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GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI	2201 ROYALE AVENUE GOLDSBORO, NC 27534

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation from January 7, 2020 through January 9, 2020.	D 000		
D 189	10A NCAC 13F .0604 (e)(2)(A-E) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (2) The following describes the nature of the aide's duties, including allowances and limitations: (A) The job responsibility of the aide is to provide the direct personal assistance and supervision needed by the residents. (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. (C) If the home employs more than the minimum number of aides required, any additional hours of aide duty above the required hours of direct service between 7 a.m. and 9 p.m. may involve the performance of housekeeping tasks. (D) An aide may perform housekeeping duties between the hours of 9 p.m. and 7 a.m. as long as such duties do not hinder the aide's care of residents or immediate response to resident calls, do not disrupt the residents' normal lifestyles and sleeping patterns, and do not take	D 189		

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the aide out of view of where the residents are. The aide shall be prepared to care for the residents since that remains his primary duty.
(E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure non-routine duties of laundry and meal service delivery were not performed by personal care aides (PCAs) between the hours of 7:00am and 9:00pm as evidenced by PCAs setting the dining room tables and plating food in the special care unit (SCU) and laundry duties of washing, drying, folding, and delivering residents' laundry.

The findings are:

1. Interview with the Administrator on 01/07/2020 at 9:30am revealed:
-The current census in the special care unit (SCU) was 23 residents.
-The current census in the assisted living section was 28 residents.

Interview with the Dietary Manager (DM) on 01/07/2020 at 9:44am revealed:
-There was one dietary aide and the DM working in the kitchen.
-One of the staff working in the SCU came to the dining room around 11:45am to get dishes,

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silverware, napkins, and place settings to "set up" for meal delivery in the SCU.
-The kitchen staff did not set up for meal service delivery in the SCU.
-A staff working in the SCU came to the kitchen at 11:45am to get the food for plating and serving the residents in the SCU.

Interview with a PCA on 01/07/2020 at 3:05pm who worked in the SCU revealed:
-The PCA "set up" the tables on the SCU for lunch and breakfast - "put food on plates, put plates out".
-The PCAs got the food from the dining room in pans and put the food on plates when they got back to the SCU with the food.
-Food scoops were provided by kitchen staff to determine how much of each item was to be served.

Interview with the SCU Coordinator on 01/07/2020 at 4:10pm revealed:
-The normal staffing for the SCU (first shift and second shift) was 1 medication aide (MA) for 8 hours, 2 nursing assistants (NAs) for 8 hours, and 1 NA for 4 hours.
-The normal staffing for the SCU (third shift) was 1 NA for 8 hours and 1 MA for 8 hours.
-The MA administered medications on the assisted living unit and the SCU on all 3 shifts and she did not know the total time the MA spent on each unit.

Interview with a PCA on 01/08/2020 at 9:51am assigned to work in the SCU revealed:
-His job duties included setting up the dining room area in the SCU for meals - "put out cups, silverware, put ice and water, tea, juice in cups, pick up food from dining room in heated containers, serve it in plates".

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-The cook and dining room staff were not on the SCU to serve resident plates - "been like that" since he had been employed at the facility.

Observation of the lunch meal preparation and delivery for the SCU on 01/08/2020 from 11:45am - 12:50pm revealed:
-The SCU Coordinator came to the kitchen in the AL section at 11:45am to pick up the food cart for the SCU and was told by the dietary manager the cart was not ready yet.
-The dietary manager placed the food items on the cart for the SCU in steel serving containers and covered the containers with aluminum foil.
-The Resident Care Coordinator (RCC) pushed the cart of food to the SCU dining area at 11:58am and closed the door to the dining room.
-One PCA and the RCC plated the food on the resident plates, using the serving size utensils provided from the kitchen.
-The door to the dining area was opened at 12:10pm and residents entered the dining area for the lunch meal.

Observation of the SCU on 01/08/2020 from 12:00pm - 12:30pm revealed:
-There were 8 resident in the hallway near the dining room and 9 residents were in the activity room (there was no staff in the activity room with the residents)
-The dining room door was closed and one PCA and the RCC inside preparing to plate the resident's lunch meal.
-The SCU Coordinator was in the hallway, but walked to the double exit doors, which lead to the AL unit, to assist a resident who was pulling on the locked door.
-The SCU Coordinator walked with the resident into a resident room and there were no staff supervising the residents in the hallway and

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activity room for approximately 10 minutes.

Interview with the SCU Coordinator on 01/09/2020 at 10:15am revealed:
-The RCC normally brought the food cart to the SCU at meal times.
-If the RCC was busy, the PCAs went to get the SCU food cart from the kitchen.
-She helped the PCAs with resident care tasks all the time and did anything that needed to be done.

Interview with the RCC on 01/09/2020 at 10:33am revealed:
-She helped with feeding and plating the food in the SCU every day.
-The process had always been that food would be delivered to the SCU on a cart and the SCU staff plated the food.

Interview with the Administrator on 01/09/2020 at 3:15pm revealed:
-She expected each PCA in the SCU to serve plates.
-There was only one person in the kitchen in the afternoon.
-She completed the staffing schedule based on census and "regulations".

2. Observation of the facility laundry room on 01/07/2020 at 9:18am revealed the laundry room was at the end of the hall across from the activity room located in the assisted living section of the facility.

Observations on the Special Care Unit (SCU) on 01/07/2020 at 2:25pm revealed:
-There were two personal care aides (PCAs) working on the SCU.
-One PCA was pushing a cart with plastic bags on top toward the exit door.

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D 189	Continued From page 5 -The second PCA was going from resident room to room delivering residents' clothes. Interview with the SCU Coordinator on 01/07/2020 at 2:25pm revealed: -Personal care staff did laundry on all three shifts. -There was no laundry staff position at the facility. -The PCAs on the first and second shifts usually did 2 - 3 loads of laundry each shift. -The laundry that was not finished by the first and second shift PCAs was finished by the third shift PCAs. Interview with a PCA working on the SCU on 01/07/2020 at 2:30pm revealed the PCAs washed, folded, and delivered residents' laundry. Second interview with the SCU PCA on 01/07/2020 at 3:05pm revealed: -Her daily job responsibilities included laundry. -Sometimes she did 2 or 3 loads of laundry per shift - "put clothes in the washer, go back to the hall. Go put in dryer - wait 60 minutes on dryer. Go back to unit and do showers and make beds" while waiting for clothes to dry. Observation of a PCA working in the assisted living (AL) section of the facility on 01/07/2020 at 4:05pm revealed she was folding clothes on a laundry cart in a resident's' room. Interview with the PCA working in the AL section of the facility on 01/07/2020 at 4:05 pm revealed: -There was a newly hired PCA working with her in the AL section. -The PCAs did laundry every day for residents who were assigned baths. -The PCAs washed towels. -There were no baths on Sunday so there was no laundry on Sundays.	D 189		

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D 189	Continued From page 6 -She probably did two loads of laundry when she worked as a PCA. -Washing clothes took about 30 minutes. -Dry clothes took about 30 - 45 minutes. -She could not give a specific time spent on folding and delivering laundry. -She did not stay in the laundry room while the clothes washed or dried. Observation of a PCA on 01/08/2020 at 8:40am revealed the PCA came out of the laundry room with a laundry barrel. Observation inside the laundry room on 01/08/2020 at 8:42am revealed the washer and dryer were in use and there was no staff inside the laundry room. Interview with the PCA on 01/08/2020 at 8:45am revealed: -She had just started a load of clothes in the laundry room. -She was working in the AL section of the facility today (01/08/2020) on the first shift. -Her job duties included washing, folding, and delivering laundry. -When she worked in the SCU, she put residents' clothes in their closets. -It could take 10 - 15 minutes to fold and deliver laundry. -She spent 1 - 1½ hours in total time doing laundry tasks. -When she went off the SCU she would tell another staff person on the SCU. -When she did a load of laundry, she would go to the laundry room, put the clothes in the washer, return to her work station, and go back to the laundry room to put the clothes in the dryer. Observation of the PCA on 01/08/2020 at	D 189		

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D 189	Continued From page 7 10:11am revealed the PCA went back in the laundry room and returned out of the laundry room at 10:16am with a cart of folder clothes. Observation of a second PCA on 01/08/2020 at 9:45am, assigned to work in the SCU revealed: -The PCA was going into the laundry room, located in the AL section of the facility, with a laundry barrel. -The PCA came out of the laundry room at 9:49am. Interview with the PCA on 01/08/2020 at 9:46am revealed he was getting ready to put some laundry in the washer and take some laundry out. Interview with the PCA on 01/08/2020 at 9:51am revealed: -He worked first shift in the SCU. -His duties included laundry. -He took laundry back to the SCU to fold and put in each residents room. -He "might" spend an hour on laundry each shift. -The time spent on laundry tasks varied because the SCU staff divided the tasks amongst themeselves. -He was able to get everything he was supposed to get done during his work day. -No one person was assigned to do laundry. Interview with a resident in the AL section on 01/09/2020 at 10:00am revealed personal care staff at the facility did her laundry. Interview with another resident in the AL section on 01/09/2020 at 2:53pm revealed: -She put her dirty laundry in the dirty clothes bin in the community bathroom. -The PCAs took the laundry in the morning and washed it.	D 189		

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D 189	Continued From page 8 -The PCAs returned the clean laundry by the end of the same day or the following day. -She did not know how long it took the aide to wash and fold the clothes. Interview with the Resident Care Coordinator (RCC) on 01/09/2020 at 10:33am revealed: -A laundry person for this 56-bed facility was not cost effective. -She was not aware of the rule regarding specific times when personal care staff were not allowed to perform non-routine personal care task. -The Administrator was responsible for assigning staff working hours. Interview with the Administrator on 01/09/2020 at 10:58am revealed: -PCA staff did whatever laundry accumulated on their halls. -The PCA were doing laundry because at 56 beds, she could not afford a laundry aide, and there was not enough work in the laundry room to keep a laundry aide busy. Second interview with the Administrator on 01/09/2020 at 3:15pm revealed: -Each PCA did laundry. -There was one PCA on the hall that would put the laundry in the washing machine and then return to their work area. -She expected each shift PCA to do laundry. -She completed the staffing schedule based on census and "regulations".	D 189		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations	D 234		

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(a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure 2-step tuberculosis (TB) testing had been completed upon admission in compliance with the control measures adopted by the commission for Health Services for 1 of 5 sampled residents (Resident #5).

The findings are:

Review of Resident #5's current FL-2 dated 04/10/19 revealed diagnoses included Alzheimer's dementia, emphysema, and incontinence.

Review of Resident #5's Resident Register revealed an admission date of 04/25/19.

Review of Resident #5's Tuberculosis (TB) Screening form revealed:
-There was documentation of a TB skin test administered to Resident #5 on 04/09/19 and read as negative on 04/12/19.
-There was no documentation of any other TB skin testing.

Interview with the Resident Care Coordinator

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(RCC) on 01/08/20 at 9:22am revealed:
-There should be results for another TB skin test for Resident #5 in the resident's record.
-The first TB skin test was completed at the facility Resident #5 was admitted from.
-The Licensed Health Professional Nurse (LHPS) usually administered a second TB skin test to residents after admission, when needed.
-She (RCC) was responsible for notifying the LHPS nurse when a resident needed a TB skin test.
-She thought she had notified the LHPS nurse that Resident #5 needed a TB skin test performed but may not have done so.
-She tried to complete 7 or 8 resident record reviews every quarter.
-She checked for completed TB skin testing results when she did resident record reviews.
-She had "probably" reviewed Resident #5's record a "couple months ago" and missed that there was no second TB skin test result for the resident.

Interview with the LHPS nurse on 01/09/20 at 12:15pm revealed:
-The RCC usually called her if there was a need for her to administer a resident a TB skin test.
-She did not recall administering a TB skin test to Resident #5.
-She would have documented the TB skin test results in the resident's record if she administered a TB skin test.
-She did not keep a copy of any TB skin test results she administered.

Interview with the Administrator on 01/09/20 at 2:20pm revealed:
-She was not aware that Resident #5 had not had a TB skin test since admission to the facility.
-Resident #5 was admitted from another facility

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D 234	Continued From page 11 and came with the results for one TB skin test. -She expected a TB skin test to be completed at the facility if the resident was admitted with results for one TB skin test. -The RCC was responsible to coordinate getting the second TB skin test completed. Based on observations, interviews, and record review it was determined Resident #5 was not interviewable.	D 234		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 1 of 5 sampled residents (#3) for failure to send a resident to the emergency department who felled two times and sustained a head injury. The findings are: Review of Resident #3's current FL-2 dated	D 273		

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D 273	Continued From page 12 12/23/19 revealed diagnoses which included Alzheimer's disease, subdural hematoma, hypertension and coronary atherosclerosis. Review of a Progress Note dated 11/21/19 revealed: -During second shift (3:00pm - 11:00pm) the nursing assistant (NA) reported Resident #3 had been pushed by another resident, lost balance, and fell onto the floor. "Did full body assessment, found to have small knot on head". -Staff asisted the resident up and applied ice packs. Notified the Resident Care Coordinator (RCC) and left a message for the resident's family. Review of an incident report dated 11/21/19 revealed: -At 8:00pm a NA reported to the medication aide (MA), supervisor in charge (SIC) another resident pushed Resident #3 out of his room causing her to fall onto the floor. -A full body assessment was completed, and the resident had a small knot on her head. -The resident was assisted from the floor into a chair and ice was applied to the knot. Interview with a second shift NA on 01/09/20 at 3:00pm revealed: -She was working on 11/21/19 (second shift) and observed Resident #3 walk into another resident's room. -The resident pushed Resident #3 backward and she fell to the floor and hit her head. -The NA called the SIC, who was on the special care unit (SCU), who assessed Resident #3. -The NA observed a knot on the back of the resident's head. -The resident was not sent to the ER.	D 273		

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Interview with the second shift SIC/MA on 01/09/20 at 3:05pm revealed:
-On 11/21/19 (second shift) a CNA informed her Resident #3 had been pushed to the floor by another resident.
-The SIC assessed the resident, who was on the floor awake, and noted there was a knot on the back of the resident's head about the size of her thumb.
-The SIC called the RCC and was instructed to apply ice (an ice pack) and monitor the resident for 72 hours.
-The RCC instructed the SIC not to send the resident to the ER since the knot was small.
-The SIC applied and ice pack to the area for about 15-20 minutes.
-If a resident fell and hit his/her head, facility policy was to send the resident to the emergency room (ER) for evaluation, but she followed the RCC's instructions instead of following facility policy.

Interview with the Administrator on 01/09/20 at 3:20pm revealed:
-She was not aware Resident #3 had a fall on 11/21/19 and hit her head.
-The SIC should have sent Resident #3 to the ER for evaluation per facility's policy.
-The RCC should not have instructed the MA/SIC not to send the resident to the ER.

Interview with the RCC on 01/09/20 at 3:45pm revealed:
-The second shift MA/SIC called her on 11/21/19 and reported that Resident #3 had fallen and hit the back of her head.
-The MA/SIC reported the resident had a small knot on the back of her head.
-The RCC instructed the MA/SIC not to send the resident to the ER but apply and ice pack to the

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area and "watch her" because she reported the knot was small.
-She should have followed facility policy and should have instructed the MA/SIC to send the resident to the ER
-She did not know why she did not follow policy.

Interview with a nurse at Resident #3's primary care provider's (PCP) office on 01/09/20 at 11:15am revealed:
-The facility did not contact the resident's PCP to report a fall and head injury on 11/21/19.
-The PCP expected the facility to send the resident to the ER for evaluation after any falls with suspected injury including head injuries such as hematomas.

Review of a second Progress Note dated 11/29/19 (no time) revealed:
-[Resident #3] was found outside on the special care unit (SCU) smoking porch lying in the bushes.
-The resident appeared to have a knot above her right eye. "Full body assessment, vital signs were checked, small goose egg knot formed".
-The RCC and the family were notified. The resident was doing okay, walking around as normal.

Review of a local ER Discharge Report for Resident #3 dated 12/04/19 revealed:
-Resident #3 presented to the ER for evaluation of a fall 5 days ago with hematoma of frontal scalp and musculoskeletal pain.
-She was accompanied by a caretaker from the facility who provided most of the resident's history.
-The caretaker stated the resident was found outside after she had fallen into some bushes.
-The caretaker reported the resident had some

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minor swelling on top of her right eye but no other injuries were noted.
-The caretaker "iced" the area of swelling initially over the next few days. The swelling had decreased slightly over time.
-The bruising had spread down through the resident's cheeks and around her chin over the past few days.
-The caregiver reported the resident was seen by family members today (12/04/19), who was concerned about the resident's appearance.
-The resident was seen by her primary care doctor today (12/04/19) and immediately sent the patient to the ER for evaluation.
-A head CAT scan (a type of 3-D x-ray used to define normal and abnormal structures in the body) showed acute right supraorbital scalp hematoma without acute intracranial process.
-The resident was discharged back to the facility on 12/04/19 at 6:17pm.

Review of a third Progress Note dated 12/05/19 (no time) revealed:
-On 12/04/19 the Administrator received a call from Resident #3's PCP's office regarding recent fall. The resident was there for a routine follow-up visit.
-The PCP was concerned about the bruises on the resident's face.
-The PCP was told the resident was not seen at the ER and she needed to be "checked out" and I agreed.
-The Administrator talked to the SIC and the RCC and learned they did not send the resident out at the time of the fall because there were no visible injuries at the time.
-The Administrator reminded the SIC and The RCC that the resident should have been sent out because no one saw the fall and did not know if she hit her head or not.

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D 273	Continued From page 16 -The resident was taken to the ER on 12/04/19 at 2:30pm and returned at 6:30pm. Interview with Resident #3's family on 01/09/20 at 10:30am revealed: -She was aware of only one fall which the facility should have sent Resident #3 to the ER for evaluation but did not. -The fall occurred outside near the gazebo in the secured area on 11/29/19 and the staff found her outside on the ground. -On 11/20/19, the facility called her and informed her of the fall but not of the severity of the injuries. -The resident's PCP called the family on 12/04/19 and via facetime and she viewed the resident's injuries. -The resident's entire face was black and blue and the PCP informed the family she needed to be evaluated in the ER for a concussion and any closed head injuries. -The facility's Administrator called the family and apologized for not sending the resident to the ER after the fall on 11/29/19. -She expected the facility to inform the resident's PCP and send her to the ER if she fell and sustained injuries. Interview with the Administrator on 01/09/20 at 11:05am revealed: -The RCC and the SIC had been trained on the fall policy and they knew the facility's policy. -They should have sent Resident #3 to the ER for evaluation after the fall on 11/29/19. -She expected either the RCC or the SIC to make the decision to send a patient to the ER for evaluation after a fall. -She was not aware of Resident #3's fall/injuries until the resident's PCP called her on 12/04/19.	D 273		

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D 273	Continued From page 17 Interview with the RCC on 01/09/20 at 10:05am revealed: -She did not remember the details of the fall Resident #3 sustained on 11/29/19. -She remembered the resident had an injury and bruises on her face and a "bump' on her head. -The knot on the resident's head was raised became much bigger (about the size of a small orange) after a few days. -The bruising on the resident's face had spread and she looked "terrible". -The resident had dementia and was not "acting" any differently and was not complaining of headaches after the injuries. -The resident's PCP was not informed of the fall or injuries because she was not sent to the ER. -She did not recall why the resident was not sent to the ER. -The resident was sent to the ER on 12/04/19 by her PCP after a scheduled office visit not related to the fall. -The facility's policy was residents were sent to the ER for evaluation immediately after a fall if they hit their heads or had visible injuries. -The SIC reported all falls to the RCC and the RCC directed the SIC to send the resident to the ER, if needed. Review of the facility's Falls Policy revealed: -When a resident has fallen, the SIC will be notified immediately. -If the resident was still down on the floor, the staff does not need to get the resident up until the SIC had checked the resident for any obvious signs of injury such as head injury, etc. -The SIC, after checking the resident thoroughly from head to toe, will assess the resident to determine if there are any injuries and if it safe to move the resident. -If there is any indication of an injury such as	D 273		

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severe bleeding, loss of consciousness, a broken bone or head injury, 911 will be called immediately.
-The RCC will complete a follow-up on the incident, including physician follow-up.

Interview with a nurse at Resident #3's primary care provider's (PCP) office on 01/09/20 at 11:15am revealed:
-Resident was seen at the PCP's office on 12/04/19 for a previously scheduled appointment.
-The PCP was concerned about the injuries to the resident's face and head.
-The residen'st face had "massive bruising" and a "large hematoma" was on the front of the resident's head.
-The facility had not reported the fall or injuries to the resident's PCP.
-The resident's family was contacted during the visit and shown the resident's injuries via facetime.
-The facility staff who accompanied the resident to the office visit informed the PCP the resident sustained a fall a few days before.
-The PCP's office manager contacted the facility's Administrator during the office visit and discussed the PCP's concerns regarding the resident's injuries and informed her of the PCP's verbal orders to send the resident to the ER for evaluation.

Interview with the Special Care Unit Coordinator on 01/08/20 at 11:30am revealed:
-She was not working on 11/29/19 when Resident #3 fell outside in thee secured area.
-The RCC and the SIC made the decision not to send the resident to the ER for evaluation.
-She always sent residents who resided in the SCU to the ER if they fell and hit their heads.
-She worked the weekend after the resident fell

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D 273	Continued From page 19 (11/30/19 and 11/31/19) and noted Resident #3 had dark facial bruising which almost covered her entire face and a large hematoma, about the size of a small orange, on the front of her head. -She did not send the resident to the ER for evaluation after the injuries worsened because the RCC had made the decision not to send the resident to the ER on 11/29/19. -The facility's policy was if a resident (especially if the resident resided in the SCU) fell and hit their head, they were always sent to the ER for evaluation of their injuries. -The resident's family was upset and questioned why she was not sent to the ER after the fall. --- The facility failed to assure the acute health care needs were met for 1 of 5 sampled residents (#3) who sustained head and facial injuries after unwitnessed and witnessed falls, placing the resident at risk for serious complications of head injuries. The facility's failure to follow-up with emergency care resulted in substanial risk for serious physical harm and neglect which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/09/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 09, 2020.	D 273		
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:	D 310		

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D 310	Continued From page 20 (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, record reviews and interviews, the facility failed to serve the therapeutic diet ordered by the physician for 1 of 1 sampled resident who had an order for nectar thickened liquids (Resident #2). The findings are: Review of Resident #2's current FL-2 dated 05/15/19 revealed: -Diagnoses included dementia alzheimer's type, hypertension, anemia, trigeminal euralgia, hypothyroidism. -An order for a no added salt (NAS), ground meats (GM), nectar thickened liquids (NTL) diet. Observation of the lunch meal on 01/08/2020 at 12:11pm at the table revealed: -Resident #2 had a 12 ounce glass of water with ice, a 12 ounce glass of tea with ice and an 8 ounce carton of milk placed in front of her. -Resident #2's glass of water with ice, glass of tea with ice and the carton of milk were not observed to have nectar thick consistency. -Resident #2 was seen removing the carton of milk from her mouth. -Resident #2 immediately started coughing. -The MA was prompted to remove Resident #2's glass of water, glass of tea and the carton of milk and take it back to the kitchen. -The MA informed the dietary aide that Resident #2's glass of water, glass of tea and carton of	D 310		

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milk required the thickening agent to be added.
-The survey team prompted the dietary staff and MA ice could not be added to beverages mixed with a thickening agent.

Interview with the medication aide (MA) on 01/08/2020 at 11:45am revealed:
-The kitchen staff was responsible for pouring the beverages at meal times for Resident #2.
-She was responsible for adding the thickening agent to the beverages for Resident #2.
-She did not know how many ounces where in each glass or cup.
-She assumed the dietary staff was using a foam cup to determine how many ounces where in the glasses or cup and it is normally 8 ounces.
-She was not aware ice would change the consistency of the beverages when a thickening agent was added.

Interview with the dietary manager on 01/08/2020 at 12:15pm revealed:
-He did not know how many ounces of the beverages were poured into each glass.
-He was trained to add ice to the beverages of residents receiving thickening agents.
-He did not know anything about adding the thickening agent because it was the responsibility of the MA to ensure it was added to Resident #2's beverages.
-He was never trained on using the thickening agent for residents.
-He was not aware ice would change the consistency of the beverages when a thickening agent was added.

Interview with a personal care aide (PCA) on 01/08/20 at 12:21pm revealed:
-Her role was feed Resident #2.
-She did know Resident #2 required a thickening

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D 310	Continued From page 22 agent to be added to her liquids. Observation of the kitchen staff and the MA preparing the nectar thickened liquid on 01/08/2020 at 12:30pm revealed: -The dietary staff, kitchen manager and the MA used a liquid measuring cup to measure 4 ounces of water, 8 ounces of tea and 8 ounces of milk and poured each into a glass or a cup. -The MA used the blue measuring device supplied in the thickening agent container to measure the correct amount of thickening agent in accordance with the directions on the label of the thickening agent. Interview with a dietary aide on 01/08/2020 at 12:46pm revealed: -She had been employed with the facility four years. -She and other dietary staff added ice to Resident #2's beverages all the time. -She was not aware ice would change the consistency of the beverages when a thickening agent was added. -She never measured the beverages using a liquid measuring cup before pouring them in the glass or cup for Resident #2. -She knew now she measured the beverages wrong and would use a liquid measuring cup to ensure the appropriate number of ounces were in the cup to notify the MA. -When she opened the carton of milk in front of Resident #2, she forgot the resident required a thickening agent to be added to her liquids. -The MA would add the thickening agent to Resident #2's glasses or cups once they were placed on the table. -She was never trained on using the thickening agent for residents.	D 310		

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D 310	Continued From page 23 Interview with the Administrator on 01/08/20 at 1:00pm revealed: -She did not know ice could not be added to a resident's beverage that were thickened. -It was the responsibility of the dietary manager to train all dietary staff. -She expected the dietary staff know how many ounces were in the glasses or cups of Resident #2 and notify the MA. Observation of Resident #2 on 01/08/20 at 5:14pm revealed: -Resident #2's beverages of water and tea were not served with ice and were nectar thick consistency. Interview with the MA on 01/09/20 at 10:02am revealed: -She has worked at the facility as a MA for three years. -She was trained how to thicken liquids by a previous MA. -Resident #2 had always been served her beverages with ice. -The dietary staff did not tell her how much liquid was in each beverage. -She would mix the thickening agent with the iced beverages. -She did notice that sometimes Resident #2 would cough when drinking her beverages. -She was not sure why Resident #2's primary care physician ordered nectar thickened liquids. -Resident #2 was placed on nectar thick liquids three years ago. Interview with Resident #2 on 01/09/20 at 10:31am revealed: -She had always received her beverages with ice. -She did occasionally drink her beverages before the thickening agent was added if she was thirsty.	D 310		

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D 310	Continued From page 24 -She would cough sometimes after drinking her beverages, sometimes she did not. -She did not know why her PCP ordered a thickening agent to her liquids. -She did not like the thickening agent being added to her beverages. -She did not have a problem swallowing beverages without a thickening agent. Interview with another personal care aide (PCA) on 01/09/20 at 10:39 revealed: -She had worked at the facility for many years. -Resident #2 started thickened liquids about a year ago. -She assisted Resident #2 with feeding assistance during meal times. -She had not seen Resident #2 drink a beverage without the thickening agent. -She had seen Resident #2 occasionally cough when she drank her beverages with the thickening agents added. -She could not remember the time the cough had occurred. -She did not report the coughing to the MA. -She assumed it was a normal cough. -She would report the coughing to the MA if the resident was coughing and choking. Interview with Resident #2's primary care provider (PCP) front office coordinator (FOC) on 01/09/20 at 11:18pm revealed: -The PCP was seeing patients and did not have time to speak directly. -Resident #2 did not have a swallow evaluation on file. -The PCP did not know where the nectar thickened liquids order originated. -The PCP had thought it came from one of Resident #2's hospitalizations. -Resident #2's next appointment with the PCP	D 310		

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D 310	Continued From page 25 was scheduled for 01/14/20. -The PCP would follow up with the resident about her diet orders. -The PCP expected the facility to follow Resident #2's diet as ordered. -The PCP did not report any possible outcomes to Resident #'2 if she had not received nectar thick liquids. Interview with the RCC on 01/09/20 at 2:21pm revealed: -Resident #2's diet was changed to nectar thickened liquids on 05/18/17. -If a resident was coughing while drinking or eating, the PCA should notify the supervisor in charge (SIC). -The SIC should notify her. -She would notify the resident's PCP. -She had not been notified that Resident #2 had been coughing while drinking or eating. _____ The facility failed to assure therapeutic diets were served as ordered for Resident #2 who was ordered nectar thick liquids and received liquids without a thickening agent added and beverages with ice during a meal. The facility's failure to assure Resident #2 received nectar thick liquids posed a risk for aspiration, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/09/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 24, 2020.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096031	A. BUILDING: _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI	2201 ROYALE AVENUE GOLDSBORO, NC 27534

(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
D912	Continued From page 26	D912		
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 ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to Health care and Nutrition and Food Service. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 1 of 5 sampled residents (#3) for failure to send a resident to the emergency department who felled two times and sustained a head injury. [Refer to Tag D276, 10A NCAC 13F. 0902(c)(3)(4) Health Care (Type A2 Violation)]. 2. Based on observations, record reviews and interviews, the facility failed to serve the therapeutic diet ordered by the physician for 1 of 1 sampled resident who had an order for nectar thickened liquids (Resident #2). [Refer to Tag D310, 10A NCAC 13F. 0904(e)(4) Nutrition and	D912		

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D912	Continued From page 27 Food Service (Type B Violation)].	D912		