Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on January 14, 2020 to January 16, 2020.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with 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, NC 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 6 sampled staff (Staff C) was tested for tuberculosis disease(TB) using the two-step skin test in accordance with the control measures adopted by the Commission for Health Services. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired on 02/11/18 as a personal care aide (PCA). -There was documentation of a TB test administered on 04/11/18 and read on 04/13/18 with negative results. -There was documentation of a second TB test administered on 02/28/19. -There was no documentation the second TB test was read and results obtained for the second TB	D 131	10A NCAC 13F .0406(a) Test for Tuberculosis Facility Executive Director (ED) and/or Business Office Manager(BOM) will assure all staff are tested for TB using the two-step skin test in accordance with the control measures adopted by the Commission for Health Services. Facility ED and BOM have completed an audit of all employee files. Facility Licensed Health Professional RN (LHPS Nurse) has been contacted and completed any outstanding TB two-step testing. Facility ED and BOM have received training along with a copy of the StateTB Guidelines. Training conducted by Area Director of Operations on 2/18/2020	2/20/2020 2/20/2020 2/20/2020 2/20/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelly Cook | TITLE: Director | (X6) DATE: 02/19/2020

Reviewed and Accepted on 02/21/20. Pamela Dailey 02/21/20

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D 131	Continued From page 1 test for Staff C. Telephone Interview on 01/16/20 at 1:00 pm with Staff C revealed: -He was administered a two-step TB skin test by the facility nurse. -He was not aware the reading and results of the second test was not documented in his personnel record. -The Business Office Manager (BOM) kept TB testing documentation in his personnel records. Interview on 01/16/20 at 1:12 pm with the BOM revealed: -The nurse would bring TB testing documentation to her to file in staffs' personnel records. -An audit was done on staff personnel records monthly. -She did not know the documentation for Staff C's second step TB testing documentation was missing. Interview on 01/16/20 at 1:10 pm with the Administrator revealed: -The nurse administered the TB skin tests to the facility staff; the documentation was given to the BOM to file. -Staff personal records were audited quarterly by the BOM for completeness. -She was not aware Staff C did not have complete information for the second TB skin test.	D 131	Facility ED and/or BOM will complete quality assurance audits on no less than 10% of employee files monthly for 3 months, then quarterly there after. Facility Area Director of Opertations (ADO), Senior Area Director of Opertations (SADO) and/or Divisional Director of Business Management (DDBM) will review employee files and quality assurance audit tools during site visits.	2/20/2020 2/20/2020
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and	D 287	10A NCAC 13F .0904(b)(2) Nutrition and Food Service Facility will assure all resident have the required proper place settings at each meal.	2/20/2020

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D 287	Continued From page 2 non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the residents were provided with a non-disposable place setting, including a fork, a spoon, a knife, and a non-disposable plate. The findings are: Observation of the lunch meal in the memory care unit (MCU) female dining room on 01/14/20 from 12:00pm to 1:10pm revealed: -There were 14 residents in the dining room. -The meal consisted of a thick slice of ham, sweet potatoes, succotash, navy beans, and a roll. -Each resident received a fork and a spoon with their place setting; five residents received a knife. -Two residents used their hands to tear the ham into bite size pieces. -Five residents picked the whole piece of ham up with their hands and took bites out of the ham. -One resident tried to pick her whole piece of ham up on her fork and dropped it in her lap. -One resident had a knife and was cutting her ham into bite size pieces. Observation of the lunch meal in the MCU female dining room on 01/15/20 from 11:55am to 12:30pm revealed: -There were 15 residents in the dining room.	D 287	ED, Care Coordinator, Dietary Manager, and/or Memory Care Manager will monitor no less than 5 meals per week for 2 months, then randomly thereafter to assure all residents have correct place settings. Dietary employees have received training on proper place settings. Training conducted by Executive Director. Facility ADO, SADO and/or DDCS will observe a meal service during monthly site visits to assure all residents have proper place settings.	2/20/2020 2/20/2020 2/20/2020

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D 287	Continued From page 3 -The meal consisted of a beef parmesan patty, garlic pasta, green beans, and a roll. -Four of the meals were chopped; eleven of the fourteen meals served contained a piece of beef patty that was topped with melted cheese; the patty was approximately 3.5 inches in diameter. -Each resident received a fork and a spoon with their place setting; two residents received a knife. -Two residents used their forks to cut the beef patty into bite size pieces. -Seven residents picked the beef patty with their hands and were taking bites out of the patty. -One resident used her fork to pick the entire beef patty up and was taking bites off the patty. Observation of the breakfast meal in the second dining room in Memory Care Unit (MCU) male side on 01/15/20 at 8:03am revealed: -There were eleven residents seated in the dining room; eight residents did not have knives. -Two pancakes that had been cut in half, pancake syrup, scrambled eggs and mandarin oranges were served. -The residents without knives used the side of their forks to cut the pancakes into bite size pieces. Observation of the lunch meal in the Assisted Living (AL) side dining room on 01/15/20 at 12:05pm revealed: -There were twenty-nine residents seated in the dining room; five residents did not have knives. -A beef patty with topped with melted cheese and a sauce, buttered egg noodles, green beans and a dinner roll were served. -Three of the residents who did not have knives used the side of their forks to cut their meat; two of the residents without knives had ground meat. Observation of the kitchen on 01/15/20 at 3:30pm	D 287		

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D 287	Continued From page 4 revealed: -There were 28 rolls of silverware prepared to send to the MCU for the dinner meal; there were 27 sets with a spoon and a fork and only one full set with a fork, spoon and a knife. -There were 91 forks, 57 spoons and 29 knives total available for residents. Review of the posted breakfast menu on 01/15/20 revealed pancakes, scrambled eggs and fresh fruit, juice and milk; bacon was available as an alternate option. Review of the posted lunch menu on 01/15/20 revealed beef parmesan patty, garlic pasta, green beans and a dinner roll were on the menu. Review of a purchase order with a local vendor dated 01/13/2020 revealed the Administrator had placed an order for expected delivery on 01/16/20 of 72 dinner forks, 72 tea spoons and 72 dinner knives. Interview with a resident in the MCU on 01/15/20 at 12:36pm revealed: -She did not have a knife to cut her meat today, 01/15/20, but she had been able to cut the meat with her fork. -"Sometimes knives were sent and sometimes they were not." -She thought knives were not sent because some of the residents may hurt each other. Interview with two residents at the same lunch table in the AL dining room on 01/15/20 at 12:05pm revealed: -They did not always get knives, but if there was a meal where one of them did not have a knife, they "borrowed" each other's. -The meat usually is not hard to cut, but the ham	D 287		

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D 287	Continued From page 5 the day before was hard to cut without a knife; neither one of them had a knife the day before. -They did not think to ask the staff for a knife; just did without one and it was "okay" they "guessed". Interview with a third resident in the AL dining room on 01/15/20 at 12:08pm revealed: -He did not always get a knife but "made do" without one. -He used his fork to cut his meat if he did not have a knife, but sometimes the meat was too tough to cut with the side of his fork. -He could have used a knife to cut his roll open at lunch if he had one. -He did not want to ask for a knife because he would have to "wait anyway". Interview with a personal care aide (PCA) for the AL on 01/16/20 at 9:33am revealed: -She did not cut food for any residents because "they did that themselves". -Everyone got a knife in the AL dining room so no one asked her for a knife; she would get a knife from the kitchen if a resident asked for one. Interview with the dietary aide on 01/15/20 at 3:30pm revealed: -She sent 27 sets of forks and spoons over to the MCU at every meal. -She did not know why knives were not sent to the MCU; "that was the way" she was trained to send the silverware to the MCU. Interview with the Kitchen Manager (KM) on 01/15/20 at 2:49pm revealed: -There were only enough knives for everyone in the AL dining room to have a knife; the MCU did not get knives. -She thought the MCU should also get knives, but it had been that way since she started on	D 287		

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D 287	Continued From page 6 12/23/19. -She thought there might have been a reason why knives were not sent to the MCU, but she was not sure what the reason would have been. -She thought the kitchen had about 40 knives for resident use. -She had brought the shortage of knives to the Administrator's attention on 01/13/20; she thought the Administration had placed an order for two dozen knives, but she was not sure when they would be delivered from the supplier. -She served 27 residents in the MCU and 34 residents in the AL; she needed at least 60 knives and would have liked to have extra knives. -She did not know residents were supposed to get a full place setting, including a fork, spoon and a knife. Interview with the Administrator on 01/15/20 at 3:38pm revealed: -She ordered forks, knives and spoons as they were needed; the KM usually let her know when an order needed to be placed. -The KM would give her a request to order silverware when there was not enough silverware or when the supply ran low; the KM had asked her to order knives on 01/13/20. -She had placed an order with the vendor for six dozen each of forks, knives and spoons on 01/13/20; she thought they would be delivered that day but did not know exactly when they would be delivered. -She did not know there were not enough knives to give each resident a knife for meals. -The staff did not send knives to the residents in MCU because the residents could hurt themselves; they cut themselves with the knives but it would depend on the resident and their ability. -Residents needed a knife to cut their food into	D 287		

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D 287	Continued From page 7 smaller pieces.	D 287		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 6 sampled residents (#3) with a physician order for double portions was served as ordered. The findings are: Review of Resident #3's current FL2 dated 12/27/19 revealed: -Diagnoses included dementia, muscle weakness, malignant neoplasm of colon, dysphagia, nausea and vomiting, hypertension and anemia. -There was an order for a mechanical soft diet with chopped meats. Review of a physician's order for Resident #3 dated 12/06/19 revealed an order for double portions. Review of a physician's diet order for Resident #3 dated 12/06/19 revealed an order for a regular diet, mechanical soft with chopped meats, double portions. Review of physician's patient encounter for	D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service Facility staff and/or management team will assure that residents are servered therapeutic diets as ordered by residents physician ED, Care Coordinator, Dietary Manager, and/or Memory Care Manager will monitor no less than 5 meals per week for 2 months, then randomly thereafter to assure residents are served the correct diets which have been ordered by physician Facility ADO, SADO and/or DDCS will observe a meal service during monthly site visits. Facility Dietary Manager will assure diet place cards are up to date and changes are made immediately when resident receives a change in diet order Facility Care Coordinator and/or Memory Care Manager will print updated diet list weekly and/ or immediately upon changes in residents physicians orders Facility ED, Dietary Manager, Care Coordinator, and Memory Care Manager will review any diet order changes during daily stand up meetings.	2/20/2020 2/20/2020 2/20/2020 2/20/2020 2/20/2020 2/20/2020

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D 310	Continued From page 8 Resident #3 dated 12/10/19 revealed: -Resident #3 was seen on 12/06/19. -Staff reported Resident #3's appetite was very good. -Resident #3 was eating all of her meals and trying to eat another resident's food. -Plan was to increase Resident #3's meals to double portions. Review of the facility's therapeutic diet list dated 01/13/20 revealed Resident #3 was to be served double portions. Observation of the kitchen on 01/14/20 at 8:54am revealed: -There was a two-page diet list dated 01/13/20 hung on the door entering the kitchen; Resident #3 was listed as a regular diet, mechanical soft entire meal with chopped meats and double portions. -There was a column that listed the date each resident's diets was updated; Resident #3's diet was last updated 12/06/19. -There were two clear acrylic stands on the hot food serving line; the stands had the pages of the diet list. -The date on the diet list on the serving line was 01/02/20; Resident #3 was listed as a regular diet, mechanical soft entire meal with chopped meats. Observation of the lunch meal service on 01/14/20 between 12:00pm and 1:00pm revealed: -Resident #3 was served chopped ham with gravy, glazed sweet potatoes, navy beans, pudding and a dinner roll. -Resident #3 consumed 100% of the lunch meal. -Resident #3 was reaching for other residents' food and was redirected by staff.	D 310	Facility staff have been in-serviced on location of resident diet order list. In-service conducted by ED.	2/20/2020

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D 310	Continued From page 9 Observation of the breakfast meal service on 01/15/20 between 8:00am and 8:45am revealed: -Resident #3 was served scrambled eggs, a pancake cut into strips, a small bowl of chopped peaches, orange juice, water and milk. -Resident #3 consumed 100% of the breakfast meal. -Resident #3 was reaching for other residents' food and was redirected by staff. Observation of the lunch meal service on 01/15/20 between 12:00pm and 1:00pm revealed: -Resident #3 was served a chopped beef parmesan patty, garlic pasta, green beans, and a dinner roll. -Resident #3 consumed 100% of the lunch meal. -Resident #3 was reaching for other residents' food and was redirected by staff. Interview with Resident #3's Primary Care Provider (PCP) on 01/16/20 at 8:37am revealed Resident #3 was ordered double portions because she was eating her food fast and was taking other residents' food. Interview with Resident #3's hospice nurse on 01/16/20 at 8:46am revealed: -Resident #3 was ordered double portions. -Resident #3's appetite had improved and Resident #3 was eating 100% of her meals. -Resident #3 was not losing weight. -If Resident #3 had an order for double portions it should be served. Interview with a personal care aide (PCA) on 01/16/20 at 9:06am revealed: -Resident #3 ate 100% of her meals. -Resident #3 always reached for other residents' food when she had ate all of hers. -She had thought if Resident #3 had more food it	D 310		

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D 310	Continued From page 10 would help; she had not told anyone. -She did not know Resident #3 had an order for double portions. Interview with the memory care manager (MCM) on 01/16/20 at 9:10am revealed: -Resident #3 had an order for double portions because Resident #3 took other residents' foods. -When the PCP wrote the order for double portions, she gave the order to the dietary manager. -She had seen Resident #3 received double portions. -She did not know Resident #3 had not received double portions at every meal service. Interview with the Administrator on 01/16/20 at 11:49am revealed: -When the PCP wrote a diet order, the MCM would give the new order to the Kitchen Manager (KM), as well as enter the new diet order into the computer. -She printed out the diet orders list and would hang the list in the dining room. -She expected the kitchen staff to follow the diet orders. -If Resident #3 did not get double portions the kitchen staff did not follow the PCP's order. Interview with the cook on 01/16/20 at 8:38am revealed: -She "learned" what each resident got on their plate; she had been the cook for two months and had memorized the diet list. -The kitchen staff used a system of laminated place cards; each place card had the resident's name and diet on it. -There was also a list with the residents' names and diets in a stand on the serving line; the place cards and the diet list always matched.	D 310		

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D 310	Continued From page 11 -The KM would update the place cards when the diet list was updated; she thought the diet list was last updated by the KM on 01/02/20. -The only update on 01/02/20 was a diet for one resident. -She only knew of two residents that were supposed to receive double portions; both residents were the diet list. -She did not know Resident #3 was ordered double portions on the most recient diet list. -Double portions were two servings of each food item on the menu; she could put the double portions on one plate or in side bowls. Interview with the KM on 01/16/20 at 12:18pm revealed: -She used the resident diet list to make place cards. -She was responsible for maintaining the place cards and updating them when there were changes; she made new place cards on Monday, 01/13/20. -She used the list the Administrator had updated on 01/10/20 to make place cards. -The Administrator updated the list weekly or more often if a diet order changed. -The place cards were used by the cooks and had each resident's name and diet on them; the cook plated the food based on the place card and then placed the card on the plate so the staff would know who to serve the plate to. -Double portions was two scoops of everything, including meats, sides and desserts. -She missed seeing the double portions for Resident #3 when she made her place cards; she forgot to update the diet list on the hot food serving line when she updated the place cards.. -She thought there was only one resident who was ordered double portions; she did not know Resident #3 was ordered double portions.	D 310		

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D 310	Continued From page 12 Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. Interview with the KM on 01/16/20 at 12:18pm revealed: -The cooks followed the list on the hot food serving line and the diet cards when plating food. -The diet cards used by the cooks had each resident's name and diet on each card; the diet cards were then placed on the trays with the finished plate for the personal care aides (PCA) to follow when serving the residents in the dining rooms. -She was responsible for maintaining the diet cards and updating them when there were changes; she made sure the diet cards matched the diet list the cooks used on the hot food serving line. -She had updated the resident meal cards used by the cook to plate the resident meals on 01/13/20; the Administrator had brought her an updated list on 01/10/20. -She forgot to update the diet list on the hot food serving line when she updated the diet cards. -The Administrator updated the diet list weekly or more often when there was a change in a resident's diet. -The Administrator posted the diet list in the dining room for the PCAs to follow; the diet list in the kitchen was supposed to match the diet list hung on the entry door to the kitchen. -She did not know the diet list the cooks used on the serving line did not match the diet list posted in the dining room. -She thought there was only one resident who was ordered double portions; she did not know Resident #3 was ordered double portions. -Double portions were two portions of every meal	D 310		

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D 310	Continued From page 13 item; double portions could be ordered for weight gain, to increase nutrition and to make sure the residents were not hungry after a meal. -She was concerned Resident #3 was not getting the double portions because Resident #3 was not getting enough to eat.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, 2 of 2 residents (#2 and #6) in the Assisted Living dining room with meals by providing assistance and prompting a resident who was visionally impaired (#2) and a resident who fell asleep during meal time and was not assisted or prompted to eat (#6) and the facility failed to assist residents in the memory care unit who required assistance with cutting meats and using silverware, were assisted upon receipt of the meal in a timely manner. The findings are: A. 1. Review of Resident #2's current FL-2 dated 01/03/20 revealed: -Diagnoses included depression, glaucoma, degenerative joint disease, macular degeneration, fracture of humorous, fracture of	D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service ED, Care Coordinator, Dietary Manager, and/or Memory Care Manager will monitor no less than 5 meals pre week for 2 months, then randomly thereafter to assure any resident requiring feeding assist, and/or prompted recieve assistance as needed. Facility ADO, SADO and/or DDCS will observe a meal service during monthly site visits to assure residents are receiving assistance with feeding as needed Facility ED, Care Coordinator and Memory Care Manager have reviewed care plans and monitored meal services to indentified residents who need feeding assistance. Facility staff have received training on feeding assistance and which residents need assistance and/or prompting. Training conduct by ED and Care Managers Facility ED, Dietary Manager, Care Coordinator, and Memory Care Manager will review any changes/concerrns regarding residents needing assistance with meal/feeding during daily stand up meetings	2/20/2020 2/20/2020 2/20/2020 2/20/2020 2/20/2020

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D 312	Continued From page 14 upper and radius ulna. -Resident #2 was ordered a regular diet. Review of Resident #2's current care plan dated 03/13/19 revealed the resident had limited range of motion and had very limited vision (blind). Review of a diet order sheet dated 01/01/20 for Resident #2 revealed there was an order for a regular diet. Observation of the lunch meal on 01/14/20 from 12:30pm until 1:00pm revealed: -A personal care aide (PCA) served Resident #2 her food in a three-compartment plate; she was served a slice of ham, lima beans, cubed sweet potatoes, a dinner roll, a bowl of pudding and coffee and water to drink. -The PCA told Resident #2 where each item was on her plate; the PCA placed a fork in Resident #2's hand and a straw in her beverages and walked away. -Resident #2 repeatedly placed her fork into the lima beans but did not pick up any food with the fork; she would raise the fork to her mouth and not have anything on the fork. -Resident #2 would get a small amount of food on her fork and the food would fall into her lap before she could get the fork to her mouth. -Resident #2's tablemate used a knife and pushed food that was on the edge of Resident #2's plate back onto the plate; Resident #2 was unaware of the assistance and continued to raise her fork to her mouth. -The PCA returned to Resident #2 at 12:42pm and asked Resident #2 if she needed anything; Resident #2 declined and the PCA walked away. -At 12:50pm the Activities Director (AD) encouraged Resident #2 to eat her pudding; the AD gave Resident #2 a spoon to eat the pudding	D 312		

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D 312	Continued From page 15 with instead of the fork she was using. -Resident #2 ate 60% of her meal; she attempted to eat the lima beans, the sweet potatoes, and pudding; she ate less than 10% of the dinner roll and did not attempt to eat the slice of ham. Observation of the lunch meal on 01/15/20 from 12:00pm until 12:30pm revealed: -At 12:05pm a PCA served Resident #2 her food in a three-compartment plate; she was served a ground beef patty topped with cheese and gravy, green beans, egg noodles, and fruit cobbler in a bowl. -The PCA cut Resident #2's beef patty into long narrow strips and placed a fork into Resident #2's hand. -At 12:10pm a medication aide (MA) cut Resident #2's meat into smaller portions; Resident #2 stabbed the meat with her fork and ate 100%. -Resident #2 tried to eat her noodles multiple times but the noodles did not stay on her fork and fell onto the table. -She ate her green beans with her fork and used her fingers to hold the beans on the fork as she raided it to her mouth. -Resident #2 was served her cobbler in a bowl and she attempted to eat the cobbler with her fork; numerous times the cobbler fell off her fork and onto the table or her lap. -Resident #2 ate 100% of her meat, she ate most of the green beans and very little of the noodles. Interview with Resident #2 on 01/16/20 at 9:08am revealed: -Her eyesight had declined over the last fifteen years; she was completely blind when she was admitted to the facility about 10 years ago. -She used to use her fork to "poke around" her plate and find her food. -She had to start using her hands to feed herself	D 312		

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D 312	Continued From page 16 about a year ago. -She was embarrassed because she had to use her hands to eat and her hands would get dirty and "messy" when she ate. -She would eat French toast and get the syrup on her hands and get sticky, so she did not eat French toastevn though she liked it. -Sometimes the facility staff would tell her where the food was on her plate and then they would leave. -The staff did not always tell her where her food was, and she would use her hands to feel for the food on the plate. -Her tablemates would help her and turn her plate for her when she was finished with an item; she was embarrassed her tablemates had to help her during the meal. -She could not feel when she had food on the fork or when it fell off the fork when she tried to bring the fork to her mouth. -Sometimes she had to change her clothes after she ate because so much food fell off her fork and into her lap her clothes got dirty. -She wore a clothing protector during the meal, but she was still "messy" after she ate. -She had never had any therapy or been taught how to eat her food since she had become blind. -She wanted staff to assist her with eating because it was getting harder to hold a fork in her hands to feed herself; she was losing use of her hands due to arthritis. -She had a PCA assist her with eating once and she felt like she ate more food; the PCA no longer worked at the facility. -She asked a PCA to assist her with eating and the PCA told her they could not assist her with eating unless she had an order for the assistance; she was told she needed an order by the PCA about two weeks ago. -She would ask her primary care physician (PCP)	D 312		

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D 312	Continued From page 17 for an order the next time she saw him; she thought it would be within the week. Interview with the PCA on 01/16/20 at 9:33am revealed: -She worked in the dining room during meals; she served beverages and plates to residents. -She walked around and checked on the residents during the meal to be sure they did not need anything else to drink and to be sure no one was coughing or choking on their food. -She did not offer to cut anyone's food; "they all get a knife to cut their food with". -She poured coffee for Resident #2 and would put a straw in it; she would tell Resident t#2 where the coffee was on the table. -She would tell Resident #2 where the food was on the plate; she would say at the top or at 12 o'clock. -Resident #2 did "pretty good" with eating after she was told were the food was on the plate; Resident #2 ate her food fast. -Resident #2 stayed clean while eating her meal; sometimes food would fall out of her mouth or off her utensil into her lap, but she wore a clothing protector. -She had asked Resident #2 if she needed assistance, but the resident had refused the help; she would have assisted Resident #2 with eating if the resident needed or wanted assistance. Interview with the medication aide (MA) on 01/16/20 at 10:02am revealed: -She only assisted residents in the dining room after she had completed administering medication to residents. -She basically walked around the dining room and observed residents to see if they were choking or needed assistance with eating. -Resident #2 needed to be told were the food was	D 312		

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D 312	Continued From page 18 on the plate but she "managed pretty well". -Resident #2 spilled some of her food onto the table when she ate; she would "scoop" the food onto the utensil and it would fall onto the table. -Resident #2 never asked for assistance with eating her meal and she never asked for anyone to cut her meat. -She would assist Resident #2 with eating if the resident asked; the resident did not have to have an order to be assisted with eating. Interview with Resident #2's PCP on 01/16/20 at 10:35am revealed: -Resident #2 had never complained about difficulties with eating her meals; neither the facility staff or the resident had informed him of any complaints or concerns. -She had not expressed interest in staff assistance when eating her meals; if she wanted assistance with meals, he would make sure she had an order for assistance with eating if necessary. -Resident #2 could possibly benefit from therapy so she could learn how to eat her meals on her own. Interview with the Administrator on 01/16/20 at 11:00am revealed: -Staff should have offered assistance to residents during meal service by serving beverages, serving plates and assist with cutting meat if needed. -She thought the residents needed an order for assistance with eating meals; she had instructed staff not to assist residents with eating unless there was an order. -Resident #2 had never asked for assistance with eating her food; she would refuse when staff offered to cut her food. -Resident #2 was a "picky" eater and did not like	D 312		

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D 312	Continued From page 19 a lot of meats. -Staff were expected to inform Resident #2 where her food was on her plate and guide her to her beverages and utensils. 2. Review of Resident #6's current FL-2 dated 12/20/19 revealed: -Diagnoses included diabetes mellitus, hypertension, hyperlipidemia, transient ischemic attack, and dysphagia. -Personal care assistance was documented for bathing, dressing and feeding. -Resident #2 was ordered a pureed diet and nectar thickened liquids. Review of progress notes for Resident #6 revealed: -On 01/06/20 resident refused to eat breakfast. -On 01/09/20 resident did not want to eat his lunch or dinner, he wanted to go back to bed and he only drank his beverages. -On 01/10/20 resident ate 100% of his breakfast. -On 01/10/20 resident ate 80% of his lunch, [staff] will continue to monitor. -On 01/14/20 resident was encouraged to eat his meal, but after several attempts the resident returned to his room to take a nap. -On 01/15/20 resident was prompted to eat, and he would eat but was dozing at the table and stated he was done with his food. Observation of the lunch meal on 01/14/20 from 12:30pm until 1:00pm revealed: -A personal care aide (PCA) served Resident #6 his food in a three-compartment plate; he was served pureed ham, pureed lima beans, pureed sweet potatoes, nectar thickened water and tea and a nutritional supplement. -Resident #6 sat in his wheelchair at the table	D 312		

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D 312	Continued From page 20	D 312		

with his head hung down; he appeared to be sleeping; a PCA woke Resident #6 up and encouraged him to eat.
-Resident #6 ate a spoonful of his ham and stopped eating; at 12:43pm the Administrator cued Resident #6 to eat by giving him his spoon and sitting down next to him.
-Resident #6 ate a spoonful of his sweet potatoes and a spoonful of the lima beans.
-The Administrator gave Resident #6 his nutritional supplement to drink, he drank 100% of the supplement.
-Resident #6 was taken out of the dining room at 12:59pm; he had eaten less than 5% of his meal.

Observation of the lunch meal on 01/15/20 from 12:00pm until 12:30pm revealed:
-At 12:00pm a PCA served Resident #6 his food in a three-compartment plate; he had a pureed ground beef patty with gravy, pureed green beans, pureed egg noodles, a nutritional supplement and nectar thickened water and tea.
-Resident #6 was sitting in his wheelchair at the table and was looking around; the PCA gave him a spoon and cued him to eat and then walked away.
-Resent #6 ate a spoonful of the pureed beef and then put the spoon down; he hung his head down and appeared to fall asleep.
-At 12:18pm Resident #6 was cued to eat by a staff who sat next to him and feed him a spoonful of food.
-Resident #6 told the staff that was assisting him with eating he was not hungry, he felt full and sleepy.
-The staff asked for a cup of yogurt from the kitchen staff and left the table after Resident #6 told them he did not want to eat the yogurt.
-A PCA brought Resident #6 an opened cup of yogurt and set it at Resident #6 place setting and

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D 312	Continued From page 21 walked away. -At 12:24pm the PCA returned to the table and sat next to Resident #6 and assisted him with eating the yogurt; Resident #6 ate 100% of the yogurt. Interview with the PCA on 01/15/20 at 12:29pm revealed: -She had not assisted Resident #6 with eating before because he usually ate 100% of his food; he was eating well about two weeks ago. -Resident #6 ate his meals on his own without assistance; he fell and broke his hip about two weeks ago and had not eaten as much since he returned from the hospital. -Resident #6 would refuse assistance if anyone [staff] asked to assist him with eating; she did not know why he let her assist him that day. Interview with a second PCA on 01/16/20 at 9:33am revealed: -She assisted residents in the dining room during meal service; Resident #6 ate on his own and did not need assistance. -Resident #6 was sleepy and had not been eating well for the last few days. -She would ask Resident #6 if he wanted to eat; he would say he just wanted to go back to his room to sleep. -She thought Resident #6's mediation made him sleepy. -Resident #6 did not ask for assistance with eating. -When a resident did not eat, she would notify the medication aide (MA) so the MA could make a note in the resident's record; she had not told the MA Resident #6 was not eating his food because it had only been a couple of days. -She had seen another PCA assisting Resident #6 with eating his food at lunch the day before.	D 312		

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D 312	Continued From page 22 Interview with the MA on 01/15/20 at 10:02am revealed: -She basically walked around the dining room and observed residents to see if they were choking or needed assistance with eating. -Resident #6 usually had a good appetite; he went from a big appetite to no appetite after he fell and had a hospital stay about two weeks ago. -Resident #6 might not have been eating because of pain in his broken hip. -She did not "force" Resident #6 to eat because he was sleepy. -She had not assisted Resident #6 with eating, but she had seen other staff cue him to eat. -Resident #6 drank all his nutritional supplements "pretty good". -She had noted in Resident #6 progress notes when he did not eat his meals. Interview with Resident #6's primary care provider (PCP) on 01/16/20 at 10:35am revealed: -Resident #6 had been in a steady decline since a fall on 12/27/19 which resulted in a fracture. -Resident #6's medication could make him sleepy and decrease his appetite; facility staff should have served Resident #6 his meals at times where he was more alert and able to eat and encouraged him to eat. Interview with the Administrator on 01/16/20 at 11:00am revealed: -Staff encouraged residents to eat at meal times and to eat in the dining room; a resident should never have left the dining room without eating. -Residents could eat in their rooms if they were not well enough to come to the dining room or their plates were saved until they were able to eat. -Resident #6 had a fall without injuries on	D 312		

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D 312	Continued From page 23 01/13/20 and was sent out to the hospital; he had not eaten well after he returned from the hospital. -Before Resident #6's last fall he would eat 80% to 100% of his meal; now he does not want to eat. -She expected the MAs to make notes in the resident's progress notes when they did not eat. -Resident #6 did not want anyone to assist him with eating; he would say he was not hungry or just said "no". -She notified the PCP after a "day or so" if a resident was not eating meals; she had not notified Resident #6's PCP that he was not eating his meals because it had just been a day since Resident #6 had not been eating. Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable. B. Observation of the lunch meal in the memory care unit (MCU) female dining room on 01/14/20 from 12:00pm to 1:10pm revealed: -There were 14 residents who were served a lunch meal service. -There were two personal care aides (PCA) present in the dining room. -Four of fourteen meals served were chopped. -Ten of the fourteen meals served contained a piece of ham that was approximately 3.5 inches by 5 inches. -Two residents used their hands to tear the ham into bite-size pieces. -Five residents picked the whole piece of ham up with their hands and took bites out of the ham. -One resident tried to pick her whole piece of ham up on her fork and dropped it in her lap. -One resident had a knife and was cutting her ham into bite-size pieces. -At 1:01pm, the Memory Care Manager (MCM) walked into the dining room and noted a resident	D 312		

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D 312	Continued From page 24 had eaten everything in her plate but her ham. -The MCM cut the ham into bite size pieces, and the resident began to eat her ham. -The residents ate 100% of the ham served. -No other staff offered to cut the residents ham into bite size pieces. Observation of the lunch meal in the MCU female dining room on 01/15/20 from 11:55am to 12:30pm revealed: -There were 15 residents who were served a lunch meal service. -There were two PCAs present in the dining room. -Four of fifteen meals served were chopped. -Eleven of the fourteen meals served contained a piece of beef patty that was topped with melted cheese; the patty was approximately 3.5 inches in diameter. -A resident ' s silverware was in a small white paper bag beside her plate; the resident began to eat pasta with her hands. -When it was pointed out the resident needed her silverware, the medication aide (MA) stated "these people eat with their hands." -When it was pointed out the resident was observed at two previous meals using a fork to eat her food, a PCA removed the silverware from the bag and gave a fork to the resident; the resident ate 100% of her meal using a fork. -Two residents used their forks to cut the beef patty into bite size pieces. -Seven residents picked the beef patty with their hands and were taking bites out of the patty. -One resident used her fork to pick the entire beef patty up and was taking bites off the patty. -At 12:23pm, the last resident to complete her meal tried to pick her entire beef patty up with her fork, a PCA asked her if she would like the beef patty to be cut up and cut the patty into bite size	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R 01/16/2020

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D 312	Continued From page 25	D 312		

pieces; the resident did not eat any of her beef patty.
-Fourteen of the fifteen residents ate 100% of the beef patty served.
-No other staff offered to cut the residents beef patty into bite size pieces.

Interview with a resident on 01/15/20 at 12:36pm revealed:
-There were a lot of residents who needed help in the dining room.
-She sometimes tried to help other residents with their meals.
-She has had to stop staff before and asked them to help residents.
-She did not want a resident to choke on their food or to lose weight because they were not eating.

Interview with a PCA on 01/15/20 at 2:57pm revealed:
-At meal times she made sure all the residents had silverware and beverages.
-She passed out plated food and observed the residents to make sure no one needed assistance.
-If a resident ' s meat was not tender enough, she would cut up the meat if the resident was not eating the meat.
-She did not notice any residents not eating their ham or beef patty.
-If she had noticed, she would have assisted the residents cut their meat.
-Some residents did not want assistance and would become agitated.
-She thought if the residents were eating it was better to leave them alone than to take a chance to agitate the residents.

Interview with a second PCA on 01/15/20 at

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D 312	Continued From page 26 3:01pm revealed: -At meals times she passed out plated food, silverware and beverages. -She was constantly looking to see if a resident was having a hard time. -She watched to see if any residents were having a hard time getting their food onto their forks. -Some residents did not use silverware to eat their food and used their hands. -If she saw someone needed assistance with cutting their meat, she would cut the meat up; if anyone needed assistance with cutting their ham or beef patty, she must have not seen it. Interview with the MCM on 01/15/20 at 3:21pm revealed: -She made rounds in the dining room daily. -She had not noticed any problems with staff not assisting residents. -She expected the PCAs to walk around the dining room to see who needed assistance. -If someone was not eating, that usually ate really well, she would expect staff to assist. -She would expect staff to cut up residents ' meats if someone needed assistance. -If staff saw someone picking up their whole piece of meat, she would expect the staff to cut it up into bite size pieces. Interview with the Administrator on 01/15/20 at 3:21pm revealed: -She made rounds in the MCU dining room at least one meal per day. -She expected staff to always be available to help if a resident needed assistance. -She expected staff to take silverware out of the package, encouraged residents to use silverware, cut up foods that needed to be cut smaller and to wipe residents hands off if the resident was eating with their hands.	D 312		

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D 312	Continued From page 27 -She would have expected staff to cut up food that needed cutting.	D 312		