STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	R 10/09/2017

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on October 4,5,6, and 9, 2017.	{D 000}	D-282 All Dietary staff have been inserviced on proper techniques of cleaning in all areas of the kitchen including the walk-in cooler and freezer. Any spill either in the kitchen or walk-ins will be quickly cleaned to ensure cleanliness at all times. All shelves will be cleaned weekly on schedule or more if needed. As the finish on shelves become "flaky" or no longer smooth, maintenance staff will reseal shelves with appropriate water proofing	
{D 282}	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 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 assure food storage areas were kept clean and free from contamination as evidenced by a heavy concentration of stains and debris on storage racks used to store perishable foods and clean pots and pans; stains on the cooler floor and dirt and grime around the door of the walk-in cooler. The findings are: Observation of the walk-in cooler on 10/04/17 at 10:55 a.m. revealed: -There were two metal storage racks on the left and right of the walk-in cooler. -The left metal storage rack contained perishable foods that included approximately 5 unwrapped whole cabbages stored uncovered in an opened box and greater than 24 eggs stored in a grey egg crate, uncovered on the lower shelf of the rack. -Both of the two metal racks had a rough and uneven finish. -The left metal rack had a build-up of a dried, flaking substance that varied from a white to	{D 282}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jamie Sm | TITLE: ADMINISTRATOR | (X6) DATE: 11/10/17

Reviewed & Accepted
LEdwards
11/21/17

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{D 282}	Continued From page 1 black and brown color that covered the rack's storage surface and a moist black substance in the crevices. -There was a large pan containing a pink colored liquid stored on the lower shelf of the right metal rack and a puddle of the same colored pink liquid on the cooler floor under the pan. -Below the right metal rack, in the corner of the floor, there were scattered areas of black stains. Interview with the Dietary Manager (DM) on 10/04/17 at 11:00 a.m. revealed: -All dietary staff were responsible for cleaning the floors in the walk-in cooler daily after the residents' dinner meals were served; the floor was last cleaned after dinner on 10/03/17. -Dietary staff did a "deep cleaning every Sunday" which included taking everything out of the cooler, thoroughly cleaning the walls and floors and removing the two metal racks and cleaning both racks outside with a pressure pump. -The metal racks were rough and stained because they had lost their outer coating from being pressure washed weekly. -The pink colored puddle came from the ham being served for lunch today and was accidentally spilled on the floor of the walk-in cooler but he had cleaned that up. -He was not sure what was causing the black stains on the floor underneath the right metal rack. -He had not noticed the dried, flaking white, black, and brown colored substance on the metal racks or the moist black substance in the crevices of the racks, but thought the build-up was caused by the moisture content in the cooler. Observation of the floor under the right metal rack on 10/04/17 at 11:00 a.m. revealed the pink colored liquid on the walk-in cooler floor had been	{D 282}	to ensure their ability to clean shelving. All door railings of walk-in refrigerator & freezer are included in the weekly cleaning schedule. This will be monitored by the Dietary manager, Administrator, and Owner of facility.	10-9-17

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{D 282}	Continued From page 2 removed. Observation of a three-tiered metal rack in the kitchen on 10/06/17 at 10:08 a.m. revealed: -The metal rack had several clean pots and pans stored in a downward position on the third storage shelf. -The storage areas of the rack had scattered areas of dusty debris dangling from the bars. -A brown, mushy substance was on the bottom of a muffin pan. Interview with a Cook on 10/06/17 at 10:10 a.m. revealed; -The pots and pans stored on the metal shelf had just been washed and were clean. -He had not noticed the brown, mushy substance on the bottom of the muffin pan. Observation of the walk-in cooler on 10/06/17 at 10:02 a.m. revealed: -There was a build-up of a dried, flaking substance that varied from a white, black, and brown color that covered the storage areas metal rack surface and a moist black build-up substance in the crevices of the left metal rack. -The left metal rack had scattered debris dangling down from the storage areas bars, and multiple areas of rust colored stains on the leg bases. -The left metal rack had a large pan containing approximately 23 unwrapped individual servings of mandarin oranges, eggs uncovered stored on top of a cardboard box, and additional eggs stored uncovered in a second opened cardboard box on the third shelf. -The white colored door way facing of the cooler had a heavy buildup of yellowish tan stains with dirt, grime, and debris embedded in the stains. -The edge of the door had a heavy concentration of black grime.	{D 282}		

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{D 282}	Continued From page 3 -The door handle was sticky and had grime in the creases. -The lower door hinge was covered in loose food debris and grime. -A latch positioned at the top of the door was covered in rust colored stains. Observation of the DM on 10/06/17 at 10:02 a.m. revealed the DM immediately removed the mandarin oranges and covered them with plastic wrap. Interviews with the DM on 10/06/17 at 10:05 a.m. and 11:23 a.m. revealed: -The mandarin oranges were "just placed in the walk in cooler" a few minutes ago. -The DM was aware that the mandarin oranges should have been covered with plastic wrap. -The walk-in cooler was cleaned daily. -The areas on the floor and the metal storage rack in the walk-in cooler and the metal storage rack in the kitchen were probably "overlooked". -He had not noticed the build-up of grime and debris around the door facing, door edges, hinge or the rust stains on the latch of the walk-in cooler. He would add these areas to the daily cleaning tasks. -The DM checked the kitchen and walk-in cooler daily for cleanliness. Interview with the DM on 10/05/17 at 11:45 a.m. revealed: -There were six cooks at the facility. -The DM had reviewed the cleaning requirements with all of the cooks. -The DM was responsible to make sure the cleanliness of the kitchen was done. Review of the facility's Dietary Cleaning List revealed:	{D 282}		

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{D 282}	Continued From page 4 -Everyday cleaning included mopping the cooler. -Deep cleaning included "special attention" to all shelving and racks. Confidential interview with dietary staff revealed: -There was not a written cleaning schedule for the kitchen but cleaning was done at least 3 times a day in the kitchen. -The dietary staff had never cleaned the floor or racks in the walk-in cooler. Interview with the Resident Care Coordinator (RCC) on 10/06/17 at 12:10p.m. revealed: -The DM was responsible to assure all cleaning needs were maintained. -The RCC was not aware of any cleaning needs in the kitchen; she observed the kitchen a week or so ago. Interview with the Administrator on 10/05/17 at 1:10 p.m. revealed: -The kitchen staff was supposed to clean all areas of the kitchen and walk-in cooler daily. -He depended on the DM to assure all areas were kept clean and expected the DM to notify him if there were any issues. -The Administrator and the Owner would have the metal storage racks in the walk-in cooler cleaned, repaired or replaced immediately. Interview with the Owner on 10/05/17 at 1:31 p.m. -The Owner expected all areas of the kitchen and the walk-in cooler to be cleaned thoroughly. -Maintenance performed a deep cleaning of the walk-in cooler every Sunday which included removing the metal storage racks and power washing them. -The Owner would have a protective coating applied to the storage racks to help keep the storage racks clean and free from any build-up.	{D 282}	review of Physican order. This practice will be monitored by RCC, or Admin or manager daily. all orders for thicken-Liquids will be given to Rcc and Rcc will assure dietary recieves a copy of all new orders and changes. all Medtechs and dietary Staff will be monitored and properly trained on the correct time consistency to assure	

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{D 282}	Continued From page 5 Interview with the Owner on 10/06/17 at 10:15 a.m. revealed: -Dietary staff removed and thoroughly cleaned the metal racks today (10/06/17). -The floors, around the cooler door and walls would be thoroughly cleaned in the walk-in cooler by staff today (10/06/17). A second observation of the walk-in cooler on 10/06/17 at 11:12 a.m. revealed: -The rust colored stains on the door latch had been removed. -The storage racks had been removed. -The black stains on the floor under the right metal storage rack had been removed. -The heavy buildup of yellowish tan stains with dirt and debris had been removed around the white colored door facing of the walk-in cooler. -The heavy concentration of black grime in the metal colored sections of the door facing had been removed.	{D 282}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure therapeutic	{D 310}	All Medtechs and Dietary were immediately trained one on one by Patty Mathews, Corp Trainer on October 5th and 6th on proper Preparation of thickner after	

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{D 310}	Continued From page 6 diets were served as ordered for 1 of 1 residents sampled, (#4) who was diagnosed with difficulty swallowing and had an order for nectar thickened liquids; and 2 of 2 residents with an order for a pureed diet (#4, #5). The findings are: 1. Review of Resident #4's current FL-2 dated 11/17/16 revealed: -Diagnoses included vascular dementia, cerebral vascular accident, residual weakness, diabetes mellitus,Chron's disease, coronary obstructive pulmonary disease, anxiety, schizophrenia, delusional disorder, bipolar disorder, and depression with psychosocial features. -There was an order for nectar thick liquids. -There was a diet order for a mechanical soft/ low concentrated sugars, chopped meats. Review of subsequent physician's orders for Resident #4 revealed: -There was an order for a pureed diet dated 05/17/17. -There was an order for a Low Concentrated Sweets, pureed diet and nectar consistent liquids dated 06/26/17. -There was an order for a regular pureed diet dated 08/17/17. -There was an order to change diet to Nectar thick liquids and to discontinue all regular liquids dated 09/14/17. Review of the facility's diet list revealed Resident #4 was on a Regular pureed diet with Thickener. Interview with the Dietary Manager (DM) on 10/04/17 at 11:00 a.m. revealed: -Resident #4 was on thickened liquids; all liquids were mixed to "thickened".	{D 310}	This practice will be monitored by RCC, or admin or manager daily All orders for thicken-liquids will be given to RCC and RCC will assure dietary recieves a copy of all new orders and changes. All medtech and dietary staff will be monitored and properly trained on the correct time consistency to assure Proper thickness.	

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{D 310}	Continued From page 7 -Resident #4 was on a regular pureed diet. -The DM and other dietary staff followed the directions that was handwritten on the lid of the thickener container when preparing Resident #4's liquids. -Resident #4 was the only resident at the facility on thickened liquids. -He did not refer to the manufacturer's labeled directions on the container when adding Thick-It to the resident's liquids. Observation of a Thick-It container (Thick-It is a powder that is dissolved in liquids to thicken thin liquids to a desired consistency when thin liquids were difficult to swallow, to prevent choking and prevent liquids from entering the lungs during the swallowing process) in the kitchen on 10/04/17 at 11:02 a.m. revealed: -There were directions handwritten on the lid of the container with a black marker: 8 ounces, 2 large scoops and 2 small scoops. -There was a dual ended blue measuring device inside of the container. One end was labeled one tablespoon and the other end labeled one teaspoon. -The manufacturer's label had directions for a nectar thick consistency to add 3 ½ - 4 teaspoons to water, apple juice, cranberry juice, and coffee/tea, 4-4 ½ teaspoons to low fat milk, 4 - 4 ½ teaspoons to nutritional drink supplements, 3 - 3 ½ teaspoons to orange juice, to every 4 ounces of liquid. -One tablespoon of Thick-It should be added to 4 ounces of food when pureeing. -There were instructions that the amount of Thick-It used may need to be adjusted to suit the thickness requirements. Observation of the DM on 10/04/17 at 12:20 p.m. revealed:	{D 310}	RCC, Admin and Owner, all or one are available at meal times to supervise and ensure the preparation of puree foods are done properly. Dietary staff continues to be inserviced and monitored and supervised recognizing the difference in consistency of foods, meats, veg ... etc ... 10.9.17	

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{D 310}	Continued From page 8 -The DM measured 8 ounces of milk, 8 ounces of water, and 8 ounces of tea in an incremented measuring cup. -The DM referred to the handwritten instructions on the Thick-It lid, added 2 tablespoons and 2 teaspoons (for a total of 8 teaspoons) to the measured 8 ounces of tea, milk and water, and stirred each of the beverages. -The liquids were nectar thickened. Observation of Resident #4 during the lunch meal on 10/04/17 at 12:35 p.m. revealed: -The resident had one episode of a rattling cough prior to being served her lunch. -The resident was served her lunch in a divided dinner plate. -The resident was served approximately 1 cup of pureed ham that was sitting in a thin liquid broth which covered the bottom sectional plate, ½ cup of pureed greens that were in a thin liquid, ½ cup of pureed peas, a cookie soaked in milk that was not thickened, 8 ounces each of nectar thickened water, tea and milk. -The resident ate approximately ½ of her ham and peas, approximately 2 spoonfuls of the broth around the ham, and began to eat the cookie soaked in milk. -Upon notification, the DM attempted to remove the cookies and milk, however, the resident refused to give the cookie and milk to the DM. -The resident ate approximately 3-4 spoonfuls of the cookie soaked in milk. -The resident did not cough and gag during the meal. Observation of Resident #4 during the dinner meal on 10/04/17 at 5:47 p.m. revealed: -The resident was served approximately one cup of pureed macaroni beef and cheese casserole, ½ cup of pureed mixed vegetables, ½ cup of a	{D 310}		

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{D 310}	Continued From page 9 pureed roll, and ½ cup of pureed cake, and 8 ounces each of nectar thickened water, tea and milk. -The resident's pureed food was in a smooth mashed potato consistency. -The resident ate all of her food and drank all of the served beverages. -The resident had one episode of rattling cough after she completed her meal. Interview with the DM on 10/04/07 at 12:50 p.m. revealed: -The DM knew that ice could not be added to thickened liquids. -The DM was not sure what consistency Resident #4's liquids should be but knew to follow the handwritten directions on the lid of the Thick-It container. -He was not sure who wrote the directions on the Thick-It lid. -He did not realize the directions on the lid did not match all of the manufacturer's directions for all liquids such as the orange juice to obtain a nectar thick consistency. Interview with the DM on 10/05/17 at 12:50 p.m. revealed: -The DM had observed that Resident #4 always had a rattling cough. -Resident #4 took large bites of food at times when she ate. -Resident #4 was a smoker. Observation of a Medication Aide (MA) during the medication pass on 10/04/2017 at 5:40 p.m. revealed: -The MA administered a medication mixed in applesauce. -The MA gave Resident #4 a small clear plastic cup half full of water without any thickener added	{D 310}		

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{D 310}	Continued From page 10 to a nectar consistency. -After swallowing the medication mixed in applesauce, Resident #4 drank the thinned liquid water as provided by the MA. -Resident #4 was not observed to cough or have any difficulty in drinking the thinned water. Interview with the MA observed on the medication pass on 10/05/17 at 5:22 p.m. revealed: -The MA normally worked second shift. -Resident #4's medications were crushed and placed in applesauce. -"Sometimes" Resident #4 took water with her medication and "sometimes" she didn't. -Resident #4 received thickener in her liquids with meals. -The MA never really questioned if the resident should have thickened water her with medications. Telephone interview with a MA on 10/06/17 at 4:04 p.m. revealed: -The MA primarily worked on first shift. -The MA usually gave Resident #4 her medication with applesauce. -She had never given liquids to Resident #4 without adding thickener. -Resident #4 did have a container of Thick-It in the medication room a few months ago but dietary staff ran out of the Thick-It supply in the kitchen and took the container from the medication room. -She was not sure if Resident #4 had a cough. -When she first started working at the facility, the Executive Director (ED) trained her on how to mix thickener. Attempted telephone interview with a second MA was unsuccessful on 10/06/17 at 4:15 p.m.	{D 310}		

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{D 310}	Continued From page 11 Based on observation and attempted interview on 10/05/17 at 12:50 p.m. Resident #4 was not interviewable. Attempted telephone interviews with Resident #4's guardian on 10/05/17 at 11:34 am and on 10/06/17 at 8:28 a.m. were unsuccessful. Interview with the Resident Care Coordinator (RCC) on 10/05/17 at 5:39 p.m. revealed: -Resident #4's medications were crushed and placed in pudding or applesauce. -The RCC had observed MAs administering medications to Resident #4 in the morning during the breakfast meal and liquids were given to her thickened. -The RCC was not aware that thin liquids were given to the resident during medication passes. -The RCC expected Resident #4 to always receive nectar thickened liquids as ordered during medication passes. -All new employees were trained on how to mix thickener by the Regional Trainer. -She was not sure who had written the instructions on the Thick-it container. Interview with the Administrator on 10/05/17 at 5:47 p.m. revealed the Administrator expected for all liquids to be mixed in a thickener as ordered by the primary care provider (PCP), including any liquids given with medications. Interview with the ED on 10/05/17 at 5:50 p.m. revealed: -The ED expected all staff to use thickener for Resident #4's liquids as ordered. -The ED had never witnessed Resident #4 being served liquids without thickener. -Resident #4 took all of her medications in applesauce and he was not aware that MAs used	{D 310}		

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{D 310}	Continued From page 12	{D 310}		

water at all when administering Resident #4's medication.
-The ED had spoken to the RCC and the Administrator and would immediately schedule a training for all staff to assure that Resident #4's liquids were always thickened as ordered, and the DM would train all dietary staff.

Telephone interview with Resident #4's Speech Therapist (ST) on 10/06/17 at 9:17 a.m. revealed:
-She was a contracted ST with a home health agency and was not the resident's primary case manager; however, she had been seeing the resident one time a week for the past several weeks.
-The resident recently had a swallow study done.
-The ST had educated the staff at the facility regarding the resident's dysphagia (difficulty swallowing) and signs and symptoms to report.
-Resident #4 should not have received any thin liquids due to the resident's difficulty swallowing.
-Resident #4 was at risk for inhaling foods and liquids into her lungs (aspiration) which could cause pneumonia.
-The resident did not have a cough on her last visit.

Interview with a second ST for Resident #4 on 10/06/17 at 11:45 a.m. revealed:
-The ST was the resident's case manager and had provided services for the resident off and on for "a long time".
-Resident #4 had difficulty clearing fluids and could aspirate.
-A recent swallow study was performed on 09/27/17.
-It was important for Resident #4 to stay on thickened liquids at all times.
-The ST had provided training on mixing thickener with the staff at the facility about a year

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{D 310}	Continued From page 13 ago. -Resident #4 should not have had thin liquids when she took her medication; applesauce and pudding should have been used instead. -The ST had discussed signs and symptoms of choking with the prior RCC. -Resident #4 could not tolerate thin liquids and was at risk for choking, pneumonia and dying because she could not swallow thin liquids safely. Review of a medical imaging report for Resident #4 dated 09/27/17 revealed: -There were no anatomical abnormalities of the larynx or proximal esophagus. -There was premature spillage with thin liquid and nectar thick consistency. -There was no penetration of the larynx or aspiration. A second interview with the ST for Resident #4 on 10/06/17 at 12:05 p.m. revealed: -She had assessed Resident #4 and her lungs were clear. -The rattling sounds when the resident coughed were coming from her throat. Telephone interview with Resident #4's primary care provider (PCP) on 10/06/17 at 9:26 a.m. revealed: -The resident was not processing foods well and the PCP ordered a swallow study a few weeks ago. -The resident had moderate dysphagia. -The resident did have a "rattling cough" many times when she was assessed. -The resident had several chest x-rays performed within the last six months, but the PCP would order another chest x-ray. Attempted telephone interview with Resident #4's	{D 310}		

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{D 310}	Continued From page 14 PCP on 10/06/17 for clarification of a possible ordered chest x-ray was unsuccessful on 10/06/17 at 10:53 a.m. Interview with the Corporate Trainer (CT) on 10/06/17 at 9:00 a.m. revealed: -The CT had in-serviced a total of four MAs yesterday (10/05/17) on the proper mixing and usage of Thick- It/thickener. -The CT routinely came to the facility at least 3 times per week and had observed medication passes for Resident #4 but always observed the resident receive her medications in the dining room when nectar thick fluids were given with her meals. -The RCC would call the PCP to inform her that Resident #4 had received liquids that were not nectar thick during the medication pass and with her meal on 10/04/17. -The CT had provided teaching with the proper mixing and usage of thickeners with dietary staff but had never trained the MAs. Refer to the review of the facility's diet manual. Refer to the interview with the Dietary Manager on 10/04/17 1:04 p.m. Refer to the interview with a Cook on 10/05/17 at 11:50 a.m. Refer to the observation of the ED on 10/04/17 at 5:00 p.m. Refer to the interview with the Executive Director (ED) on 10/04/17 at 5:00 p.m. 2. Review of Resident #5's current FL-2 dated 06/27/17 revealed: -Diagnoses included Alzheimer's disease,	{D 310}		

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{D 310}	Continued From page 15 hypertension, osteoporosis, and gastro-esophageal reflux disease. -There was a diet order for pureed, No Added Salt (NAS). Review of subsequent physician's orders for Resident #5 revealed: -There was an order dated 08/17/17 for a NAS pureed diet. -There was an order dated 09/13/17 for Ensure twice daily with snacks. Review of the facility's diet list dated 09/12/17 revealed Resident #4 was on a NAS, pureed diet with Ensure twice daily with snacks. Observation of Resident #5 during the lunch meal on 10/04/17 at 12:35 p.m. revealed: -The resident was served her lunch in a divided dinner plate. -A staff member fed the resident throughout the meal. -The resident was served approximately 1 cup of pureed ham that was sitting in a thin liquid broth which covered the bottom sectional plate, ½ cup of pureed greens that were in a thin liquid, ½ cup of pureed peas, a cookie soaked in milk that was not pureed, 8 ounces each of water, tea and milk. -The resident ate approximately 50 percent of her meal. -The resident did not cough and gag during the meal. Observation of Resident #5 during the dinner meal on 10/04/17 at 5:47 p.m. revealed: -The resident was served approximately one cup of pureed macaroni beef and cheese casserole, ½ cup of pureed mixed vegetables, ½ cup of a pureed roll, and ½ cup of pureed cake, and 8 ounces of water, tea and milk.	{D 310}		

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{D 310}	Continued From page 16 -A staff member fed the resident throughout the meal. -The resident's pureed food was in a smooth mashed potato consistency. -The resident ate and drank 40 percent of the food and beverages served. -The resident did not cough and gag during the meal. Telephone interview with Resident #5's primary care provider (PCP) on 10/06/17 at 9:26 a.m. revealed: -Resident #5 typically did not have issues with a chronic cough. -Resident #5 did not have issues with dysphagia (difficulty swallowing). -The resident was on a pureed diet because of her dementia and was ordered pureed as a safety precaution. -Resident #5 could tolerate thin liquids. Telephone interview with a Social Worker (SW) at the local Department of Social Services (DSS) on 10/06/17 at 11:19 a.m. -Resident #5 was a ward of DSS. -The guardian was not available today but the SW had the guardian's notes from past visits with Resident #5. -There was no mention in the guardian's notes that Resident #5 had been coughing or gagging on his visits and no documentation of any issues with her meals. Interview with a Speech Therapist on 10/06/17 at 11:45 a.m. revealed: -Resident #5 was not receiving speech therapy. -Dementia and behavior affected a person's swallowing ability. Based on observation and attempted interview on	{D 310}		

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{D 310}	Continued From page 17 10/05/17 at 12:50 p.m. Resident #5 was not interviewable. Refer to the review of the facility's diet manual. Refer to the interview with the Dietary Manager on 10/04/17 1:04 p.m. Refer to the interview with a Cook on 10/05/17 at 11:50 a.m. Refer to the observation of the ED on 10/04/17 at 5:00 p.m. Refer to the interview with the Executive Director (ED) on 10/04/17 at 5:00 p.m. Review of the facility's diet manual for pureeing foods revealed: -Drain liquid from portions needed for pureed preparation. -Not all food would need to be drained. -Process food until they are fine and uniform in texture. -Add potato flakes or commercial thickeners to puree foods that were too thin. Interview with the Dietary Manager on 10/04/17 1:04 p.m. -He had a prior experience in dietary as a dietary assistant before his employment at the facility. -He had prepared the pureed food for the lunch meal today (10/04/17). -He was told by the local health department that it was important for pureed foods not to be dry, so he added chicken broth after the ham was pureed. -He used a food processor to puree the food and always placed the processor on the puree setting. -He did not add any thickeners when he pureed	{D 310}		

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{D 310}	Continued From page 18 foods. -Pureed foods should be smooth like baby food. Interview with a Cook on 10/05/17 at 11:50 a.m. -He had worked at the facility for 2 months. -When he started at the facility the DM trained him in food preparation for pureed diets. Observation of the Executive Director on 10/04/17 at 5:00 p.m. revealed: -The ED had a bowl of macaroni and beef casserole and a bowl of green beans that had been pureed. -The consistency of the puree was not smooth and had small chunks of solid food. Interview with the Executive Director (ED) on 10/04/17 at 5:00 p.m. -The ED wanted to make sure the consistency of the pureed foods was correct. -The ED had worked with the dietary staff today (10/04/17) to make sure the pureed diets were prepared to the right consistency. -The RCC had called the PCP to see if thickener could be ordered to use in the residents' food when preparing the pureed diets. -The ED would consult the facility's dietician for guidance when preparing pureed foods. -The ED understood that pureed foods should be in a smooth, mashed potato consistency. The facility failed to assure therapeutic diets were served as ordered for Resident #1 who was not able to swallow thinned liquids safely, was at risk for potential aspiration, was ordered to receive nectar thick liquids and was observed receiving thin liquids during a medication pass and during a meal observation. The facility's failure to assure Resident #4 received nectar thick liquids posed a risk of pneumonia or choking which was	{D 310}		

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{D 310}	Continued From page 19 detrimental to the health and safety of the resident, which constitutes a Type B Violation. Review of the facility's Plan a Protection dated 10/06/17 revealed: -All Medication Techs and Dietary were immediately trained one on one by the Corporate Trainer on 10/05/17 and 10/06/17 on the proper preparation of thickener after review of Physician order, One Med Tech would be in-serviced on 10/07/17. -This training would be completed by 10/07/17. -This practice would be monitored by the Resident Care Coordinator, Administrator or Manager daily. -All ordered for thicken liquids would be given to the Resident Care Coordinator who would assure dietary received a copy of all new or changed orders. -All Med Techs and Dietary Staff would be monitored and properly trained on time consistency to assure proper thickness. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 23, 2017.	{D 310}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	{D 358}		

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{D 358}	Continued From page 20 This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure medications were administered as ordered to 1 of 4 sampled residents (#6) who had a physician's order for a blood thinner. The findings are: Review of Resident #6's current FL-2 dated 06/12/2017 revealed: -Diagnoses included vascular dementia, cerebrovascular accident, hypertension, diabetes, depression, hyperlipidemia, neuropathy, and atrial fibrillation. -There was a physician's order for Warfarin (generic for Coumadin, used as a blood thinner to prevent blood clots) 4 milligram (mg) tablet every day. Review of a home health (HH) agency worksheet for Resident #6 dated 09/22/2017 revealed: -There were results documented for PT/INR of 38.1/3.2 (PT/INR is prothrombin time/international normalized ratio and measures the amount of time for blood to clot). -There were results documented for INR (international normalized ratio) of 3.2. -There was a physician's order to change Coumadin dose to 3mg daily and repeat PT/INR in one week. Review of a HH agency worksheet for Resident #6 dated 09/29/2017 revealed: -There were results documented for PT of 44.1.	{D 358}	Facility started a Medtech Communication Notebook for all new changes and new orders. Due to the monitor and Procedure in Place, Facility as had no issues such as this Since the Survey.	

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{D 358}	Continued From page 21 -There were results documented for INR of 3.7. -There was a handwritten verbal physician's order to hold Coumadin dose for 3 days then resume 3mg Monday -Wednesday and 2.5mg Thursday - Sunday and repeat PT/INR in one week. -There was a handwritten note in the section of the form for "patient/responsible party notified" that "[staff named] - med tech" was notified. Review of a Communication/Coordination of Care form for Resident #6 from the HH agency dated 09/29/2017 and signed by the HH Registered Nurse revealed: -Resident #6's PT results was 44.1 and the INR was 3.7. -The Family Nurse Practitioner (FNP) was notified. -Dosage change orders were left at the facility. -The resident assessment by the HH nurse revealed no complaints of pain, no signs or symptoms of respiratory distress, no skin breakdown. -The next PT/INR date was documented as 10/06/2017. Review of the September 2017 electronic Medication Administration Records (eMARs) for Resident #6 revealed: -Coumadin 3mg take one tablet every day was printed to the eMARs and scheduled for administration daily at 5:00pm. -There was documentation of administration for Coumadin 3mg tablet daily, including 09/29/2017 and 09/30/2017. -There was no documentation on the eMARs indicating the 09/29/2017 physician's order to hold Coumadin 3mg for three days -There was a "stop date: 5-Oct-2017 4:00am" printed to the eMARs.	{D 358}	Facility reviewed all MD orders on Quickmar and compared them with the physician orders. All medications were checked to confirm the medications are currently in house. All homehealth agencies were notified that they are to report all new orders to RCC or medtech incharge.	

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{D 358}	Continued From page 22 Review of the October 2017 eMARs for Resident #6 revealed: -Coumadin 3mg take one tablet by mouth every day was printed to the eMARs and scheduled for administration daily at 5:00pm. -There was documentation of administration for Coumadin 3mg tablet daily from 10/01/2017 - 10/04/2017. -There was no documentation on the eMARs indicating the 09/29/2017 physician's order to hold Coumadin 3mg for three days -There was a "stop date: 5-Oct-2017 4:00am" printed to the eMARs. Interview with the Resident Care Coordinator (RCC) on 10/04/2017 at 6:10pm revealed: -The Coumadin order dated 09/29/2017 was sent directly to the pharmacy from the Primary Care Provider (PCP). -The Coumadin order dated 09/29/2017 for Resident #6 went to the pharmacy after the pharmacy closed on 09/29/2017. -The pharmacy did not input the order to Resident #6's eMARs until 10/02/2017. -She did not know why the 09/29/2017 Coumadin order for Resident #6 was not on the resident's eMARs. Interview with the UC on 10/05/2017 at 8:55am revealed: -The pharmacy was responsible to input orders to the eMARs. -New orders for residents were immediately available to the MAs for view and administration once entered to the eMARs by the pharmacy. -She had the capability to input certain orders to the eMARs, like antibiotics to prevent delay in starting the medication. -She could access resident eMARs from an offsite location if notified by the staff of a new	{D 358}	Facility will start a notebook to include new orders and changes. This will be a shift change book. All medtechs will be inserved on the new process of the notebook usage. Rcc will review all orders X 30 days to assure accuracy. In the absence of Rcc, medtech will assure orders are faxed and Rcc is aware of any new orders or changes at all times.	

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{D 358}	Continued From page 23 order. Interview with Resident #6 on 10/05/2017 at 6:05pm revealed: -The resident was on a lot of medications. -The resident was on a blood thinner. -The resident had not noticed any bleeding "lately". -The resident had noticed bleeding of the gums, but did not remember the last time bleeding was noticed. Interview with the RCC on 10/06/2017 at 9:00am revealed: -Any new orders were immediately faxed to the pharmacy. -She usually faxed new orders to the pharmacy if she was in the facility. -The MAs were responsible to fax new orders to the pharmacy in her absence. -The pharmacy ientered all orders to the eMARs unless there was an order for an antibiotic that came in to the facility during the weekend. -If an order came in during the weekend, the staff would call the RCC and she could input the order in the eMAR system. -The RCC was the only staff at the facility with the capability to enter orders to the eMARs. -She normally only entered orders to the eMARs for medications already in the facility or antibiotics. -She was not working on 09/29/2017 when the Coumadin order for Resident #6 was received in the facility from the PCP by fax. -When the Home Health Nurse (HHN) came to the facility, the HHN obtained the PT/INR for the resident and would consult with the PCP once the PT/INR was obtained. Until the PCP responded back, the facility would not have order changes. -Sometimes the PCP would respond back	{D 358}	Facility will use paper mars for emergency input on all new orders in the absence that RCC is not available or pharmacy is closed. paper mars will be effective as of 10.6.17. Pharmacy was notified and paper mars will be recieved at the facility tonight.	

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{D 358}	Continued From page 24 immediately or it may take a while before the PCP responded. -The PCP sent an order to the pharmacy on 09/29/2017 at 16:52 to hold the Coumadin 3mg on Friday, Saturday, and Sunday. -The 09/29/2017 Coumadin order would have been received at the fax machine located at the staff work station. -The MA on duty would have been responsible to receive the faxed order and remove the medication from the medication cart. -The pharmacy was not opened on the weekend. -The Coumadin 3mg daily was not held on Friday, Saturday, or Sunday because it popped up on the eMARs. -The MAs administered medications based on what showed up on the eMARs. -She had explained to the PCP on 10/05/2017 that Resident #6's Coumadin was not held as ordered because the change order was not entered to the eMARs. -The RCC did not know about the 09/29/2017 Comadin order for Resident #6 until the RCC returned to the facility on 10/02/2017. -If she had known about the 09/29/2017 Coumadin order for Resident #6, she could have entered the order to the eMAR and the Coumadin would have been held. Telephone interview with the Pharmacist on 10/06/2017 at 9:25am revealed: -The most current order for Resident #6's Coumadin was dated 09/29/2017 with instructions to hold Coumadin 3mg for 3 days, then Coumadin 3mg tablet Monday, Tuesday, Wednesday; and Coumadin 2.5mg tablet Thursday, Friday, Saturday, Sunday. -The PCP wanted the Coumadin held 9/29/2017, 9/30/2017, and 10/01/2017. -It looked like the pharmacy received the order	{D 358}	RCC will be responsible to ensure new Orders accurately transcribed and visible to the Quick Mar with in 2 hours. All Medtechs will be retrained on Processing new orders by 16.10.17 Correction Date 10.10.17	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 25 from the facility on 10/02/2017. -The 09/29/2017 Coumadin order was entered onto the eMAR on 10/02/2017. -The facility was responsible to put hold on the eMAR. -Any orders received in the pharmacy after 12noon on a Saturday would not be entered on the eMAR until the pharmacy opened the following Monday. -The facility had the capability to enter temporary orders to the eMARs. -It did not look like the pharmacy had received a faxed copy of the 09/29/2017 order from the PCP which was sometimes done. -The only copy of the order he was able to see in the pharmacy was the visit report that included the PCP order. -He thought the facility eMARs were set up that the facility had to accept orders entered by the pharmacy before the order was visible to the eMAR for administration. This was kind of a last check for the order to ensure no mistakes were made in entering the order to the eMAR. -The potential effects to the resident of having been administered the Coumadin when it was supposed to be held could be bleeding. -The residents INR was indicated on the order as 3.7 which was high. Interview with the HHN on 10/06/2017 at 9:55am revealed: -She had visited Resident #6 on 10/06/2017 to repeat the PT/INR. -Resident #6's PT was 51.1 and the INR was 4.3. -The PT/INR was high but not considered a panic level. -She had asked the resident about noticing any bleeding in stools, gums, urine, or nosebleeds and the resident denied any bleeding. -She assessed the resident and found no signs of	{D 358}		

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	HAL043026	A. BUILDING: _____ B. WING _____	R 10/09/2017

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{D 358}	Continued From page 26 bruising. -After pricking the resident's finger to obtain the blood sample, the HHN only had to apply pressure to the site for about 30 seconds which was "pretty normal". -Resident #6's PT/INR results obtained today (10/06/2017) could be the result of the resident having been administered the Coumadin when it was supposed to be held on 09/29/2017, 09/30/2017, and 10/01/2017. -If the facility had held the Coumadin as ordered, the PT/INR most likely would have gone down. -She had contacted the FNP with the results of the 10/06/2017 PT/INR and was waiting for the FNP to respond. -She had also notified the FNP by text that the Coumadin was not held for 3 days as ordered which would help the FNP determine the adjustment to the Coumadin dosage. Telephone interview with the FNP on 10/06/2017 at 11:36am revealed: -She was aware Resident #6's INR was high. -She would recheck the resident's INR in 1 week. -The targeted range for Resident #6's INR was 2 -3. -When the INR went above 3 - 3.5, she would hold the Coumadin for a day or two and restart at a lower dose. -A PT/INR of 51.1/4.3 should be considered high. -She was notified "a day or two ago" the Coumadin had not been held as ordered and she ordered for the PT/INR to be rechecked in a week. -There was always the risk for bleeding but she did not see any substantial harm to the resident. -She would be recommending a hold of the Coumadin with today's results and rechecking the PT/INR in 3 days.	{D 358}		

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{D 358}	Continued From page 27 Interview with the RCC on 10/06/2017 at 11:50am revealed the PCP had called the RCC with order changes for the Coumadin and she was currently processing the new orders. Review of the PCP order for Resident #6 dated 10/06/2017 revealed: -Hold all Coumadin for 10/06/2017, 10/07/2017, 10/08/2017. -Recheck PT/INR on 10/09/2017. -Do not restart any Coumadin until MD receives results from new PT/INR and gives new orders. Interview with a MA on 10/06/2017 at 2:40pm revealed: -Medications were administered to residents according to the eMARs, -The MAs were not able to make changes to eMAR orders. Interview with a second MA on 10/06/2017 at 2:50pm revealed: -If the MA's initialed the eMARs, it meant the MA was documenting administration for the medication. -The MA did not know there was an order to hold Resident #6's Coumadin 3mg. -If the MA had known there was an order to hold Resident #6's Coumadin, the Coumadin would have been held. -The MA was not aware of anybody in the facility who could input orders to the eMARs. Interview with a third MA on 10/06/2017 at 3:00pm revealed: -The MA could not recall administering Coumadin to Resident #6. -If the MA's initialed the eMARs, it meant the MA was documenting administration for the medication.	{D 358}		

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{D 358}	Continued From page 28 -The MA did not know there was an order to hold Resident #6's Coumadin 3mg. -There should be documentation on the eMAR to indicate when a medication should be held and the medication would not pop up on the eMAR of held. The facility failed to ensure Coumadin was administered as ordered by a licensed prescribing practitioner. This medication error exposed the resident to potentially adverse effects of increased bleeding which was detrimental to the residents' health and safety. This constitutes a Type B Violation. The facility submitted the following Plan of Protection on 10/06/2017: -The facility has reviewed all MD orders on the Quik-MAR and compared them with the physicians orders. -All medications were checked to confirm the medications are currently in house. -All home health agencies were notified that they are to report all new orders to the Resident Care Coordinator or Medication Adie in charge only. -The facility with start a notebook to include new orders and changes. This will be a shift change book. -All medication aides will be in-serviced on the new process of the notebook usage. -The Resident Care Coordinator will review all orders for 30 days to assure accuracy. -In the absence of the Resident Care Coordinator (RCC) the Medication Aide will assure orders are faxed and the RCC is aware of any new orders or changes at all times. -The facility will use paper MARs for emergency input on all new orders in the absence that RCC is not available or the pharmacy is closed. Paper MARs will be effective as of 10/06/2017.	{D 358}		

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{D 358}	Continued From page 29 Pharmacy was notified and paper MARs will be received at the facility tonight. -The RCC will be responsible to ensure new orders are accurately transcribed and visible to the Quik-MAR within 2 hours. -All MAs will be retrained on processing new orders by 10/10/2017. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 23, 2017.	{D 358}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state regulations as related to therapeutic diets not being served as ordered for 1 of 1 sampled residents (Resident #1), and medications not being administered as ordered for 1 of 4 sampled residents (Resident #6). The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 residents	{D912}		

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{D912}	Continued From page 30 sampled, (#4) who was diagnosed with difficulty swallowing and had an order for nectar thickened liquids; and 2 of 2 residents with an order for a pureed diet (#4, #5).[Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)]. 2. Based on record reviews and interviews, the facility failed to ensure medications were administered as ordered to 1 of 4 sampled residents (#6) who had a physician's order for a blood thinner.[Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	{D912}		