/11	)  / <b>2017</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		-
AL EVAND	SED ACCIOTED I IVINO	3032 N C	HIGHWAY 16 SO	ОИТН		
ALEXANDER ASSISTED LIVING TAYLORSV		VILLE, NC 286	81			
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 310	Continued From page	: 15	D 310			
	Resident #10 was to lidet.	oe served a lactose free				
	•	weekly therapeutic diet 7 revealed there were no				
	Review on 10/9/17 at 10:00am of the refrigerator and food storage pantry revealed there were no lactose free dairy items.					
	Observation on 10/10/17 at 12:05pm of the lunch meal revealed Resident #10 was served one serving of chicken salad, one serving of cottage cheese, one serving of cole slaw, one serving of pasta salad, and 4 crackers.					
		nen on 10/10/17 at 12:06pm propriate meal served to				
	#10 revealed: -Resident #10 had ea cheeseDietary aide removed	/17 at 12:10pm of Resident ten 75% of her cottage d the meal plate from the e remainder of the cottage				
	with the Cook revealershe "forgot" Resident diet"I guess I got too bus -The Cook had worke 2017The Cook was trainershe looked in the me	t #10 was on a lactose free sy, it won't happen again." ed at the facility since April				

Division of Health Service Regulation

servings.

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Division of Health Service Regulation

STATEMENT	of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
		hal002004	B. WING		R-C <b>10/11/2017</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXANDER ASSISTED LIVING		HIGHWAY 16 SO				
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 310	Continued From page	e 16	D 310			
	the special diet orders -The Administrator was food. Interview on 10/10/17	as responsible for ordering				
	Resident #10 was on	a lactose free diet.				
		aled there had been no 10 having any stomach				
		at 3:31pm with Resident I no stomach discomfort.				
		interview on 10/11/17 at nt #10's guardian was				
	Physician Assistant re	at 3:05pm with the facility's evealed the only detriment to eiving a lactose free diet was				
		ok on 10/9/17 at 1:00pm d not have any food service e facility.				
	Refer to the interview 10/10/17 at 9:40am.	with the Administrator on				
	increased the risk of f and passing into the i	o provide a lactose free diet food not properly digesting ntestine which can lead to ed feeling, and diarrhea.				

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12/30/16 revealed:

E. Review of Resident #11's current FL2 dated

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
	hal002004	B. WING		I	R-C <b>)/11/2017</b>	
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
ALEXANDER ASSISTED LIVING		C HIGHWAY 16 SOU				
(X4) ID SUMMARY STATEMEI PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	NT OF DEFICIENCIES BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 310 Continued From page 17  -Diagnoses included gastro disease, anxiety disorder, pschizophrenia, history of soforthere was an order for a value of the therapeutic of dated 7/28/17 posted in the Resident #11 was to be seen the seed of the facility week to 10/9/17 for the vegetarian of the vegetarian diet menus should be 1 cup stir fry with rice, 1 1/2 ounce egg roll, 10 oranges and 1 roll.  -The vegetarian diet menus hould be 3 ounces of veggioe, 1/2 cup field peas, 1/2 peach bread pudding, and Observation on 10/9/17 at meal revealed:  -Resident #11 was served one serving of cornbread, of cabbage, and one serving -There was no stir fry with the there was no protein serving end of the serving of the s	paranoid coliosis. Vegetarian diet.  diet list for residents e kitchen revealed rved a vegetarian diet.  ly menu diet book on diet revealed: for lunch on 10/9/17 in tofu, 1/2 cup of fried rediction of dinner on 10/10/17 gie sausage sloppy cup coleslaw, 1/2 cup 1 roll.  12:10pm of the lunch one serving of of mandarin oranges. It is in the meal.  15:00pm of the dinner one serving of fruit it ith the resident had aurant. It is is ges sloppy joe. It is in the meal.	D 310				

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PRINTED: 10/27/2017

Division	of Hoolth Convine Requ	lation			FORM	APPROVED
STATEMENT	of Health Service Regul FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		R-C <b>10/11/2017</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
ALEXANDER ASSISTED LIVING		HIGHWAY 16 SE SVILLE, NC 286				
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ULD BE COMPLET	
D 310	Continued From page	e 18	D 310			
	sausage in the facility	<i>1</i> .				
		nt #11 on 10/11/17 at				
	2:00pm revealed: -She was only served	I the side items.				
	-Sometimes she orde outside restaurants.	red food delivered from				
	Interview with the Cook on 10/9/17 at 1:00pm revealed: -The Cook did not know that he needed to give a					
	resident on vegetaria -"(Resident #11) has	· ·				
		n on her tray. Like a peanut				
		ve any food service training				
	9:00am revealed:	nd Cook on 10/10/17 at				
	-The Cook had worke 2017.	ed at the facility since April				
		ed by two other Cooks. enu book for what to serve				
	the residents and in the	he back of the book for the				
		he board in the kitchen for				
	the special diet orders -The Administrator wa	s. as responsible for ordering				
	foodMost of the time the	Cook would give the				
		de items without substituting				

Division of Health Service Regulation

10/10/17 at 9:40am.

Refer to the interview with the Administrator on

The failure to provide a balanced vegetarian diet increases the risk of a diet low in protein which can raise the risk of muscle loss, falling, slow

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DIVISION	of fleatili Service Regu	lation				
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
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			D WING		R-	
		hal002004	B. WING		10/1	11/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE ZIP CODE		
				,		
ALEXANDER ASSISTED LIVING		HIGHWAY 16 S				
		IAYLURS	/ILLE, NC 286	81		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORT OR L	230 IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	MAIL	D/IIE
				,		
D 310	Continued From page	e 19	D 310			
	l					
	_	eakness, fractures and even				
	osteoporosis.					
		t #12's current FL2 dated				
	7/11/17 revealed:					
	_	Alzheimer's dementia,				
	-	anxiety, and hypertension.				
	-There was an order f	for a pureed diet.				
	_	menu for residents dated				
	7/18/17 posted in the	kitchen revealed Resident				
	#11 was to be served	a pureed diet.				
	Review of the facility	menu book on 10/10/17 for				
	the puree diet reveale	ed the lunch menu was to be				
	1/3 cup pureed Cook'	s choice entree, 1/2 cup				
	pureed rice or noodle	s, 3/8 cup pureed Cook's				
		cup pureed fruit, and 1/3				
	cup pureed roll.					
	Observation on 10/10	0/17 at 12:05pm of the lunch				
		ent #12 was served one				
		tage cheese, one serving of				
		ad, one serving of chocolate				
	·	ving of chopped pasta salad				
	with visible nickel size	•				
	WITH VISIBIC HICKOLSIZE	ou opiral noodies.				
	Surveyor notified diet	ary aide on 10/10/17 at				
	12:06pm of inappropr					
		lately purced lood.				
	Observation on 10/10	)/17 at 12:10pm of lunch				
		2's plate was removed and				
		riately pureed food items.				
	replaced with appropr	natery pureed 1000 items.				
	Intonvious with the Co	ok on 10/10/17 at 0:00am				
		ok on 10/10/17 at 9:00am				
	and 12:30pm revealed					
		ident #12 was on a pureed				
	diet.					
	-The Cook "thought th	ne pasta salad looked				
	pureed enough".					

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Division of	<u>of Health Service Regu</u>	lation			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		hal002004	B. WING		R-C <b>10/11/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
ALEXAND	DER ASSISTED LIVING		HIGHWAY 16 SO SVILLE, NC 2868		
(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 APPROPI DEFICIENCY)	BE COMPLETE
D 310	Continued From page	20	D 310		
	the residents and in the servings.  -There was a list on the special diet ordersThe blender was use pudding like consister.  Review of the resident revealed Resident #1  Interview with the fact 10/11/17 at 11:00 am in the consister.  The Physician Assist Resident #12 had we resident #12 had we resident #12 was "or the weight loss was resident ysupplements.  The PA was aware Redietary supplements.  The PA was "not considerary supplements.  The PA was "not considerary supplements.  The PA was determined telephone 10:08 am with Resident unsuccessful.  Based on observation reviews it was determined interview and 10/9/17 arevealed he did not he outside the facility.  Refer to the interview the Administrator.  Pureed foods should	enu book for what to serve the back of the book for the serve the board in the kitchen for serve to board in the kitchen for serve to pure the food into incy.  Ints' weights for six months 2 had a 20lb weight loss.  Ility's Physician Assistant on revealed: Iteration (PA) was aware that ight loss.  Intervelopment to we weight the serve that ight loss.  Intervelopment to we were that ight loss.  Intervelopment to we we were that ight loss.  Intervelopment to we we were that ight loss.  Intervelopment to we were that ight loss.  Intervelopment to we were the weather that ight loss.  Intervelopment to we we we were the weather that ight loss.  Intervelopment to we were the weather that ight loss.  Intervelopment to we we were the weather that ight loss.  Intervelopment to we we we were the weather that ight loss.			

Division of Health Service Regulation

facility's failure to serve a pureed diet increased

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Division of Health Service Regulation

1 , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURY COMPLETE		
			7 11 2012211101		R-C		
		hal002004	B. WING		10/11/2	2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
AL EVAND	DER ASSISTED LIVING	3032 N C H	IIGHWAY 16 S	ОИТН			
TAYLORS		TAYLORS	/ILLE, NC 286	81			
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 310	Continued From page	21	D 310				
	result in food or liquid	and choking which can going into the windpipe ags and causing aspiration					
	their employment at ti -The Administrator tra -The Administrator wo diets with the CooksThe Administrator ha and monitored the ac -The Administrator wa weekThe last meal the Ad was on October 5, 20 -The Administrator, the	d: bod service training prior to he facility. hined the kitchen staff. buld go over the residents' and oversight of the kitchen tivity. has in the facility five days per ministrator had observed 17. he lead Cook, and the RCC food items needed to be d completed the Food					
	therapeutic diets were therapeutic diets and served to 6 of 6 samp #5, #9, #10, #11, and honey thick liquids, no vegetarian, lactose fro orders including Resipureed and honey thi aspirated, and was su The facility's failure to was detrimental to the	thickened liquids not being bled residents (Resident #3, #12) related to puree and concentrated sweets, ee, and chopped meat diet dent #5 was not served a					

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an A2 Violation.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R-C	
		hal002004	B. WING		10/11/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 S			
			ILLE, NC 286			_
(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 APPROPR DEFICIENCY)	BE COMPLET	E
D 310	Continued From page	22	D 310			
D 358	The facility provided a 10/9/17 that included: -The Administrator will all cooks the proper will of pudding and the driving an	a Plan of Protection on  Il immediately discuss with vay to serve pureed food. be served the consistency inks the consistency of ed as ordered. The Medication Aide will a for compliance. The Administrator and inator to review the diet list ent is receiving the proper will conduct an inservice to reding therapeutic diets and EFOR THE TYPE A2 HOT EXCEED NOVEMBER  If Medication Administration me shall assure that the nistration of medications, prescription, and treatments	D 358			

Division of Health Service Regulation

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					R-	C
		hal002004	B. WING		1	1/2017
			-		1 10/1	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 S			
		TAYLORS	/ILLE, NC 286	81		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	23	D 358			
	This Rule is not met a FOLLOW-UP TO TYP	-				
	The Type A2 Violation continues.	n is abated. Non-compliance				
	THIS IS A TYPE B VI	OLATION				
	reviews, the facility fa were administered as residents during the n errors in medication a inhalers, Ventolin HFA #8, and hydrocortison Resident #4; lisinopril	A and Atrovent, to Resident				
	The findings are:					
	evidenced by 5 medic	nedication passes observed				
	4/18/17 revealed: -Diagnoses included is obstructive pulmonaryThere was an order f dose inhaler 1 puff by (Ventolin is a fast actitreat COPD)There was an order f by mouth daily. (Atrov bronchial dilator used)	for Ventolin 90mcg metered mouth one time a day.  Ing bronchial dilator used to for Atrovent inhaler one puff vent is a long acting				

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Division o	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
						0
			B. WING		R-C	
		hal002004	B. WING		10/1	11/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		3032 N.C.I	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286			
			TILLE, NC 200			1
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
		,		DEFICIENCY)		
D 358	Continued From page	24	D 358			
	subsequent physician	n's orders dated 9/8/17				
		00mcg metered dose inhaler				
	1 puff one time a day	•				
	i pair one time a day	•				
	Observation of a med	lication pass on 10/10/17 at				
	7:19am revealed:	modificit page on 16/16/17 at				
		Coordinator (RCC) prepared				
		olid dose oral medications to				
	Resident #8.	ond dose oral medications to				
		administered Ventolin.				
	rediaent no wao not	daminotered ventenn.				
	Interview on 10/10/17	at 7:20am with the RCC				
		ninistered all medications				
	schedule on the elect					
		d (eMAR) for 8:00am.				
	, anning and record	a (GW/ II t) for G.GGain.				
	Review of Resident #	8's October 2017 eMAR on				
	10/10/17 at 10:40am					
		90 mcg inhaler one puff one				
	time daily scheduled	-				
	•	aler was documented as				
	administered on 10/1					
	daminiotored on 10/1	or ir at o.ooaiii.				
	Observation of medic	ations on hand for				
		10/17 revealed Resident #8				
		90 mcg inhaler on the				
		able for administration.				
	modication care availe	able for darminotration.				
	Interview on 10/10/17	at 8:12am with the RCC				
	revealed:	at 6. 12am with the 1160				
		ted the resident's eMAR				
		lication cart screen for				
	medications to be add					
	medication pass.	Timilotorea daring the				
		dministered Resident #8's				
	tablets but overlooked					
	resident's scheduled	•				
		nes asked for his inhaler				
		morning but he had not				
	asked for the inhaler					
	asked for the initialet	una morning.	1			

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Division o	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					R-	C
		hal002004	B. WING		1	1/2017
					1 10/1	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SC			
		TAYLORS	SVILLE, NC 286	81		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 358	Continued From page	25	D 358			
	-She used the option documentation of mer 8:00amThe eMAR system h incorporate a barcode did not use the barcode line of the provided did not use the barcode did not use the barcode line of the provided did not use the barcode did not use the b	to "document all" for the dication administration at ad the capacity to e scanning system but she de scanning routinely.  The at 2:20 pm with Resident preathing was difficult some call if he received his ler this morning. The aller some days, but not every acing any shortness of breath at 4:30pm with the addinger eresponsible to administer g to orders on the eMAR. The addingter that the addingter in the and the addingter a				
		ministered all medications				

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schedule on the electronic Medication

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DIVISION	i Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					l R-	0
		h =1000004	B. WING		1	
		hal002004			10/1	11/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
		3032 N C I	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286			
24.0.1=	CLIMMA DV CT		1		NI.	2/2
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI		DATE
				DEFICIENCY)		
D 358	Continued From page	26	D 358			
D 000	Continued From page	5 20	D 330			
	Administration Record	d (eMAR) for 8:00am.				
		8's October 2017 eMAR on				
	10/10/17 at 10:40am					
	<u>-</u>	inhaler one puff one time				
	daily scheduled at 8:0					
	-Atrovent inhaler was					
	administered on 10/10	0/17 at 8:00am.				
	Observation of medication on hand for					
		10/17 revealed Resident #8				
	•	inhaler on the medication				
	cart available for adm	inistration.				
	Interview on 10/10/17	at 8:12am with the RCC				
	revealed:	at 6. 12am with the NCC				
		ted the resident's eMAR				
		lication cart screen for				
	medications to be adr					
	medication pass.	Timistered during the				
		dministered Resident #8's				
	tablets but overlooked					
	resident's scheduled i	S .				
		nes asked for his Atrovent				
	for the inhaler this mo	orning but he had not asked				
		3				
		to "document all" for the				
		dication administration at				
	8:00am.	. 1.0				
	-The eMAR system ha					
	•	e scanning system but she				
	aid not use the barco	de scanning routinely.				
	Intoniow on 10/10/17	at 2:20pm with Resident #8				
	revealed:	at 2.20pm with Resident #6				
		reathing was difficult some				
	days.	reating was unifout SUITE				
	-He was unable to red	call if he received his				
	Atrovent inhaler this r					
	, wover a mindle tills i		1			1

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-He received the inhaler some days, but not every

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Division C	Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
					l R-	C	
hal002004		hal002004	B. WING		1	1/2017	
		1101002004			10/1	1/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ALEVAND	ED 40010TED   11/11/0	3032 N C H	IGHWAY 16 SO	ОИТН			
ALEXAND	ER ASSISTED LIVING	TAYLORSV	ILLE, NC 286	81			
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
			ļ	DEI IGIENGT)		<u> </u>	
D 358	Continued From page	e 27	D 358			1	
D 358	dayHe was not experient today.  Interview on 10/10/17 Administrator reveale -Medication aides we medications according -He was not made aw morning, that Resider Atrovent inhaler by th  B. Review of Resider 7/2/17 revealed diagnor coronary artery disease.	cing any shortness of breath  " at 4:30pm with the d: re responsible to administer g to orders on the eMAR. vare, until later in the nt #8 did not receive his e RCC.  Int #4's current FL2 dated hoses included hepatitis C, se, and hypertension.  Int #4's FL2 dated 6/19/17	D 358				
	twice a day. (Lisinopri combination with other blood pressure.	er medications to lower 4's current FL2 dated 7/2/17					
	documentation stating because of recent rer pressure without this	mmary dated 7/3/17 with g "discontinue lisinopril nal failure and control blood medication".					
	7:35am revealed: -The Resident Care C and administered 6 or	e tablet) was administered to					

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Interview on 10/10/17 at 7:45am with the RCC revealed she had administered all medications

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _				
		hal002004	B. WING		R-	C <b>1/2017</b>	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	1 10/1	1/2017	
			IGHWAY 16 SO				
ALEXAND	ER ASSISTED LIVING		ILLE, NC 286				
(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 358	Continued From page	e 28	D 358				
	schedule on the elect Administration Record including any schedule Review of Resident # 10/10/17 at 10:50am -An entry for Lisinopri day scheduled for add 8:00pm. -Lisinopril 10 mg was administered twice da and 10/10/17 at 8:00a	ronic Medication d (eMAR) for 8:00am led topical medications.  4's October 2017 eMAR on revealed: I 10 mg one tablet twice a ministration at 8:00am and documented as aily from 10/1/17 to 10/09/17, am.					
	Observation of medication on hand for administration on 10/10/17 revealed Resident #4 had a bubble pack of lisinopril 10 mg dispensed on 10/9/17 with 27 of 28 tablets remaining.						
	Interview on 10/10/17 at 8:12am with the RCC revealed: -She routinely consulted the resident's eMAR displayed on the medication cart screen for medications to be administered during the medication passMedications appeared on the eMAR one hour before the scheduled time of administration and displayed for one hour after the scheduled time of administration.						
	a representative for the revealed:  -The facility was respondischarge summaries treatment orders, and summaries to the contract pharmathe eMAR system.  -The facility approved.	onsible to fax all hospital , FL2s, medication and l physician encounter					

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DIVISION	of Health Service Regu	lation			_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		hal002004	B. WING		10/11/2017
		1181002004			10/11/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		3032 N C	HIGHWAY 16 SC	OUTH	
ALEXAND	ER ASSISTED LIVING	TAYLORS	VILLE, NC 286	81	
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(710)
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D 358	Continued From page	29	D 358		
	aides to administer th				
	I	cy had documentation for			
	receiving Resident #4				
		cy had no documentation			
	_	t #4's current FL2 dated			
		discharge dated 7/3/17.			
		not discontinued on the			
	eMAR.				
	Interview on 10/10/17 at 11:00am with Resident				
	#4 revealed:				
	_ ·	sit at the end of June 2017 to			
	early July 2017.				
		e changed but he was not			
	_	made to his medications.			
		hospital informing him he			
	might have any kidne				
	_	pressure was pretty normal			
	now.	inantil was disceptioned			
	-ne did flot know ii iis	inopril was discontinued.			
	Interview on 10/10/17	at 4:00pm with the RCC			
	revealed:	at 4.00pm with the NCC			
	-She had been in her	current position for 4			
	weeks.	carrent position for 1			
	-The RCC and/or the	Administrator was			
	responsible to fax all				
	•	, and FL2s to the contract			
		and eMAR information.			
		acy entered orders on the			
	eMAR.	ioy chicroa cracic chi alc			
		leased the new medication			
		the eMAR system for the			
	medication aides.	and the art of the art are			
		ystem in place to audit the			
	residents' records for	-			
		medications listed on the			
	eMARs.				
		d Resident #4's FL2 when			

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he was readmitted from the hospital because the

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Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D WING		R-	-
		hal002004	B. WING	<del></del>	10/1	1/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SC VILLE, NC 286			
	OLIMANA DV OT				N.	
(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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 358	Continued From page	e 30	D 358			
	readmission was before position.	ore she assumed the RCC				
	-She was not aware F was not listed on the	Resident #4's lisinopril 10 mg 7/2/17 FL2.				
		at 4:30pm and 11/11/17 at				
	4:00 pm with the Adm	re responsible to administer				
		g to orders on the eMAR.				
		ministrator were responsible				
		faxing orders and discharge				
	summaries to the pha					
		s according to current				
	orders.	cy entered orders on the				
	eMAR.	icy entered orders on the				
	_	viewed eMAR entries and				
		then the medication order				
		eMAR for medication aides				
	to administer the med	lications. urrently have a system in				
		ers, including discharge				
	summaries, were faxe					
	-Going forward the fa	cility would stamp, date and				
	_	enting the order had been				
	faxed to the pharmac					
	was not listed on the	esident #4's lisinopril 10 mg 7/2/17 FL2.				
	I	on 10/11/17 at 8:52am with				
		Practitioner (NP) revealed:			ĺ	
	-The NP was aware F hospitalization at the					
		Resident #4's lisinopril 10			l	
	mg discontinued if the					
	summary and FL2 ha	· ·				

Division of Health Service Regulation

medication should be discontinued.

-She stated there was no harm for Resident #4 taking lisinopril 10 mg up until this day (10/11/17) but the facility should discontinue lisinopril 10 mg

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			74. 501251110		R-C	
		hal002004	B. WING		10/11/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 S			
	CLIMMA DV CT		ILLE, NC 286			
(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 COMPLE	ETE
D 358	Continued From page	e 31	D 358			
	at this time.					
	7/2/17 revealed a phy chloride 10 milliequiva (Potassium chloride is used to increase low blood. Potassium is a electricity in the body function.)	t #4's current FL2 dated vsician's order for potassium alent (meq) one tablet daily. It is a potassium supplement potassium levels in the n electrolyte that conducts and is crucial for heart				
	Observation of a medication pass on 10/10/17 at 7:35am revealed: -The Resident Care Coordinator (RCC) prepared and administered 6 oral medicationsOne potassium chloride 10 meq tablet was administered to Resident #4 at 7:35am.					
	Review of Resident #4's hospital discharge dated 7/3/17 revealed documentation to "continue potassium chloride daily (this medication may possibly need to be discontinued since Lasix (a fluid pill used for swelling and lowering blood pressure but cause potassium levels to fall) is now being changed to as needed".					
	Review of Resident # subsequent physician discontinue potassiun	s order dated 7/27/17 to				
		10/17 revealed Resident #4 potassium chloride 10meq				
	10/10/17 at 10:50am -An entry for Potassiu	4's October 2017 eMAR on revealed: um chloride 10 meq once diministration at 8:00am				

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Division of	of Health Service Regu	lation					
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		R-C <b>10/11/2017</b>		
					1 10/1	1/2017	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA				
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SO VILLE, NC 286				
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	OULD BE COMPLETE		
D 358	Continued From page	2 32	D 358				
	administered on 10/1	0 meq was documented as 0/17 at 8:00am.					
	revealed:						
	-She routinely consulted the resident's eMAR displayed on the medication cart screen for medications to be administered during the medication pass.  -Medications appeared on the eMAR one hour before the scheduled time of administration and displayed for one hour after the scheduled time of administration.						
	Telephone interview of a representative for the revealed:	on 10/10/17 at 10:53am with ne contract pharmacy					
		onsible to fax all hospital , FL2s, medication and l physician encounter					
	the eMAR system.	cy entered the orders into					
	the orders to appear of aides to administer the						
	receiving Resident #4	cy had documentation for L's FL2 dated 6/19/17. Icy had no documentation					
	for receiving Resident 7/2/17, the hospital di	t #4's current FL2 dated scharge dated 7/3/17, or the ed 7/27/17 to discontinue					
	#4 revealed:	at 11:00am with Resident					

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early July 2017.

-His medications were changed but he was not

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PRINTED: 10/27/2017

Division	of Health Service Regu	lation			FORM	/ APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		1	11/2017
NAME OF P	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	ſE, ZIP CODE		
ALEXAND	DER ASSISTED LIVING		HIGHWAY 16 SC SVILLE, NC 2868			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE DATE
D 358	aware of the changes -He thought his blood nowHe did not know if powas discontinued.  Interview on 10/10/17 revealed: -She had been in her weeksThe RCC and/or the responsible to fax all discharge summaries pharmacy for review a -The contract pharma eMARThe Administrator rel orders to show up on medication aidesShe did not have a s residents' records for compared to current re eMARsShe was not aware F chloride 10 meq was  Interview on 10/10/17 4:00 pm with the Adm -Medication aides we administering medica the eMAR.	s made to his medications. If pressure was pretty normal obtassium chloride 10 meq  That 4:00pm with the RCC current position for 4  Administrator were medication orders, s, and FL2s to the contract and eMAR information. acy entered orders on the leased the new medication the eMAR system for the eystem in place to audit the medication orders medications listed on the Resident #4's potassium discontinued on 7/27/17.  That 4:30pm and 10/11/17 at hinistrator revealed:	D 358			

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orders.

eMAR.

for reviewing orders, faxing orders and discharge

-The contract pharmacy entered orders on the

-The Administrator reviewed eMAR entries and approved the entries, then the medication order

summaries to the pharmacy for adjusting residents' medications according to current

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
			A. BUILDING: _								
		hal002004	B. WING		R-C 10/11/2017						
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
ALEXANDER ASSISTED LIVING 3032 N C HIGHWAY 16 SOUTH											
TAYLORSVILLE, NC 28681											
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE						
D 358	Continued From page 34		D 358								
	would appear on the to administer the medThe facility did not cuplace to verify all orders summaries, were faxedGoing forward the fasign all orders documfaxed to the pharmace.  Telephone interview of Resident #4's Nurse Inter	eMAR for medication aides dications.  urrently have a system in ers, including discharge ed to the pharmacy. cility would stamp, date and enting the order had been yy.  on 10/11/17 at 8:52am with Practitioner (NP) revealed: Resident #4 had a end of June 2017. Resident #4's potassium ontinued since the resident reduction medication									
	summary dated 7/3/1 documenting a potass 06/29/17. (The refere results was 3.5 to 5.1 value for Resident #4 for review.  3. Review of Resider -A current FL2 dated hydrocortisone 0.5% cream used to treat raday.  Observation of a med 7:35am revealed: -The Resident Care Comment of the potassis of the pot	4's hospital discharge 7 revealed laboratory results									

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY						
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:  A. BUILDING:		COMPLETED						
						R-C					
		hal002004	B. WING		1	1/2017					
		1101002004			10/1	1/2017					
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE							
ALEXANDER ASSISTED LIVING 3032 N C HIGHWAY 16 SOUTH											
ALEXAND	EK ASSISTED LIVING	TAYLORS	VILLE, NC 286	81							
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)					
PREFIX	· · · · · · · · · · · · · · · · · · ·		PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE					
TAG			TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE	DATE					
				DEFICIENCY)							
D 358	Continued From page 35		D 358								
	1.3										
	oral medication, and										
	-Hydrocortisone crear	m was not applied to									
	Resident #4.	Resident #4.									
	Interview on 10/10/17 at 7:45am with the RCC										
	revealed she had administered all medications schedule on the electronic Medication Administration Record (eMAR) for 8:00am										
	including any scheduled topical medications.										
	molading arry concadi	ica topicai medicatione.									
	Observation of medication on hand for										
	administration on 10/10/17 at 11:30am revealed										
	Resident #4 did not have hydrocortisone 0.5%										
	cream available for administration on the medication cart or in back-up stock.										
	Review of Resident #4's October 2017 eMAR on 10/10/17 at 10:50am revealed: -An entry for Hydrocortisone cream 0.5% cream with instructions as follows: For insect bites,										
		es: Apply twice a day as									
	needed. Hydrocortisone 0.5% cream was scheduled for prn (as needed) administration.  -There was no entry for hydrocortisone 0.5% cream apply 4 times a day listed on the October 2017 eMAR.										
-Hydrocortisone 0.5% cream was not											
		nistered from 10/1/17 to									
	10/10/17.										
	Interview on 10/10/17	at 9:12am with the BCC									
	Interview on 10/10/17 at 8:12am with the RCC revealed:				ľ						
-She routinely consulted the resident's eMAR displayed on the medication cart screen for				ĺ							
	medications to be adr				ĺ						
	medication pass.	minotorea during tile									
		ed on the eMAR one hour			ĺ						
		time of administration and			l						

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administration.

displayed for one hour after the scheduled time of

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PRINTED: 10/27/2017

Division of	of Health Service Regu	ılation			FURI	MAPPROVED
STATEMEN <sup>*</sup>	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPL	
		hal002004	B. WING		I	-C <b>11/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
			HIGHWAY 16 SO			
ALEXAND	DER ASSISTED LIVING	TAYLOR	SVILLE, NC 286	81		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 358	Continued From page	e 36	D 358			
	the medication.  Telephone interview of a representative for the revealed:  -The facility was respondischarge summaries treatment orders, and summaries to the core-the contract pharmathe eMAR system.  -The facility approved the orders to appear aides to administer the theorem of the contract pharmaters of the contract pharmaters of the pharmacy could #4's hydrocortisone of the representative of the pharmacy could #4's hydrocortisone of the representative of the pharmacy could #4's hydrocortisone of the representative of th	on 10/10/17 at 10:53am with the contract pharmacy tonsible to fax all hospital states, FL2s, medication and diphysician encounter intract pharmacy. The orders which allowed on the eMAR for medication the orders. The orders acy had documentation for the explain why Resident 10.5% cream was not listed on times a day as ordered on				

-He had a few dry spots he would use the cream on if it was offered to him.

Interview on 10/10/17 at 4:00pm with the RCC revealed:

-He had not been administered the cream in a

Interview on 10/10/17 at 11:00am with Resident

-He was aware he had a cream to apply to rashes

-She had been in her current position for 4 weeks.

-The RCC and/or the Administrator was responsible to fax all medication orders, discharge summaries, and FL2s to the contract pharmacy for review and eMAR information.

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#4 revealed:

at one time.

long time.

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  A. BUIL  B. WING  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CIT  ALEXANDER ASSISTED LIVING  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PREFIX	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BITTER OF CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION DEFICIENCY)	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CI  ALEXANDER ASSISTED LIVING  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX	NG  CITY, STATE, ZIP CODE  AY 16 SOUTH  NC 28681  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	R-C 10/11/2017 (X5) COMPLETE
NAME OF PROVIDER OR SUPPLIER  ALEXANDER ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREI	CITY, STATE, ZIP CODE  AY 16 SOUTH  NC 28681  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	10/11/2017  (X5) COMPLETE
NAME OF PROVIDER OR SUPPLIER  ALEXANDER ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREI	CITY, STATE, ZIP CODE  AY 16 SOUTH  NC 28681  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	10/11/2017  (X5) COMPLETE
NAME OF PROVIDER OR SUPPLIER  ALEXANDER ASSISTED LIVING  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX	AY 16 SOUTH  NC 28681  ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) E COMPLETE
ALEXANDER ASSISTED LIVING  3032 N C HIGHWAY TAYLORSVILLE, NO  (X4) ID PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX	AY 16 SOUTH  NC 28681  ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SE COMPLETE
ALEXANDER ASSISTED LIVING  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREI	NC 28681  ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SE COMPLETE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREI	ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BI FAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SE COMPLETE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE	REFIX (EACH CORRECTIVE ACTION SHOULD BIFAG CROSS-REFERENCED TO THE APPROPRIAD DEFICIENCY)	SE COMPLETE
IAG (AEGGENIGINI GINEGONIALION) [AI		
D 358 Continued From page 37 D 358	58	
-The contract pharmacy entered orders on the eMAR.  -The Administrator released the new medication orders to show up on the eMAR system for the medication aides.  -She did not have a system in place to audit the residents' records for medication slisted on the eMARs.  -She was not aware Resident #4's had an order for hydrocortisone 0.5% cream apply 4 times a day.  Interview on 10/10/17 at 4:30pm and 11/11/17 at 4:00 pm with the Administrator revealed:  -Medication aides were responsible to administer medications according to orders on the eMAR.  -The RCC and the Administrator were responsible for reviewing orders, faxing orders and discharge summaries to the pharmacy for adjusting residents' medications according to current orders.  -The contract pharmacy entered orders on the eMAR.  -The Administrator reviewed eMAR entries and approved the entries, then the medication order would appear on the eMAR for medication aides to administer the medications.  -The facility did not currently have a system in place to verify all orders, including discharge summaries, were faxed to the pharmacy.  -Going forward the facility would stamp, date and		
sign all orders documenting the order had been faxed to the pharmacy.  The facility failed to ensure medications were administered as ordered to 2 of 4 residents during the medication pass on 10/10/17.		

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Readmission orders dated 07/02/2017 from a

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		D.0	
		hal002004	B. WING		R-C <b>10/11/2017</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AI EYAND	DER ASSISTED LIVING	3032 N C F	IIGHWAY 16 S	оитн		
ALLXANL	EN AGGISTED EIVING	TAYLORS	/ILLE, NC 286	81		
(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 APPROPI DEFICIENCY)	BE COMPLETE	
D 358	of hypertension and of acute renal failure, we Medications administration and or cream. The medication 4 at risk of renal failur imbalance that could and other organs assipotassium. In addition diagnosis of chronic ordinators of copposition of co	sident # 4, with a diagnoses locumentation of recent ere not implemented. ered incorrectly included chloride, and hydrocortisone on errors placed Resident # re again and electrolyte affect the resident's heart ociated with elevated in, Resident #8, with a obstructive pulmonary end to receive Ventolin and ered exposing him to risk of D symptoms like shortness energy. The facility's failure effective system for the ications was detrimental to of the residents and this violation.  In provided by the facility on the diagram of the diagram of the incoming orders exposed to assure all orders are a timely manner. The reviewed by the Resident Care Coordinator	D 358	DEFICIENCY)		
	-The Administrator wi properly handled. CORRECTION DATE	Il check to assure orders are				

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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				
	hal002004	B. WING	R-C <b>10/11/2017</b>				
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS CITY STATE ZIP CODE					

## ALEXANDER ASSISTED LIVING

3032 N C HIGHWAY 16 SOUTH

	DER ASSISTED LIVING TAYLOR	SVILLE, NC 28681		
(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 39	D 358		
	VIOLATION SHALL NOT EXCEED November 25, 2017.			
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		
	10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).  This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 2 of 4 (#2 and #8) sampled residents related to documenting PRN (as needed) administration for Percocet (Oxycodone-Acetaminophen is generic for Percocet).			

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		D 0	
		hal002004	B. WING		R-C 10/11/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 SC			
			ILLE, NC 286			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 367	Continued From page	e 40	D 367			
	The findings are:					
	8/9/17 revealed: -Diagnoses included a status, congestive heat atrial fibrillationMedications ordered 10mg-acetaminopher reliever used to treat every 6 hours as need.  Review of Resident # physician's order date 10mg-acetamenophe is brand name) take 2 needed.	included oxycodone in 325mg (a narcotic pain severe pain) take 2 tablets ded.  2's record revealed a ed 09/05/17 for oxycodone in 325mg (Percocet 10-325 2 tablets every 6 hours as				
		s of medication documented inistered from 9/7/17 to s of oxycodone				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R-C	
		hal002004	B. WING	<del></del>	1	1/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 S			
			ILLE, NC 286			
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	<del>2</del> 41	D 367			
	10mg-acetaminopher administered on the S-There were 2 doses 10mg-acetaminopher administration, includ MA administering mereffectiveness on Resi eMAR from 09/07/17  Oxycodone 10mg-acet documented on Resid administration but not administered on the Sas follows:  -On 9/7/17 at 11:30pr CSCS, but not documented con 9/8/17 at 12:00ar CSCS, but not documented con 9/8/17 at 12:00ar CSCS, but not documented con 9/8/17 at 12:00ar CSCS, but not documented con the Sas follows:	a 325mg documented as September eMAR. of oxycodone a 325mg not documented for ing date, time, reason given, dication, and the dent #2's September 2017 to 09/30/17.  etaminophen 325mg was dent #2's CSCS for a documented as September 2017 eMAR were in - 2 tablets documented on the eMAR. in - 2 tablets documented on the eMAR.				
	revealed: -An entry for oxycodo 325mg take 2 tablets -Documentation of do 10mg-acetaminopher included date and tim given, MA that admini the effectiveness of tr -Oxycodone 10mg-ac documented for 26 do Review of Resident # 10mg-acetaminopher 10/9/17 compared to eMAR revealed there medication document administered matchin documented correctly	a 325mg administered e administered, reason istered the medication, and ne medication. setaminophen 325mg was uses on the eMAR.  2's CSCS for oxycodone a 325mg from 10/1/17 to Resident #2's October 2017 were 26 doses of				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		hal002004	B. WING		R-C 10/11/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 S			
		TAYLORS	/ILLE, NC 286	81		
(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 367	Continued From page	<del>2</del> 42	D 367			
	Resident Care Coord	inator (RCC).				
	Refer to interview on Administrator.	11/11/17 at 4:15pm with the				
	4/18/17 revealed diag	nt #8's current FL2 dated gnoses included mood ain injury, history of muscle and neck pain.				
	Review of Resident #8's record revealed physician's orders dated 8/9/17, and 9/8/17, and for oxycodone 5mg-acetaminophen 325mg (a narcotic pain reliever used to treat severe pain) one tablet every 6 hours as needed for pain.					
	narcotic pain reliever					
	revealed: -An entry for oxycodo 325mg take 1 tablet e -Documentation of do 5mg-acetaminophen included date and tim given, MA that admini the effectiveness of th -Oxycodone 5mg-ace	325mg administered e administered, reason istered the medication, and				
	count sheet) for oxyco 325mg from 9/7/17 to Resident #8's Septen	8's CSCS (controlled drug odone 10mg-acetaminophen 9/30/17 compared to ober 2017 eMAR revealed: s of medication documented				

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DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		hal002004	B. WING		10/11/2017	
			-		10/11/2011	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
AI EYAND	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 SC	DUTH		
ALEXAND	ER ASSISTED LIVING	TAYLORS	VILLE, NC 286	81		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)	
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
			-	DETIGIENCY)		
D 367	Continued From page	e 43	D 367			
	on the CSCS as admi	inistered from 9/7/17 to				
	9/30/17.	mistered from 5/1/17 to				
	-There were 72 doses	s of avvcadane				
		325mg documented as				
	administered on the e					
	-There were 4 doses					
		325mg not documented as				
		ident #8's September 2017				
	eMAR.	ident #00 Coptember 2017				
	OND 11 C.					
	Oxycodone 5mg-acet	aminophen 325mg was				
	,	nistration on Resident #8's				
		ented as administered on				
	the September 2017					
	-	- 1 tablet documented on				
	CSCS, but not docum					
	-On 9/10/17 at 1:00pr	n - 1 tablet documented on				
	CSCS, but not docum	nented on the eMAR.				
	-On 9/12/17 at 5:30pr	n - 1 tablet documented on				
	CSCS, but not docum	nented on the eMAR.				
	-On 9/25/17 at 8:00pr	m - 1 tablet documented on				
	CSCS, but not docum	nented on the eMAR.				
		8's October 2017 eMAR on				
	revealed:	_ ,				
		ne 5mg-acetaminophen				
	_	every 6 hours as needed.				
	-Documentation of do					
	5mg-acetaminophen					
		e administered, reason				
	•	istered the medication, and				
		ne medication from 10/1/17				
	to 10/5/17 at 1:12pm.					
		staminophen 325mg was nistered for 15 doses on the				
	eMAR from 10/1/17 to					
		taminophen 325mg was				
	documented as disco	ntinued on 10/5/17.				

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-An entry for oxycodone 7.5mg-acetaminophen 325mg take 1 tablet every 6 hours as needed

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	IRVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
L-1000004			B. WING		R-C	
		hal002004	D. WING	<del></del>	10/11	/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AL EVAND	SED ACCICTED LIVING	3032 N C H	IIGHWAY 16 S	ОИТН		
ALEXAND	ER ASSISTED LIVING	TAYLORS	ILLE, NC 286	81		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	: 44	D 367			
D 307	beginning on 10/5/17Oxycodone 7.5mg-actablet every 6 hours as a administered 15 tin 10/10/17.  Review of Resident #5mg-acetaminophen 7.5mg-acetaminophen 10/10/17 compared to 2017 eMAR revealed: -There were 29 doses as administered on the 10/10/17There were 15 doses 5mg-acetaminophen 3 administered on the edocumented as administered on Residoses documented as #8's October 2017 eM  Oxycodone 5mg-acet oxycodone 7.5mg-acet oxycodone 7.5mg-acet oxycodone 7.5mg-acet oxycodone 2017 eMAR to compared to doses do on Resident #8's CSC -On 10/7/17 at 11:30p	cetaminophen 325mg take 1 as needed was documented mes fron 10/5/17 to  8's CSCS for oxycodone 325mg and oxycodone 325mg from 10/1/17 to be Resident #8's October is of medication documented a CSCS from 10/1/17 to a for oxycodone 325mg documented as MAR matching 15 doses histered on the CSCS. a of oxycodone a 325mg documented as dent #8's CSCS and 12 a administered on Resident MAR.  aminophen 325mg and betaminophen 325mg histered on Resident #8's from 10/1/17 to 10/10/17 bocumented as administered CS revealed the following: bom - 1 oxycodone a 325mg tablet documented				
	documented on the el -On 10/9/17 at 8:30pr	MAR. n - 1 oxycodone n 325mg tablet documented e CSCS, but not				

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Based on observation and record review,

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		I .	R-C <b>)/11/2017</b>	
	PROVIDER OR SUPPLIER  DER ASSISTED LIVING	STREET AU 3032 N C	DDRESS, CITY, STATI	UTH			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TON SHOULD BE	(X5) COMPLETE DATE	
D 367	not documented on the doses of oxycodone of mg administered but to October 2017 eMAR.  Refer to interview on Resident Care Coord  Refer to interview on Administrator.  Interview on 11/11/17 Care Coordinator (RC -She had been in her weeksShe administered me -She was responsible medication orders, inducumentation and tradministrationShe was not aware redocumenting for date reason given, medicate the medication, and the medication for all procontrolled substances -She currently had a semonitoring and accoumedications received medications administration and pharmacy invoice -She did not have a semonitoring residents' CS	ses of oxycodone 325 mg administered but the September eMAR and 2 7.5mg-acetaminophen 325 thot documented on the  11/11/17 at 4:00pm with the inator (RCC).  11/11/17 at 4:15pm with the  at 4:00pm with the Resident CC) revealed: current position for 4  redications to the residents. If or managing residents' cluding managing acking medication  medications aides were not and time administered, tion aide (MA) administering the effectiveness of the medications, especially septem in place for inting for controlled compared to controlled compared to controlled compared using the CSCS sheets esc. yestem in place for routinely SCS records compared to for "PRN" medications to the eMAR.	D 367	DEFICIENC			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		hal002004	B. WING		R-C <b>10/11/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
ΔΙ ΕΧΔΝΩ	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 SC	DUTH	
ALEXAND	PER ASSISTED LIVING	TAYLOR	SVILLE, NC 2868	31	
(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 367	Continued From page	e 46	D 367		
	administered as order -The RCC was responsible were document medications on the result. He was not aware m documenting administ medications on the C for date and time adminedication aide (MA) medication, and the experience of the RCC was responsible to the RCC was	nsible to manage assure medications were red. nsible to ensure medication ing administration of esidents' eMARs. edication aides were tration of "PRN" controlled SCS but not documenting ninistered, reason given, administering the effectiveness of the medications, especially			
D 399	(h) The facility shall ediversions are reported enforcement agency are Registry as required by suspected drug diversions.	B (h) Controlled Substance B Controlled Substance Bensure that all known drug Bed to the pharmacy, local law Bensure that all known drug Bed to the pharmacy, local law Bensure that all known drug Be	D 399		
	This Rule is not met Based on interviews a facility failed to assure diversion was reporte enforcement as requi	and record reviews, the e that a known drug d to the local law			

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The findings are:

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
			1				
			B. WING		R-		
		hal002004	B. WING		10/1	1/2017	
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
		3032 N C I	HIGHWAY 16 S	оитн			
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286				
	CLIMMA DV CT		1		\		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE	
				DEFICIENCY)			
D 399	Continued From page	. 47	D 399				
D 000	Continued From page	; +1	5 000				
	Interview with the Adr	ministrator on 10/11/17 at					
	2:00pm revealed:						
		Coordinator (RCC) brought					
	to his attention, date i	not known, that staff had					
	tampered with Reside	ent #2's Percocet and					
	Resident #8's Percoc	et, which were in bubble					
	packs in the medication	on cart.					
		ation card had 2 tablets of					
	Percocet in each bub						
		een opened on Resident					
		of the 2 Percocet in each					
	bubble had been replaced	aced with a Tylenol tablet,					
	and the back of the bi	ubble taped over.					
	-Resident #8 had a m	edication card of Percocet					
	with 1 tablet in each b	oubble.					
		cet bubble pack had 2					
	bubbles which had be						
	•	d with a Tylenol tablet and					
	the back of the bubble	•					
		, Staff G, was working on					
		n the shift prior to the RCC					
	finding the tampered						
		acility on the day following					
	-	ampered medications and					
	was requested to be	_					
	-Staff G's urinalysis te						
	presence of narcotics						
	•	led for a week, had not					
		, and was no longer an					
	employee.						
		completed and reported to					
	the Health Care Person						
	-He did not think he n						
		cement since it was only					
	"five pills."						
		acy to obtain replacements					
	for the missing medic	ations.					

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Review of Resident #2's record revealed: -A current FL2 dated 8/9/17 with diagnoses

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DIVISION	n nealth Service Regu	laliuli				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					l R-	0
		h-1002004	B. WING		1	
		hal002004	1	<del>-</del>	10/1	1/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		3032 N C I	HIGHWAY 16 S	оитн		
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286			
04.0.15	CLIMMA DV CT		1	PROVIDER'S PLAN OF CORRECTION		2/5
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
D 399	Continued From page	. 19	D 399			
D 333	Continued From page	: 40	D 399			
	including altered men	tal status, congestive heart				
	failure, and atrial fibril	lation.				
	-A physician's order d	lated 9/5/17 for oxycodone				
	10 mg-acetaminophe	n 325 mg (a narcotic pain				
	reliever used to treat	severe pain) 2 tablets every				
	6 hours as needed.					
	Based on record review	ew and observation of				
	Resident #2 on 10/11/17, it was determined the					
	resident was not interviewable.					
	Review of Resident #	8's record revealed:				
	-A current FL2 dated	4/18/17 with diagnoses				
	including mood disord	der, traumatic brain injury,				
	and back and neck pa	ain.				
	-A physician's order d	ated 9/8/17 for Percocet				
	5-acetaminophen 325	5 mg (a narcotic pain reliever				
	used to treat severe p	pain) one tablet every 6				
	hours prn (as needed	) for pain. Hold for sedation.				
	Interview on 10/10/17	at 2:20 pm with Resident				
	#8 revealed:					
	-He depended on stat	ff to administer his				
	medications as ordered	ed.				
	-He could not recall a	time when his medications				
	were not administered	d as ordered.				
	-He did not know all the	he medications that he				
	received.					
	Interview with the RC	C on 10/11/17 at 4:25 pm				
	revealed:					
	-She did not notice th	e medications had been				
	tampered with during	shift change when she and				
		ide, Staff G, reconciled the				
	control drug count on					
	•	lministering medication on				
		that some of Resident #8's				
	· ·	rcocet in bubble packs had				
	been opened and was					

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-She reported the discovery of the tampered

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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	ES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		hal002004	B. WING		R- 10/1	-C 1 <b>1/2017</b>
NAME OF PROVIDER OR SUF	PPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXANDER ASSISTED	LIVING		HIGHWAY 16 SO VILLE, NC 286			
PREFIX (EACH	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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	SHOULD BE COMPLETE	
on 10/11/17 -She routine for Resident -On a facility Resident #2' Percocet and last bubble a backThe 4th from the 2nd and been tamped -The last bubble and has she observed Tylenol to idded.  Review of the 24-Hour Initial Working Day -There was a residents' nat -A medication individualThe question a crime?" was -The question a crime? "was -The question a crim	th the Host at 3:05pr ely examire the Host and Tylenol and had been the Host at H	spice Nurse for Resident #2 m revealed: ned the medications on hand g visits. te not known, she observed tet bubble pack had a tablet in the 5th from the the bubble had no Percocet. The last bubble had not a Percocet and Tylenol taped to close in the back. Tarkings on the Percocet and tablets.  Care Personnel Registry the dated 9/20/17 and the 5 dated 9/26/17 revealed: tion of staff diverting that G, was the accused there a reasonable suspicion of the dyes. The last bubble had not that the staff G, was the accused there a reasonable suspicion of the dyes. The last bubble had not that the staff G, was the accused there a reasonable suspicion of the dyes. The last bubble had not that the staff G, was the accused there a reasonable suspicion of the dyes. The last bubble had not that the staff G, was the accused	D 399			

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hours as needed for pain revealed: -The dispense date was 9/8/17.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
						c
		h =1000004	B. WING	B WING		
		hal002004	J		10/1	1/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		3032 N C	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286			
		IATLORS	VILLE, NC 200	81		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
D 399	Continued From page	e 50	D 399			
	The Developed	desiriate and form				
		were administered from				
		28 tablets, and 2 tablets				
	were destroyed on 9/2	23/17.				
		2's Percocet controlled drug				
		10/325 mg, 2 tablets every				
	6 hours as needed for pain, for a total of 24 doses revealed: -The dispense date was 9/5/17.					
	-The Percocet tablets	were administered from				
	9/16/17 to 9/22/17 for a total of 24 doses with a 0 balance.					
		ne interview with Staff G on				
	10/11/17 at 3:37pm w	as unsuccessful.				
D912	G.S. 131D-21(2) Dec	laration of Residents' Rights	D912			
	0.0. 1012 21(2) 200	idiation of recoldence regime				
	G.S. 131D-21 Declar	ration of Residents' Rights				
		ave the following rights:				
	2. To receive care an	5 5				
		e, and in compliance with				
		state laws and rules and				
	regulations.	state laws and rules and				
	regulations.					
	This Dula is not meat	an avidenced by				
	This Rule is not met	-				
		ns, interviews, and record				
	reviews, the facility failed to assure all residents received care and services which were adequate,					
		ompliance with relevant				
		s and rules and regulations				
	related to nutrition and	d food service, infection				
	prevention requireme	nts, medication				
	administration and im	plementation.				
	The findings are:					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
711101111111	or dorate or the transfer of t	IDENTIFICATION NOMBER.	A. BUILDING:			
		hal002004	B. WING		R-C <b>10/11/2017</b>	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 S			
			ILLE, NC 286			
(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	
D912	reviews, the facility fadiets for 6 of 6 sample #5, #9, #10, #11, and ordered related to pur concentrated sweets, and chopped meat did 10A NCAC .0904(e)(4 Service (Type A2 Viol B. Based on observatinterviews, the facility and appropriate infectimplemented for blood sharing glucose meterof 4 sampled resident [Refer to Tag 932 G.S. Infection Prevention For Type B Violation).]  C. Based on observative administered as residents during the merrors in medication and inhalers, Ventolin HFA #8, and hydrocortison Resident #4; lisinopril Resident #4 after the discontinued. [Refer .1004(a) Medication A Violation).]  D. Based on observative reviews, the Administ management, operation of the sample of the	ations, interviews, and record iled to ensure all therapeutic ed residents (Resident #3, #12) were served as ree, honey thick liquids, no vegetarian, lactose free, et orders. [Refer to Tag 310 4) Nutrition and Food ation).]  Itions, record reviews and failed to assure adequate tion control procedures were d glucose monitoring by rs between residents for 4 ts, (#3, #4, #6 and #7).  3. 131D-4.4(A)(b) ACH Requirements (Unabated tions, interviews, and record iled to ensure medications ordered for 2 of 4 sampled nedication pass related to administration of oral A and Atrovent, to Resident the cream topically to and potassium chloride to medications had been to Tag 358 10A NCAC Administration (Type B	D912			
		nts' rights as evidenced by substantial compliance with governing adult care				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		hal002004	B. WING		R-C <b>10/11/2017</b>		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE. ZIP CODE	1 1911		
			HIGHWAY 16 SC				
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 286				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	KIATE	DATE	
5040				,			
D912	Continued From page	e 52	D912				
	homes as related to n	nedication administration,					
	nutrition and food ser	vice, and infection control,					
		inces. [Refer to Tag 980 G.S					
		on (Unabated Type A2					
	Violation).]						
D932 G.S. 131D-4.4A (b) ACH Infection Prevention		D932					
	Requirements						
	C C 121D 1 11 1 1 1	Care Home Infection					
	Prevention Requirem						
	Frevention Requirem	ents					
	(b) In order to preven	t transmission of HIV,					
		C, and other bloodborne					
		It care home shall do all of					
	the following, beginning	ng January 1, 2012:					
	(1) Implement a writte	en infection control policy					
		deral Centers for Disease					
		on guidelines on infection					
		s at least all of the following:					
		single-use equipment used					
		cous membranes, and other					
		isinfection of reusable					
	residents.	it are used for multiple					
		s and equipment, including					
		agents, and schedules.					
		ection control devices and					
	supplies.						
	d. Blood and bodily flu	uid precautions.					
		ollowed when adult care					
	· ·	d to blood or other body					
		on in a manner that poses a					
	•	smission of HIV, hepatitis B,					
		oloodborne pathogens.					
	t. Procedures to prohi	ibit adult care home staff				1	

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with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident,

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPL	
		hal002004	B. WING		R- 10/1	-C 1 <b>1/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			HIGHWAY 16 SC			
ALEXAND	ER ASSISTED LIVING	TAYLORS	VILLE, NC 286	81		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D932	Continued From page	e 53	D932			
	facility's infection con (3) Update the infection necessary to prevent hepatitis B, hepatitis ( pathogens.	ndition resolves. tor compliance with the trol policy. on control policy as the transmission of HIV, C, and other bloodborne				
	This Rule is not met FOLLOW-UP TO TYPE	•				
	Based on these finding Violation was not aba	ngs, the previous Type B ted.				
	interviews, the facility and appropriate infectimplemented for blood sharing glucose meter of 4 sampled resident.  The findings are:  Observation on 10/09 stick blood sugar (FS-The Resident Care Coblack glucometer cas name, containing a B with the same resider FSBS check for the reglucometer.	Coordinator (RCC) opened a e, labeled with a resident's rand A glucometer labeled nt's name, and obtained a esident named on the				

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ווטופועום	n nealth Service Regu	lation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Υ	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		COMPLETED	
			B. WING		R-C		
		hal002004	B. WING		10/11/20	17	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE			
			HIGHWAY 16 S	,			
ALEXAND	ER ASSISTED LIVING						
		TAYLORS	/ILLE, NC 286	81			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		MPLETE DATE	
IAG	REGOEMONT ON E	iso BENTI TING IN GRAW (NOIN)	TAG	DEFICIENCY)	., (1)		
			+				
D932	Continued From page	e 54	D932				
	dianagabla langing da	wice to perform the FCDC					
		evice to perform the FSBS.					
		of the test strip, lancing					
	· ·	ipe in the biohazard waste					
	container affixed to th	e medication cart.					
		edication cart on 10/9/17 at					
	11:45am revealed:						
	-	lucometer cases located on					
	the medication cart.  -The black glucometer cases were labeled with residents' names and contained a Brand A						
	glucometer labeled w	ith a matching resident's					
	name.						
	-No other glucometers	s were observed on the					
	medication cart.						
	Telephone interview of	on 10/9/17 at 4:20pm with					
		ne Brand A glucometer					
		ter was recommended for					
	•	n and should not be shared.					
		dures were recommended.					
	Tto diominodiom process	daree were recommended.					
	Based on the Center	for Disease Control (CDC)					
	guidelines for infection	, ,					
	recommendations are						
		lucometers) should not be					
		ents. If the glucometer is to					
		~					
		n one person, it should be					
		ed per the manufacturer's					
		nufacturer does not list the					
		on, the glucometer should					
	not be shared betwee	en residents.					
		at 11:48am with the RCC					
		were administered FSBS					
	and one resident rece	-					
	diagnoses of a blood	borne pathogen.					
	Interview with the RC	C on 10/9/17 at 11:50am					

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revealed:

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDIEAN	or dortheorion	IDENTIFICATION NONDER.	A. BUILDING: _			
		hal002004	B. WING	<del></del>	R- 10/1	C 1/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AI EYAND	ER ASSISTED LIVING	3032 N C H	IGHWAY 16 SO	отн		
ALLXAND	EN AGGIGTED EIVING	TAYLORSV	ILLE, NC 286	81		
(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
D932	Continued From page	e 55	D932			
	-She had worked at the a while, and had been about 4 months this tire. She worked as a Me coming back to the far as the RCC for 4 to 5 of the former RCC.  -The facility policy war glucometer assigned only on the assigned only on the assigned.  A. Review of Resided 2/9/17 revealed: -Diagnoses included gastroesophageal referenal insufficiency, ur insulin dependent dia -A physician's order for acting insulin used to sliding scale insulin (Stimes a dayA physician's order for insulin used to lower	ne facility previously, left for neworking at the facility for me. dication Aide (MA) since cility and had been training weeks due to the departure s for each resident to have a to the resident, and used resident.  In #3's current FL2 dated schizophrenia paranoid type, lux disease, back pain, mild inary tract infection, and betes. or Novolog insulin (a rapid lower blood sugar levels) as SSI) subcutaneously three				
	Review Resident #3 subsequent physician's orders dated 9/8/17 revealed an order for Novolog 100 U/ml Flexpen (a type of insulin administration device) insulin use per sliding					
	give orange juice with 2 units; 200-249= 4 u 300-349= 8 units; 350	ding scale less than 70 = 2 packs of sugar; 150-199= nits; 250-299= 6 units; 0-399= 10 units; greater than nedule daily at 6:00am, d 9:00pm daily.				
	FSBS values recorde	3's glucometer revealed d in the glucometer's history locumented on Resident				

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PRINTED: 10/27/2017

Division of Health Service Regulation							
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		R-C <b>10/11/2017</b>		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE			
AL EVANE	NED 40010TED 1 11/11/10	3032 N C	HIGHWAY 16 S	оитн			
ALEXANL	DER ASSISTED LIVING	TAYLORS	SVILLE, NC 286	81			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE	
D932	Continued From page	e 56	D932				
	(eMAR) from 9/15/17 as follows:  -Time and date were and date displayed or 12:02pm on 10/09/17  -A FSBS reading on 5 matched the October 6:00am.  -No FSBS reading on 5 matched the October on 10/08 at 9:00pm.  -A FSBS reading on 5 matched the October 4:00pm with an additi glucometer history on was not documented 10/6.  -A FSBS reading on 5 did not match the Oct 9:00pm as 283.  -A FSBS reading on 5 matched the Septemb 6:00am with an additi in the glucometer hist that was not documer eMAR on 9/23.  -A FSBS reading of 2 September 2017 eMA no FSBS reading reconstruction.	Administration Record to 10/9/17 were inconsistent not set correctly. The time in the glucometer was 5/21 at at 11:06am. S/21 at 8:39am of 140 2017 eMAR on 10/9 at 5/21 corresponded to 331 ated on the October eMAR on 10/6 at onal FSBS recorded in the 15/20 at 5:00 am of 266 that on the October eMAR on 10/15 at 11:27 am of 196 that ober 2017 eMAR on 10/1 at					

history.

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September 2017 eMAR for 9/15 at 11:00am, but no FSBS reading recorded in the glucometer's

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		hal002004	B. WING		R-C 10/11/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 S			
			ILLE, NC 286			
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D932	Continued From page	e 57	D932			
	10/1/17 to 10/9/17 (at -Novolog 100 U/ml Floscale as needed. Slic give orange juice with 2 units; 200-249= 4 u 300-349= 8 units; 350 400 give 12 units was -An entry for FSBS at and 9:00pm dailyFSBS values were dopportunities.  Review of Resident # 9/15/17 to 9/30/17 rev -An entry for Novolog use per sliding scale aless than 70 = give or sugar; 150-199= 2 un 250-299= 6 units; 300 units; greater than 40 transcribed on the elv -An entry for FSBS widen with 4:00pm, and 9:00pm -FSBS values were dopportunities.  Based on review of Rhistory compared to that and October 2017, Refore extra and one incin October 2017, and FSBS values in September 100 -	expen insulin use per sliding ding scale less than 70 = 12 packs of sugar; 150-199= 12 packs of sugar; 150-199= 150-399= 10 units; greater than stranscribed on the eMAR. 16:00 am, 11:00am, 4:00pm, ocumented for 33 of 33  3's September eMAR from realed: 100 U/ml Flexpen insulin as needed. Sliding scale range juice with 2 packs of its; 200-249= 4 units; 10-349= 8 units; 350-399= 10 00 give 12 units was lAR. 11:00am, daily. 11:00am, daily. 12:00cumented for 64 of 64  esident #3's glucometer's nee eMARS for September esident #3 had one missing, correctly documented FSBS one extra and 3 missing ember 2017.				

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first shift MA.

Refer to interview on 10/10/17 at 9:00am with a

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STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_		R-C	
		hal002004	B. WING		10/11/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AI FXAND	ER ASSISTED LIVING	3032 N C H	IGHWAY 16 SC	ОИТН		
TAYLORS			ILLE, NC 286	81		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D932	Continued From page	e 58	D932			
	Refer to interview on Resident Care Coord	10/9/17 at 4:40pm with the inator (RCC).				
	Refer to interview on 10/10/17 at 9:30 am v	10/9/17 at 4:40pm and with the Administrator.				
	7/2/17 revealed: -Diagnoses included I disease, hypertensior injury, mixed dementi diabetes, and chronic -An order for Novolog	•				
	Review Resident #4's subsequent physician's order dated 9/8/17 revealed an order for Novolog SSI as follows: less than 200 no insulin; 200-250= 1 unit; 251-300= 2 units; 201-350= 3 units; 351-400= 4 units; 401-450= 5 units; 451-500= 6 units; greater than 500 inject 8 units, recheck blood sugar in 1 hour, if not below 400 call MD. Schedule daily at 6:00 am, 11:00 am, and 4:00 pm.					
	FSBS values recorde compared to values of #3's October 2017 an electronic Medication (eMAR) from 9/23/17 as follows: -Time and date were and date displayed or 8:04pm on 10/09/17 a-A FSBS reading on 9	Administration Record to 10/9/17 were inconsistent not set correctly. The time in the glucometer was 9/3 at				

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6:00am.

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Division (	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		hal002004	B. WING		R-C 10/11/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
AI EYAND	AED ASSISTED I IVING	3032 N C	HIGHWAY 16 SC	ОИТН		
ALEXANL	DER ASSISTED LIVING	TAYLOR	SVILLE, NC 286	81		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D932	Continued From page	: 59	D932			
	-No FSBS reading on documented on the Oat 4:00pm. (A FSBS vesident #3 glucome reading on 10/6 at 4:00pm. (A FSBS vesident #3 glucome reading on 10/6 at 4:00pm. (A FSBS reading on documented on the S9/23 at 6:00am. (A FS recorded in Resident an extra reading on 9  Review of Resident #10/1/17 to 10/9/17 (at -There was an entry fless than 200 no insu 251-300= 2 units; 201 units; 401-450= 5 unit than 500 inject 8 units hour, if not below 400 -There was an entry fam, and 4:00 pm daily -FSBS values were dopportunities.  Review of Resident # from 9/23/17 to 9/30/7 -There was an entry fless than 200 no insu 251-300= 2 units; 201 units; 401-450= 5 unit than 500 inject 8 units hour, if not below 400 -There was an entry fam, and 4:00 pm daily am, and 4:00 pm daily and	9/1 corresponded to 266 lectober 2017 eMAR on 10/6 lectober 2017 eMAR on 10/6 lectober 2017 eMAR on 10/6 lectober 2066 was recorded in ter's history as an extra lopm).  8/18 corresponded to 202 leptember 2017 eMAR on less value of 202 was lectober eMAR from lector of 200 was lectober eMAR from lectober eMAR from lector lectope lector lectope lectop				

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Based on review of Resident #4's glucometer's history compared to the eMARS for September

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
		hal002004	B. WING		10/11	/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SO VILLE, NC 286			
0(4) ID				PROVIDER'S PLAN OF CORRECTIO	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D932	2 Continued From page 60		D932			
D932	and October 2017, Revalues missing in the history with FSBS val and at the same time glucometer's history.  Refer to interview on night shift Medication.  Refer to interview on first shift MA.  Refer to interview on Resident Care Coord.  Refer to interview on 10/10/17 at 9:30 am v.  C. Review of Resident 7/24/17 revealed: -Diagnoses included i retardation, and diabeter and the company of the c	esident #4 had two FSBS resident's glucometer's ues of the same amount found extra in Resident #3's  10/10/17 at 8:50am with a Aide (MA).  10/10/17 at 9:00am with a  10/9/17 at 4:40pm with the inator (RCC).  10/9/17 at 4:40pm and with the Administrator.  Int #7's current FL2 dated insomnia, mild mental etes mellitus for Lantus (a long acting blood sugar) insulin 10 units es daily. to check finger stick blood am daily.  Is subsequent physician's der dated 9/8/17 to check	D932			
	compared to values d #7's October 2017 an electronic Medication	locumented on Resident				

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-Time and date were set correctly on the

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		hal002004	B. WING		10/11/2017	
		Tidio02004			10/11/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
AI EYAND	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 S	DUTH		
TAYLOR		TAYLOR	SVILLE, NC 286	81		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	V (X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		
TAG	REGULATORI OR I	130 IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	UAIL 5/112	
D932	Continued From page	e 61	D932			
	glucometer.					
	•	10/9 at 5:23am for 102 that				
	_	2017 eMAR on 10/9 at				
	6:00am.					
	-A FSBS reading on 9	9/26 at 5:29am of 83 that				
	matched the October	2017 eMAR on 9/26 at				
	6:00am with an additional FSBS recorded in the					
	glucometer history on 9/26 at 9:13pm of 124 that was not documented on the October eMAR on					
	9/26.					
	-A FSBS reading of 8					
		AR on 9/20 at 6:00am, but				
	_	orded in the glucometer's				
	historyA FSBS reading on 9	0/17 at 5:17am of 68				
	_	2017 eMAR on 9/17 at				
		onal FSBS recorded in the				
		9/17 at 5:15am of 112 that				
		on the October eMAR on				
	9/17.					
	-A FSBS reading on 9	9/16 at 5:25am of 267 that				
	did not match the Oct	ober 2017 eMAR on 9/16 at				
	6:00am documented	for 91.				
		7's October eMAR from				
	10/1/17 to 10/9/17 rev					
	_	ood sugar daily at 6:00 am,				
	use onsite blood gluc	ose protocnol. cheduled at 6:00am daily.				
	-FSBS values were d					
	opportunities.	ocumented for 9 of 9				
	оррогинисэ.					
	Review of Resident #	7's September eMAR from				
	9/11/17 to 9/30/17 rev					
		ood sugar daily at 6:00 am,				
	use onsite blood gluc					
	transcribed on the eM					
	-An entry for FSBS so	cheduled at 6:00am daily.				

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opportunities.

-FSBS values were documented for 20 of 20

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Division o	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						0
		h = 100000 4	B. WING		R-C	
		hal002004			10/1	11/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		3032 N C	HIGHWAY 16 S	OUTH		
ALEXAND	ALEXANDER ASSISTED LIVING TAYLOR					
	OLIMANA DV OT					1
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
D932	Continued From page	. 63	D932			
D932	Continued From page	8 02	D932			
	Based on review of R	Resident #7's glucometer's				
	history compared to t	he eMARS for September				
	and October 2017, Re	esident #7 had two FSBS				
	values documented o	on the September 2017				
	eMAR but not recorde	ed in the resident's				
	glucometer history, ar	nd three extra FSBS values				
	recorded in the gluco	meter's history but not				
	documented on the resident's September 2017					
	eMAR.					
	Refer to interview on	10/10/17 at 8:50am with a				
	night shift Medication	Aide (MA).				
	Refer to interview on	10/10/17 at 9:00am with a				
	first shift MA.					
	Refer to interview on	10/9/17 at 4:40pm with the				
	Resident Care Coord	inator (RCC).				
	Refer to interview on	10/9/17 at 4:40pm and				
	10/10/17 at 9:30 am v	with the Administrator.				
	D. Review of Reside	nt #6's current FL2 dated				
	7/24/17 revealed:					
		anxiety, mild intellectual				
	disabilities, and diabe					
		for Byetta (a non-insulin				
	injection used to lowe	<b>G</b> ,				
	~	efore breakfast and one				
	hour before supper.					
		to check finger stick blood				
	sugar (FSBS) at 6:00	am.				
	Deview Devide 1112	and a surround advised to the state of				
		subsequent physician's order				
		n order dated 9/8/17 to				
	check FSBS at 6:00a	m daily.				
	Davidson of Davidson 17	KOIs alvas assats a second of				
		6's glucometer revealed				
	FSBS values recorde	ed in the glucometer's history				

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STATEMENT	OT HEAITN SERVICE REGU FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		R-C <b>10/11/2017</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STAT	TE, ZIP CODE		
ALEXAND	ALEXANDER ASSISTED LIVING 3032 N C H TAYLORSV					
(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 COMPLETE	
D932	#6's October 2017 an electronic Medication (eMAR) from 9/15/17 as follows:  -Time and date were and date displayed or 9:55am on 10/09/17 a-A FSBS reading on 8 matched the October 6:00am with an additi glucometer history on was not documented 10/9. (FSBS 331 corr documented on Resid 9:00pm but not record glucometer history.)  -A FSBS reading of 9 October 2017 eMAR FSBS reading record history.  -A FSBS reading record history.	documented on Resident d September 2017 Administration Record to 10/9/17 were inconsistent not set correctly. The time in the glucometer was 5/20 at at 3:20pm. 6/19 at 11:59pm for 102 2017 eMAR on 10/9 at onal FSBS recorded in the in 5/19 at 3:23pm of 331 that on the October eMAR on esponded to a FSBS value dent #3's eMAR for 10/8 at ded in Resident #3's  1 documented on the for 10/2 at 6:00am, but no ed in the glucometer's	D932			
	glucometer's history of value.)  Review of Resident # 10/1/17 to 10/9/17 review. An entry to check block.	corresponded to the missing 6's October eMAR from yealed: bod sugar daily at 6:00am. cheduled at 6:00am daily.				

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opportunities.

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					R-C	
		hal002004	B. WING		1	1/2017
NAME OF D	ROVIDER OR SUPPLIER	CTDEET AF	DDRESS, CITY, STAT	E ZIR CODE		
NAME OF T	TOVIDER OR SOLT LIER		HIGHWAY 16 SO			
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 2868			
	OLIMANA DV. OT					
(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 APPROPRIATE OF THE APPR	BE	(X5) COMPLETE DATE
				DEFICIENCY)		
D932	Continued From page	e 64	D932			
		6's September eMAR from				
	9/15/17 to 9/30/17 rev	ood sugar daily at 6:00am.				
		cheduled at 6:00am daily.				
	-FSBS values were d	ocumented for 16 of 16				
	opportunities.					
	Based on review of R	Resident #6's glucometer's				
	history compared to the eMARS for September					
		esident #6 had two FSBS				
		on the October 2017 eMAR				
		e resident's glucometer BS value recorded in the				
		out not documented on the				
		117 eMAR (corresponding to				
	a value documented	Resident #3's eMAR for				
		recorded in Resident #3's				
	glucometer history), a					
		September 2017 eMAR not #6's glucometers history (A				
	FSBS value recorded	-				
		nd not documented on				
		corresponded to the FSBS				
	missing value).					
	Refer to interview on	10/10/17 at 8:50am with a				
	night shift Medication					
		10/10/17 at 9:00am with a				
	first shift MA.					
	Refer to interview on	10/9/17 at 4:40pm with the				
	Resident Care Coord	·				
	Defer to intensions	10/0/17 at 1:40nm and				
		10/9/17 at 4:40pm and with the Administrator.				
	TOTTOTIT AL S.SU AIII \	with the Aumillionatol.				
	Interview on 10/10/17	at 8:50am with a night shift				

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Medication Aide (MA) revealed:

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PRINTED: 10/27/2017

Division of	of Health Service Regul	lation			FURIV	IAPPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		R-C <b>10/11/2017</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ΔΙ ΕΧΔΝΓ	DER ASSISTED LIVING	3032 N C	HIGHWAY 16 S	ОИТН		
ALLACITE		TAYLORS	VILLE, NC 286	81		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	JLD BE COMPLETE	
D932	Continued From page	65	D932			
	-She had worked as a years.  -The facility policy wa -She used alcohol wip glucometer after she eresident's name.  -She did not recall a treglucometer between resident's name.  -She did not know how missing or extra in a geglucometer was accided resident due to a staff overlooked changing residents.  Interview on 10/10/17 MA revealed:  -She had been a MA revealed:  -She checked residentime a day and 2 checks once daily.  -Each resident had a them for checking FS for another resident.  -When she cleaned a alcohol to clean the great of the she always checked.	In MA at the facility for 3 Is to not share glucometers. It is to clean the entire checked a resident's FSBS. It is labeled with the assigned a residents. It is residents. It is reading would be glucometer unless the entally used for another is person being in a hurry and the glucometer between It is residents. It is residents worked. It is residents received FSBS and should not be used glucometer. It is glucometer, she used lucometer. It is glucometer assigned to BS and should not be used glucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer. It is glucometer assigned to BS and should not be used lucometer.				

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revealed:

alcohol wipes.

Interview on 10/9/17 at 4:40pm with the RCC

-Staff had been instructed that glucometers should not be shared between residents.

-The facility staff routinely clean glucometers with

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE COMI			
		hal002004	B. WING		I	R-C <b>)/11/2017</b>
	ROVIDER OR SUPPLIER DER ASSISTED LIVING	3032 N C	DDRESS, CITY, STATE HIGHWAY 16 SOI	UTH		
(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 ( (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D932	the wipes on the gluc -The RCC provided a wipes on 10/9/17 at 4 the medication room.  Interview with the Adr 4:40pm and 10/10/17 -The facility policy wa glucometer assigned be used only for that -There was no systen monitor the residents' compared to the FSB the residents' eMARS -The glucometers sho disinfected since each glucometer.  The facility failed to in control procedures co Disease Control and infection control for 3 #4, #6 and #7) with or By allowing the sharir residents, including R of hepatitis C, without facility exposed reside serious blood borne il	fecting wipes but did not use ometers. container of disinfecting:45pm that were stored in  ministrator on 10/9/17 at at 9:30 am revealed: s each resident had a to the resident and should resident's FSBS. In in place to routinely glucometers' history S values documented on S. buld not need to be in resident had an assigned in plement proper infection ensistent with Centers for Prevention guidelines on of 4 sampled residents (#3, reders for FSBS monitoring. In go of glucometers between the ents to the risk of contracting linesses, including hepatitis, to the health and safety of	D932			
D980	G.S. § 131D-25 Impl		D980			
	G.S. 131D-25 Implem	nentation				
	Responsibility for imp	lementing the provisions of				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		h-100004	B. WING		R-C	
		hal002004	J		10/11/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 S			
		TAYLORSV	ILLE, NC 286	81		
(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 APPROPE DEFICIENCY)	BE COMPLETE	
D980	Continued From page	e 67	D980			
	this Article shall rest v facility. Each facility s	vith the administrator of the shall provide appropriate element the declaration of				
	This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION  Based on these findings, the previous Type A2 Violation was not abated.					
	Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to medication administration, nutrition and food service, infection control, and controlled substances.					
	The findings are:					
	weekHe provided oversightreatment orders, nutrinad in-serviced the st prevention measures.	d: as in the facility five days per at for medication and rition and food service, and aff on proper infection				
	administered as order	assure medications were red. nsible to assure medication ing administration of sidents' eMARs.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
						R-C	
		hal002004	B. WING		I	/11/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	ZIP CODE			
ALEXAND	DER ASSISTED LIVING	3032 N C	HIGHWAY 16 SOU	тн			
	T		SVILLE, NC 28681				
(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	
D980	Continued From page	e 68	D980				
	medications on the C Sheet but not docume administered, reason administering the medications, especia the MARs.  Non-compliance iden included:  A. Based on observat reviews, the facility fadiets for 6 of 6 sample #5, #9, #10, #11, and ordered related to pur concentrated sweets,	tified during the survey  tions, interviews, and record liled to ensure all therapeutic led residents (Resident #3, #12) were served as ree, honey thick liquids, no vegetarian, lactose free, let orders. [Refer to Tag 310 14) Nutrition and Food					
	interviews, the facility and appropriate infectimplemented for blood sharing glucose meter of 4 sampled resident [Refer to Tag 932 G.S. infection Prevention F. Type B Violation).]  C. Based on observative reviews, the facility faction were administered as residents during the regrors in medication a inhalers, Ventolin HF. #8, and hydrocortisors.	A and Atrovent, to Resident					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
						R-C	
		hal002004	B. WING			)/11/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE			
ALEXAND	DER ASSISTED LIVING		C HIGHWAY 16 SOI				
	I		SVILLE, NC 28681				
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D980	Continued From page	e 69	D980				
	discontinued. [Refer	medications had been to Tag 358 10A NCAC Administration (Type B					
	interviews, the facility accuracy of the electr Administration Record and #8) sampled residocumenting PRN (as Percocet (Oxycodone	onic Medication ds (eMARs) for 2 of 4 (#2 dents related to s needed) administration for e-Acetaminophen is generic to Tag 367 10A NCAC					
	E. Based on observations, interviews, and record reviews, the facility failed to protect all food being stored, prepared, and served by the facility from contamination. [Refer to Tag 282 10A NCAC .0904(a)(1) Nutrition and Food Services.]  F. Based on observations, interviews, and record review, the facility failed to ensure at least a three-day supply of perishable food and a						
	five-day supply of nor facility based on the r concentrated sweets,	n-perishable food was in the menus for regular, no and vegetarian therapeutic 85 10A NCAC .0904(a)(4)					
	facility failed to assure diversion was reporte	d to the local law red by state law. [Refer to					
		ailure to provide oversight y for all licensure rule areas					

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  DATE  DATE  DATE  DATE  DATE  DEFICIENCY)		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  D980  Continued From page 70  resulted in 2 residents not receiving 5 medications as ordered; exposing residents to						R-C	
ALEXANDER ASSISTED LIVING  3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D980 Continued From page 70  resulted in 2 residents not receiving 5 medications as ordered; exposing residents to  3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  DPROVIDER'S PLAN OF CORRECTION (X5) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE  D980 Continued From page 70  resulted in 2 residents not receiving 5 medications as ordered; exposing residents to			hal002004	B. WING		10/1	1/2017
ALEXANDER ASSISTED LIVING  TAYLORSVILLE, NC 28681  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH CORRECTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  D980 Continued From page 70  resulted in 2 residents not receiving 5 medications as ordered; exposing residents to	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D980 Continued From page 70 resulted in 2 residents not receiving 5 medications as ordered; exposing residents to	ALEXAND	DER ASSISTED LIVING					
resulted in 2 residents not receiving 5 medications as ordered; exposing residents to	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
the risk of of contracting serious blood bome illnesses when glucometers were shared; placing 6 residents at risk when therapeutic diets were not served as ordered which included the hospitalization of Resident #5 after the facility served a meal without following the physician orders for thickened liquids and a pureed diet; inaccurate documentation of pri controlled medication; law enforcement not notified for drug diversion; inappropriately storing and thawing food; and an insufficient supply of food to meet the menus. The failure of management in providing oversight in these areas exposed residents to substantial risk that death or serious physical harm or neglect would occur and constitutes a Type A2 Violation.  The Plan of Protection provided by the facility on 10/11/17 revealed:  -The Administrator will work with all staff to assure all violations are addressed, correct and maintained going forward.  -A staff meeting will be conducted to educate all staff of any problems in order to correct them and to get and remain in compliance.  -The Administrator wand the Resident Care Coordinator will continue to monitor all the issues and continue to work on all areas until correct.  -The areas out of compliance will be monitor to assure they remain in compliance.		resulted in 2 residents medications as ordered the risk of of contracti illnesses when glucor 6 residents at risk who not served as ordered hospitalization of Resserved a meal withou orders for thickened linaccurate documents medication; law enfor diversion; inappropriate food; and an insufficienthe menus. The failure providing oversight in residents to substantiphysical harm or negliconstitutes a Type A2  The Plan of Protection 10/11/17 revealed:  -The Administrator will assure all violations a maintained going forwork. A staff meeting will be staff of any problems to get and remain in continue to workup. The areas out of communication of the result o	s not receiving 5 ed; exposing residents to ng serious blood borne meters were shared; placing en therapeutic diets were d which included the ident #5 after the facility t following the physician iquids and a pureed diet; ation of prn controlled cement not notified for drug itely storing and thawing ent supply of food to meet e of management in these areas exposed al risk that death or serious ect would occur and violation.  If work with all staff to are addressed, correct and vard. e conducted to educate all in order to correct them and compliance. and the Resident Care mue to monitor all the issues on all areas until correct. inpliance will be monitor to	D980	DEFICIENCY)		

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