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 |
|---|---|---|---|
| | HAL031016 | A. BUILDING: ______ B. WING ______ | 05/18/2022 |

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| WALLACE GARDENS | 1052 NE RAILROAD STREET WALLACE, NC 28466 |

| (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 |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey on May 17, 2022 through May 18, 2022. | D 000 | | |
| D 067 | 10A NCAC 13F .0305(h)(4) Physical Environment<br><br>10A NCAC 13F .0305 Physical Environment<br>(h) The requirements for outside entrances and exits are:<br>(4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, interviews, and record reviews the facility failed to ensure 7 of 7 exit doors accessible to residents were armed with a sounding device that activated when opened and allowed residents who were intermittently disoriented and/or known to have wandering behavior to leave the facility without staff knowledge (#5, #6, #7).<br><br>The findings are:<br><br>Observations upon entrance to the facility on | D 067 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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05/17/22 at 8:45am and intermittently throughout the day until 5:30pm revealed:
-There was no audible sounding device when the front/entrance door to the facility was opened.
-The door was unlocked.

Observation of the exit door from the activity room on the North hall of the facility on 05/17/22 at 9:45am and intermittently throughout the day until 5:30pm revealed:
-There was no audible sounding device when the exit door from the activity room on the South hall was opened.
-The door was unlocked.

Observation of the exit door on the North hall of the facility on 05/17/22 at 10:00am and intermittently throughout the day until 5:30pm revealed:
-There was no audible sounding device when the door to the side exit door of the South hall of the facility was opened.
-The door was unlocked.

Observation of the exit door located in the back of the facility on 05/17/22 from 3:00pm until 5:30pm revealed:
-There was no audible sounding device when the exit door was opened.
-The door was unlocked.

Observation of the side exit door of the facility on 05/17/22 at 3:00pm and intermittently throughout the day until 5:30pm revealed:
-There was no audible sounding device when the door was opened.
-The door was unlocked.

Observation of the exit door from the activity room on the South hall of the facility on 05/17/22

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at 3:00pm and intermittently throughout the day until 5:30pm revealed:
-There was no audible sounding device when the exit door from the activity room on the South hall was opened.
-The door was unlocked.

Observations of the exit door at the end of the South Hall on 05/17/22 at 11:30am and 5:30pm revealed:
-The exit door was unlocked.
-There was no sounding device when the door was opened.
-The exit led to a fenced area with an unlocked gate that led tthat opened to the driveway and a two-lane highway in front of the facility.

Observation of the inside front facility entrance on 05/17/22 at 3:17pm revealed:
-The entrance door was not locked and residents could go and come freely.
-There was a door sensor located on the inside top right of the door.
-There was a wired sensor located on the top right inside the door frame.
-The door sensor did not contact the door frame sensor when closed.
-There was no alarm sounding device when the door was opened.
-The Resident Care Coordinator's (RCC) office was located on the right side of the entrance foyer facing the door.

Observation of the nurse's station on 05/17/22 at 3:30pm revealed there was an alarm monitoring box located on the left wall of the nurse's station with a key in the bottom left corner of the box.

Observation of the facility on 05/18/22 at 7:50am revealed:

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-The Resident Care Coordinator (RCC) and surveyor entered through the facility's front door.
-The door was unlocked and an alarm did not sound.

1. Review of Resident #7's current FL-2 dated 01/26/22 revealed:
-Diagnoses included Alzheimer's dementia and psychosis.
-The resident was ambulatory.
-His orientation status was documented as not applicable.

Review of Resident #7's current care plan dated 01/26/22 revealed:
-He had a history of paranoid schizophrenia, dementia, and psychosis.
-He was forgetful, required reminders, and was sometimes disoriented.
-He had history of developmental disabilities and mental illness.
-The resident required staff supervision with ambulation.

Interview with the MA on 05/17/22 at 3:31pm revealed:
-Resident #7 would exit seek but did not wander.
-Resident #7 was ambulatory and walked to the door sitting on the floor beside it.
-Resident #7 looked up and down the halls for an opportunity to leave.
-Resident #7 was easily directed away from the doors.
-Resident #7 had never left the facility independently that she was aware of.

Interview with the Administrator on 05/17/22 at 3:50pm revealed Resident #7 was diagnosed with dementia and staff knew to watch him when he was outside the facility.

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Interview with the Resident Care Coordinator (RCC) on 05/17/22 at 3:57pm revealed:
-Resident #7 was diagnosed with Alzheimer's dementia and required staff to watch him more closely because of dementia.
-About two weeks ago, Resident #7 walked out of the facility into the facility parking lot looking for his car.
-Resident #7 was confused and did not have a car.

Telephone interview with Resident #7's mental health Physician's Assistant on 05/18/22 at 12:28pm revealed:
-Resident #7 was diagnosed with dementia and schizophrenia.
-He had expressive aphasia (a communication disorder that made it difficult to produce speech) and needed monitoring for safety reasons.
-She expected staff to know when the resident exited the facility for overall resident safety.

Based on observations, interviews, and record reviews, Resident #7 was not interviewable.

Refer to the interview with the RCC on 05/17/22 at 3:17pm.

Refer to the interview with the MA on 05/17/22 at 3:31pm.

Refer to the interview with the Administrator on 05/17/22 at 3:50pm.

Refer to a second interview with the RCC on 05/17/22 at 3:57pm.

2. Review of Resident #6's current FL-2 dated 01/02/22 revealed:

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-Diagnosis included bipolar schizoaffective disorder.
-He was verbally abusive and ambulatory.
-His orientation status was documented as not applicable

Review of Resident #6's current care plan dated 01/02/22 revealed:
-He had a history of developmental disabilities and mental illness.
-He was forgetful, required reminders, and was sometimes disoriented.
-He was independent with ambulation.

Interview with the medication aide (MA) on 05/17/22 at 3:31pm revealed:
-Resident #6 wandered to the apartment complex located beside and behind the facility asking for money about one year ago.
-Resident #6 was very confused at times.
-On Sunday, 05/15/22, she was in her car for lunch and saw Resident #6 in the facility parking lot heading to the same apartment complex.
-She backed up and told Resident #6 to go back to the facility porch.
-Resident #6 told her he was just walking.
-She called another MA from her car and told the MA she needed to keep a watch on Resident #6 because she saw him heading to the apartment complex.
-Resident #6 did return to the facility porch.

Interview with the Administrator on 05/17/22 at 3:50pm revealed:
-Resident #6 was confused at times.
-Resident #6 was very aware of his surroundings.
-Resident #6 stood in the parking lot or on the edge of the road and looked at things.
-Resident #6 sat on the porch.
-She did not know Resident #6 was leaving the

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facility for the apartment complex Sunday, 05/15/22.
-The MA probably told the RCC Resident #6 was leaving the facility on Sunday, 05/15/22, and the RCC handled that situation.

Telephone interview with Resident #6's mental health provider on 05/18/22 at 12:25pm revealed:
-Resident #6 had mild cognitive impairment and was diagnosed with schizophrenia.
-She expected staff to know when the resident exited the facility for overall resident safety.

Interview with the Resident Care Coordinator (RCC) on 05/17/22 at 3:57pm revealed:
-Resident #6 was confused and easily agitated at times.
-She saw Resident #6 from her home located behind the facility on Sunday, 05/15/22, at about 8:00am, walking in the facility driveway.
-She walked on her front porch, called Resident #6's name, and the resident turned around and walked back to the facility.
-She called facility staff to tell them Resident #6 was outside, staff went out the side door of the facility, and redirected the resident back inside.
-About two to three years ago, Resident #6 had a history of leaving the facility and walking around the town.
-At that time, the police would see Resident #6 in the community and return him to the facility.
-She did not know Resident #6 was walking towards the apartment complex around lunch on 05/15/22.

Based on observations, interviews, and record reviews, Resident #6 was not interviewable.

Refer to the interview with the RCC on 05/17/22 at 3:17pm.

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| D 067 | Continued From page 7<br><br>Refer to the interview with the MA on 05/17/22 at 3:31pm.<br><br>Refer to the interview with the Administrator on 05/17/22 at 3:50pm.<br><br>Refer to a second interview with the RCC on 05/17/22 at 3:57pm.<br><br>3. Review of Resident #5's current FL-2 dated 04/01/22 revealed:<br>-Diagnosis included cognitive impairment.<br>-He was ambulatory.<br><br>Review of Resident #5's current care plan dated 02/02/22 revealed he was forgetful, required reminders, and was sometimes disoriented.<br><br>Observations of Resident #5 on 05/17/22 at 10:15am revealed:<br>-The resident was walking along the distal paved parking area in front of the facility.<br>-The resident rounded the corner of the parking area and began to walk along the side of the driveway.<br>-The resident continued to walk along the driveway that headed toward a two-lane highway until he was approximately halfway down the driveway.<br>-The resident turned around and began to walk back toward the facility parking area along the distal side of the driveway.<br><br>Interview with a resident seated on the porch on 05/17/22 at 10:15am revealed:<br>-Resident #5 was a "walker".<br>-He had never known Resident #5 to walk to the highway, and Resident #5 did not leave the parking/driveway. | D 067 | | |

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Observation of the Medication Aide (MA) working on the South Hall on 05/17/22 at 10:18am revealed she went to the unlocked and unalarmed activity room door and called Resident #5 by name. The resident continued to walk in the parking/driveway.

Interview with the Medication Aide (MA) on 05/17/22 at 10:18am revealed she was going to the office to notify the Administrator that Resident #5 was walking in the parking/driveway in front of the facility and toward the two-lane highway.

Observation of Resident #5 on 05/17/22 at 10:21am revealed he walked toward the facility with a staff walking alongside the resident.

Review of Resident #5's facility progress note dated 04/14/22 revealed:
-His walks must be monitored daily because Resident #5 walked to the highway in front of the facility and turned back around and walked to the facility.
-The resident did not look to see if traffic was coming and going.
-The facility staff banned together to redirect Resident #5 from walking to the highway.
-Resident #5 was administered an as-needed medication to treat anxiety.
-The Resident Care Coordinator (RCC) called Resident #5's family member to speak to the resident.
-The RCC wrote the progress note.

Telephone interview with Resident #5's psychiatric provider on 05/18/22 at 11:51am revealed:
-She could not determine if Resident #5 was safe to walk outside of the facility on his own due to his

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mental illness.
-Some days Resident #5 would be ok to walk outside by himself but if he experienced hallucinations or hearing voices. he would not be safe to walk outside of the facility on his own.

Interview with the Resident Care Coordinator on 05/17/22 at 3:20pm revealed:
-Resident #5 walked to the highway in front of the facility on 04/14/22.
-The resident did not walk across the highway.
-She redirected Resident #5 back to the facility because she did not think the resident knew how close he was to the highway.
-The MA administered Resident #5 his as-needed medication for anxiety.
-Resident #5 constantly walked inside and around the facility.
-She directed the facility staff to keep a closer watch on Resident #5 because he walked so much.
-On 05/17/22, other facility residents notified her that Resident #5 had walked toward the highway.
-She redirected Resident #5 back into the facility because he had walked toward the highway.

Based on observations, interviews, and record reviews, Resident #5 was not interviewable.

Refer to the interview with the RCC on 05/17/22 at 3:17pm.

Refer to the interview with the MA on 05/17/22 at 3:31pm.

Refer to the interview with the Administrator on 05/17/22 at 3:50pm.

Refer to a second interview with the RCC on 05/17/22 at 3:57pm.

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Interview with the RCC on 05/17/22 at 3:17pm revealed:
-The sensor on the door and door frame was a wired alarm sensor.
-Some residents may wake confused in the middle of the night and walk outside the facility into the road.
-The facility did not have residents who wandered.
-Her office was located beside the front entrance door and she could monitor to door for who entered and exited.
-The residents were only allowed to enter and exit throught the activity room doors.
-All door alarms were turned on every night by third shift (11:00pm - 7:00am) staff to keep the residents safe from walking into the road should any resident wake confused because management staff was not in the facility at night.
-All doors were locked every night at around 8:30pm to keep strangers from walking into the facility.
-The front door was unlocked and disarmed around 6:30am every day by first shift staff because there was more staff during the day.
-The remainder of the facility doors were unlocked and disarmed between 8:30am and 9:00am daily by her or the medication aides (MA).
-There was an alarm box located at the nurse's station that would alert when doors were opened when armed.

Interview with the MA on 05/17/22 at 3:31pm revealed:
-The box on the left wall of the nurse's station was the facility alarm box.
-She locked all the doors at 9:00pm when she staffed so strangers would not enter the facility.
-Between 10:30pm to 11:00pm, the third shift

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| D 067 | Continued From page 11<br>personal care aide (PCA) turned the key located on the bottom left of the box to arm all the doors.<br>-The doors would signal a sounding device at the alarm box located at the nurse's desk when armed and opened.<br>-Two residents residing in the facility wandered.<br>-One of the residents who wandered was confused and confined to a wheelchair but could stand.<br>-That resident would go outside occasionally but did not go to the road.<br>-Residents were only allowed to enter and exit the two activity room doors located on the end of both hallways which exited onto the front porches of the facility.<br>-She was not worried about the doors not being armed or residents leaving the facility because staff were frequently on the hall providing resident care and could monitor the doors.<br>-She was trained about one year ago by a third shift PCA on the facility door alarm and locking process.<br><br>Interview with the Administrator on 05/17/22 at 3:50pm revealed:<br>-Across the street from the facility was a car recycling center.<br>-Residents were not allowed to leave the facility or go to the apartment complex.<br>-Staff were supposed to call a Code Red when they saw a resident leaving the facility.<br>-A Code Red signaled all staff to stop what they were doing and respond to the resident in an attempt to redirect the resident back to the facility.<br>-Staff were to call the RCC or Administrator when a resident was seen leaving the facility so the RCC or Administrator could go to the facility to assist.<br>-The RCC resided directly behind the facility.<br>-The doors were armed between 7:30pm to | D 067 | | |

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8:00pm nightly to alert staff if residents tried to leave the building.
-The doors were disarmed by her or the RCC around 8:00am every day because she and the RCC were in the building.
-She thought there were six doors in the facility and residents had access to five of them.
-She educated staff to watch any resident who had a dementia diagnosis and was not their normal baseline.

A second interview with the RCC on 05/17/22 at 3:57pm revealed:
-There were no residents in the facility who wandered.
-She expected staff to redirect any resident observed walking towards the road or apartment complex, the PCA would tell the MA, and the MA would tell her immediately.
-She was available to the staff 24 hours a day 7 days a week.
-The facility did not constantly alarm the doors because they were not a Special Care Unit (SCU).

A second interview with the Administrator on 05/17/22 at 4:25pm revealed she did not think there were residents in the facility who had to be monitored to the point of constantly alarming the doors to alert staff if the residents chose to walk outside.

______________________

The facility failed to ensure the exit doors door on the assisted living unit were equipped with a sounding device and resulted in 3 residents who were disoriented exiting the building without the staff's knowledge (Resident #5, #6, #7), including Resident #7 who was diagnosed with dementia and left the facility without staff knowledge to look for his car.  This failure resulted in substantial risk

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| D 067 | Continued From page 13<br>for serious physical harm or death to the residents and constitutes a Type A2 violation.<br>______________________<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on May 17, 2022, for this violation.<br><br>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 18, 2022. | D 067 | | |
| D 269 | 10A NCAC 13F .0901(a) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews the facility failed to provide personal care according to the care plan and assessed needs for 1 of 5 residents sampled (#1) relating to indwelling urinary catheter care (#1).<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 02/02/22 revealed:<br>-Diagnoses included hypertension and schizophrenia.<br>-She was incontinent of bladder and bowel. | D 269 | | |

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Review of Resident #1's current care plan dated 02/02/22 revealed:
-She was forgetful, needed reminders, sometimes disoriented, and used a wheelchair for mobility.
-She was totally dependent on staff for bathing, dressing, toileting, and transfers.

Observation of Resident #1 on 05/18/22 at 10:45am revealed:
-Resident #1 was sitting in her room in a wheelchair.
-The resident's urinary catheter bag was hanging below her bladder on the wheelchair.
-The personal care aide (PCA) removed the urinary catheter bag from the wheelchair and dropped it on the floor, under the front of the wheelchair.
-The PCA pushed the wheelchair to the bedside.
-The PCA picked up Resident #1's urinary catheter bag and laid it in the resident's lap.
-Two PCAs assisted Resident #1 to stand from the wheelchair.
-Resident #1's urinary drainage bag fell from the resident's lap onto the floor in front of the wheelchair between the resident's legs.
-The two PCA's assisted Resident #1 to turn and pivot to the bed.
-Resident #1's urinary tubing was pulled up the resident's buttocks, out the back of the resident's waist band of her pants, between the seat and back of the wheelchair, under the seat, while the urinary drainage bag was on the floor.
-Resident #1's urinary catheter tubing was pulled tight without slack and the two PCA's transferred the resident to the bed.
-The first PCA picked the urinary drainage bag up from the floor, under the wheelchair seat, between the seat and back of the wheelchair and held it up approximately two feet over the resident

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who laid in bed.
-There was 600ml of cloudy yellow urine in the bag and urine with sediment in the tubing.
-The second PCA retrieved a urinal from Resident #1's bathroom and held it under the urinary drainage bag.
-The first PCA pulled the drainage spout from the clip of the urinary drainage bag and inserted it inside the urinal.
-The first PCA unclamped the drainage spout and drained the urinary drainage bag while holding it above the resident laying on the bed.
-The first PCA tapped the drainage spout on the inside of the urinal as the urine dripped from the spout.
-The first PCA clamped the urine drainage spout closed and placed it back in the holding device on the bag.
-Both PCAs pulled down Resident #1's pants and incontinent brief.
-The first PCA repositioned Resident #1's urinary catheter tubing and bag.
-Both PCAs pulled up Resident #1's incontinent brief and pants.
-The PCAs did not clean Resident #1's urinary catheter tubing or perineal area.

Interview with the first PCA on 05/18/22 at 10:48am revealed:
-Third shift staff dressed Resident #1 this morning, 05/18/22, prior to her arriving at work for first shift at 7:00am.
-This was the first time today she had performed incontinent checks or emptied Resident #1's urinary catheter drainage bag since arriving for work at 7:00am today, 05/18/22.
-She performed incontinent checks every two hours.
-She checked urinary catheter bags once a shift to ensure they were draining.

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-She emptied urinary catheter bags twice a shift.
-She had not received catheter care training from the facility since beginning work about one year ago.
-She knew how to perform catheter care because of her PCA experience.

Interview with the second PCA on 05/18/22 at 10:50am revealed she had not received catheter care training since starting work at the facility one month ago.

Interview with the Administrator on 05/18/22 at 10:00am revealed:
-It was the Resident Care Coordinator's (RCC) responsibility to train staff on catheter care.
-She knew the RCC was performing catheter care training to staff because she observed the training two months ago.
-She expected staff to clean urinary catheter tubing with water and a washcloth each time incontinent checks were performed or when emptying the urinary catheter drainage bag.
-She expected staff to wash the perineal area with soap and water each time incontinent care was performed, or urinary catheter bags were emptied to decrease the chance of urinary tract infections.
-She did not know how a urinary catheter bag was supposed to be positioned.

Interview with the RCC on 05/18/22 at 11:36am revealed:
-Staff were to position urinary catheter bags below the residents' bladder to prevent backflow of urine into the bladder.
-Urinary catheter bags were not to be placed on the floor because of risk for contamination.
-Staff were not to touch the urinary drainage spout on anything when draining the bag because

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of risk for contamination.
-Catheter training was last performed by the Licensed Health Professional Support (LHPS) nurse one year ago.
-The first PCA who drained Resident #1's urinary catheter bag should have known how to perform correct catheter care because she had worked at a skilled facility in the past and was trained on catheter care when hired at the facility one year ago .

Interview with the LHPS nurse on 05/18/22 at 1:04pm revealed:
-She had not performed catheter care training for staff since she began working at the facility almost one year ago.
-Staff were not to lay urinary drainage bags on the floor or touch the drainage spout to anything because of a risk for contamination.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

D 282 — 10A NCAC 13F .0904(a)(1) Nutrition and Food Service — D 282

10A NCAC 13F .0904 Nutrition and Food Service
(a) Food Procurement and Safety in Adult Care Homes:
(1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.

This Rule is not met as evidenced by:
Based on observations and interviews the facility failed to ensure the kitchen was clean and

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protected from contamination related to flies in the kitchen and pantry, not wearing gloves when preparing a thickened beverage, touching resident food with contaminated gloves, and not wearing a hairnet during meal preparation.

The findings are:

a. Observations of the pantry on 05/17/22 at 11:40am revealed:
-There were three flies flying in the pantry.
-There were seven dead flies on the pantry floor.

Observations of the kitchen on 05/17/22 from 12:26pm to 12:45pm revealed:
-The cook was preparing lunch.
-There was a basket of fried chicken tenders propped over the deep fryer.
-There were two flies flying over the basket of chicken tenders and three flies on the wall to the right and behind the basket of chicken.
-There was a garbage can directly beside the prep bar with several flies swarming over the garbage can.
-The Administrator draped an unfolded garbage bag over the top of the garbage can.
-There was a fly crawling on a pair of scissors laying on the prep bar between a pan of cornbread and the garbage can.
-There was a fly crawling on the lid and the rim of a pitcher of tea prepared for residents located beside the hot bar.
-The cook prepared 14 resident plates with food and placed them uncovered, on the serving bar.
-Flies swarmed over the uncovered plates.
-The Administrator tore long paper towels from the dispenser and draped them on top of the residents plates.
-The paper towels did not entirely cover the plates.

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-Flies landed on top of the paper towels that covered the plates.
-The cook cut two chicken tenders with the scissors the fly was crawling on without washing the scissors.

Interview with the cook on 05/17/22 at 12:01pm revealed:
-Flies enter the dining room and kitchen when the dining room doors were open to allow residents in for meals.
-She sprayed a flying insect killer in the air of the kitchen, dining room, and pantry after residents ate their meals and left the dining room daily.
-The flying insect killer would not kill all the flies.

Interview with the Administrator on 05/17/22 at 12:47pm revealed:
-She called the facility's contracted pest control company one week ago and told them of the fly problem.
-The facility's pest control representative told her to use a fly bait around the outside of the facility.
-She was waiting for the pest control representative to contact her with a plan to control the flies.
-She covered all surfaces in the kitchen with sheets and sprayed flying insect repellant in the air to treat the files.
-After the droplets fell, she would clean all the kitchen surfaces.
-She covered the prepared resident plates with a single long paper towel to protect the resident's food from flies during the lunch meal service on 05/18/22.

Telephone interview with the facility's contracted pest control company's secretary on 05/18/22 at 8:11am revealed:
-The pest control technician was last at the facility

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on 04/22/22 for a general pest control visit that did not include flies.
-The service visit note dated 04/22/22 documented there were gaps in the facility doors which could allow flies and other flying insects entrance in the facility.
-The gaps in the facility doors had been documented on several visits.
-The facility did not have a flying insect control contract, which would be in addition to their general services.
-The first time the Administrator spoke with the pest control company regarding flies and a flying insect contract was on 05/17/22.
-On 05/17/22, the Administrator called the pest control company to schedule a fly treatment for the facility.

Telephone interview with the facility's contracted pest control technician on 05/18/22 at 10:19am revealed:
-There was a door located in the rear of the facility to the right of the kitchen that had a big gap which created issues with pests entering the facility since February 2022.
-Flies and other flying insects could enter the facility through that gap and had been a problem for the facility since February 2022.
-He told the Administrator about the door gap and the fly problem in February 2022.
-The Administrator did not repair the door or pursue a fly control service.
-The facility asked him for flying insect killer spray during his visits.
-He did not provide the facility with flying insect killer spray because the droplets could land on food and food products which was not safe for the residents.
-The Administrator called him on 05/17/22 requesting a fly control service.

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-The facility did not have a fly control service until 05/17/22 when the Administrator called.

b. Observation of the kitchen on 05/17/22 at 1:14pm revealed:
-The Resident Care Coordinator (RCC) placed her hand into a thickening powder four times as she prepared a thickened beverage for a resident with ungloved hands and without a hair net.
-The RCC's hands touched the inside rim of the container.

Interview with the RCC on 05/17/22 at 5:56pm revealed:
-She prepared a resident's thickened liquid today to help the cook.
-She washed her hands prior to placing them into the thickening powder container.
-She did don a hair net when entered the kitchen during lunch service on 05/17/22.

Interview with the Administrator on 05/18/22 at 10:00am revealed:
-She expected any staff preparing meals or beverages for residents to wear gloves to protect the food from contamination.
-She expected the RCC to have worn gloves prior to preparing a thickened beverage for a resident because her hands could become contaminated before she prepared the beverage.
-She expected any staff in the kitchen to wear a hair net to protect food from contamination.
-Hair nets were available for all staff in the kitchen.
-She saw the RCC place her ungloved hand in a thickening powder container during lunch service on 05/17/22.
-She did not correct the RCC because the RCC washed her hands when she entered the kitchen and at that time, she did not think it was a risk for

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contamination.

Interview with the RCC on 05/18/22 at 11:36am revealed she should have worn gloves when preparing a thickened beverage for Resident #3 to prevent contamination.

Second observation of the kitchen on 05/17/22 at 5:46pm revealed:
-The RCC entered the kitchen, washed her hands, and donned gloves.
-The RCC did not don a hair net.
-The RCC prepared food for a resident using the blender.
-With gloved hands, the RCC touched a drawer handle, opened the drawer, removed a spoon, touched the sink facet handle, touched the blender and lid twice, held the blender plug with one hand and pressed the blend button on the blender with the other.
-Wearing the same gloves, the RCC placed her hand in the blender, stirred the meat with her gloved hand, scooped the meat from the blender on to the resident's plate and patted the meat with the same gloved hand.

Interview with the RCC on 05/18/22 at 7:55am revealed she prepared the pureed meat on 05/17/22 at 5:46pm for the cook because the cook was nervous.

Interview with the Administrator on 05/18/22 at 10:00am revealed:
-She expected the RCC to have used a spoon to plate the resident's food instead of a gloved hand because she had touched other surfaces and was at risk for contaminating the food.

Interview with the RCC on 05/18/22 at 11:36am revealed she should have used a spoon to touch

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| D 282 | Continued From page 23<br>Resident #3's food instead of her gloved hand. | D 282 | | |
| D 310 | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were prepared as ordered for 2 of 5 resident sampled (#1, #3) who had orders for pureed meats (#3) and nutritional supplements (#1).<br><br>The findings are:<br><br>1. Review of Resident #3's current FL-2 dated 03/16/22 revealed:<br>-Diagnoses included cerebrovascular disease, left hemiplegia, and dementia without behavior disturbance.<br>-There was an order for a regular diet with nectar thick liquids and pureed meats.<br><br>Review of Resident #3's care plan dated 04/01/22 revealed Resident #3 required total assistance with eating.<br><br>Review of a diet order for Resident #3 dated 03/29/22 revealed nectar thickened liquids were | D 310 | | |

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ordered due to dysphagia.

Review of a diet list on 05/17/22 at 11:42am posted in the kitchen, and dated 2022, revealed pureed meats was documented beside Resident #3's name.

Review of a modified diet list dated 03/24/09, on 05/17/22 at 11:43am, posted in the kitchen revealed instructions for preparing a pureed diet.
-The food should be smooth with no lumps, yet cohesive, and resemble pudding.

Observation of the kitchen on 05/17/22 at 1:10pm revealed:
-The cook placed three fried chicken tenders in a blender.
-The cook blended the chicken tenders to a dry, crumble texture.
-The cook did not add liquid to the crumbled chicken.
-The cook placed the crumbled chicken onto Resident #3's plate.
-Resident #3's chicken was not of puree consistency.
-The Resident Care Coordinator (RCC) exited the kitchen with Resident #3's plate in her hand that contained the dry, crumbled chicken.

Observation of Resident #3 on 05/17/22 at 1:30pm revealed:
-Resident #3 was in his room sitting up in bed and the RCC sat beside the resident with his plate of food on a tray.
-The RCC placed a spoon of the dry, crumbled chicken in Resident #3's mouth.
-Resident #3 chewed and swallowed the chicken.
-The personal care aide (PCA) entered the room and gave the RCC a container of strawberry banana flavored yogurt.

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-The RCC scooped the dry, crumbled chicken and then some yogurt on the spoon and fed to Resident #3.
-Resident #3 did not cough or choke while chewing and swallowing the chicken.

Interview with the cook on 05/17/22 at 1:38pm revealed:
-She was trained in July 2021 by the previous kitchen manager to puree foods by placing the food items in the blender without adding anything to create a creamy texture.
-She had not received additional training at the facility since July 2021.

Interview with the Administrator on 05/17/22 at 1:40pm revealed:
-The facility did not currently have a kitchen manager.
-She thought pureed foods was of a soft consistency.
-Resident #3's chicken was to be blended until soft in order to meet the pureed consistency.
-The RCC was responsible to ensure kitchen staff knew how to prepare a pureed diet.

Interview with the RCC on 05/17/22 at 1:45pm revealed:
-Pureed foods were not dry.
-Resident #3's chicken just looked dry and hard when pureed because it was fried.
-She fed Resident #3 the crumbled chicken during the lunch service on 05/17/22.
-When she realized Resident #3's chicken was not pureed, she asked the PCA to bring her a pudding to mix with the resident's chicken.
-She then mixed Resident #3's chicken with pudding to give it a pureed texture.
-Resident #3 did not have problems eating the crumbled chicken or chicken mixed with pudding.

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-The cook could have added water to Resident #3's chicken when in the blender to make it a consistency to prevent the resident from choking when eating.

A second observation of the kitchen on 05/17/22 at 5:56pm revealed:
-The RCC placed six thin slices of turkey in the blender.
-The RCC added water to the turkey and blended.
-The RCC placed the blended turkey slices on Resident #3's plate in preparation to serve the resident.
-The meat consistency was moist with chunks.
-When prompted, the RCC placed the blended turkey back in the blender, added more water, and blended again.
-The meat consistency was moist with chunks.
-The RCC placed the moist meat with sliced chunks on Resident #3's plate.

A second interview with the RCC on 05/17/22 at 6:00pm revealed:
-The turkey slices were blended until puree consistency prior to being prompted during dinner preparation on 05/17/22.
-Resident #3 did not like his meat to be of liquid texture.

Telephone interview with a dietician for the facility's contracted food distributor on 05/18/22 at 9:42am revealed pureed foods should be served a little thinner than mashed potatoes, the texture was smooth, not granulated, and not a liquid consistency.

Interview with the Administrator on 05/18/22 at 10:00am revealed:
-It was her overall responsibility for the past five

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| D 310 | Continued From page 27<br>months to ensure dietary staff prepared and served therapeutic diets as ordered.<br>-She realized Resident #3's chicken served during the lunch meal on 05/17/22 was not pureed when she saw the RCC taking the meal to the resident in his room.<br>-She stopped the RCC and told her at that time Resident #3's chicken was not of pureed consistency.<br>-The RCC told her she was going to use pudding to mix with Resident #1's chicken as she fed the resident.<br>-It was the responsibility of the RCC to train dietary staff on how to prepare therapeutic diets.<br>-She did not answer when asked what dietary training the RCC had received.<br><br>Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.<br><br>Refer to telephone interview with a dietician for the facility's contracted food distributor on 05/18/22 at 9:42am.<br><br>Refer to interview with the Administrator on 05/18/22 at 10:00am.<br><br>2. Review of Resident #1's current FL-2 dated 02/02/22 revealed:<br>-Diagnoses included hypertension, osteoarthritis, and schizophrenia.<br>-The resident was dependent upon staff for feeding and was semi-ambulatory.<br>-There was an order for a nutritional supplement drink three times daily with meals.<br><br>Review of an undated nutritional supplement list on 05/17/22 at 11:42am posted in the kitchen revealed Resident #1 was to have nutritional | D 310 | | |

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supplement three times daily with meals.

Observation of Resident #1 on 05/17/22 at 1:15pm during lunch service revealed:
-The resident was in a wheelchair located in the dining room eating lunch.
-The resident was served two chicken tenders, corn bread, macaroni and cheese, spinach, strawberry banana yogurt, sweat tea, and water.
-She was not served a nutritional supplement drink.

Interview with the cook on 05/18/22 at 9:38am revealed:
-She thought she served Resident #1 a nutritional supplement drink with her lunch meal on 05/17/22.
-Sometimes Resident #1 would place things in her pockets.
-Maybe Resident #1 placed her nutritional supplement drink served with lunch on 05/17/22 in her pocket.

Observation of Resident #1 on 05/18/22 at 9:25am during breakfast service revealed:
-The resident was in a wheelchair located in the dining room eating breakfast.
-She was served grits, eggs, sausage links, water, and juice.
-She was not served a nutritional supplement drink.

Interview with the dietary aide on 05/18/22 at 9:30am revealed:
-She knew which residents were to be served nutritional supplement drinks because of repetition in serving the residents.
-There was also a dietary book located in the kitchen that contained diet orders.
-She forgot to serve Resident #1 her ordered

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nutritional supplement drink with her breakfast meal this morning, 05/18/22.

Telephone interview with a dietician for the facility's contracted food distributor on 05/18/22 at 9:42am revealed:
-Nutritional supplements were ordered for resident who needed increased protein or calories, had chewing problems, or did not eat well.

Interview with the Administrator on 05/18/22 at 10:00am revealed:
-It was her overall responsibility for the past five months to ensure dietary staff prepared and served nutritional supplements as ordered.
-She thought the diet order sheets had a place for the provider to check for nutritional supplements.
-She thought all residents who were ordered nutritional supplements received them during the random meal observation on 05/17/22.

Interview with the Resident Care Coordinator (RCC) on 05/18/22 at 11:36am revealed:
-Resident #1's nutritional supplement order was on the current FL-2 dated 02/02/22.
-She made a mistake by not including the nutritional shake order on the diet order posted in the kitchen.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

Refer to telephone interview with a dietician for the facility's contracted food distributor on 05/18/22 at 9:42am.

Refer to interview with the Administrator on 05/18/22 at 10:00am.

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Telephone interview with a dietician for the facility's contracted food distributor on 05/18/22 at 9:42am revealed:
-She was not the facility's dietician.
-She provided menus for the facility as a service for the facility's contracted food distributor.
-She was available to provide therapeutic diet training for the facility if requested.
-She had not provided dietary training for the facility since prior to the COVID-19 epidemic.
-She had not been asked by the facility to provide therapeutic diet training since the COVID-19 epidemic.

Interview with the Administrator on 05/18/22 at 10:00am revealed:
-The facility had not had a dietary manager for five months.
-The RCC was responsible for updating dietary staff when diet orders changed.
-She and the RCC did random meal observations to ensure diets were served as ordered.
-There had not been dietician training for the dietary staff since before the COVID-19 epidemic.
-It was the responsibility of the RCC to give the dietary staff diet order sheets.

D912 — G.S. 131D-21(2) Declaration of Residents' Rights — D912

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:

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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 related to physical environment.

The findings are:

1. Based on observations, interviews, and record reviews the facility failed to ensure 7 of 7 exit doors accessible to residents were armed with a sounding device that activated when opened and allowed residents who were intermittently disoriented and/or known to have wandering behavior to leave the facility without staff knowledge (#5, #6, #7).. [Refer to Tag 0067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type A2 Violation).]