STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060148	A. BUILDING: _____ B. WING _____	06/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTONWOOD COTSWOLD	5215 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an Annual Survey on June 6-8, 2018 with an exit conference via telephone on June 11, 2018.	D 000	D269 and D273: Waltonwood Cotswold will assure personal care and supervision according to the resident care plan. The Wellness Coordinators will review the Residents Care Plans with the Resident Care staff on a daily basis during daily line ups and on an ongoing basis to assure the Care Plans are being followed consistently and updated accordingly. The Wellness Coordinator and Culinary Service Manager conducted Therapuetic Diet trainings on 6/8 with all Culinary and Resident Care staff. All Culinary associates were re-trained using the North Carolina Food Orientation Manual by June 18th. By consistently reviewing the care plan with front line staff and monitoring the care plan for updates and accuracies the community will prevent this from happening again. This will be monitored by the Resident Care Manager, Executive Director and Wellness Coordinator. All deficiencies were corrected by June 18, 2018.	
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide cueing and reminders to 1 of 5 residents, (#3) according to the needs identified on the care plan. The findings are: Review of Resident #3's current FL2 dated 02/27/18 revealed: -Diagnoses included Parkinson's disease, dementia, dysphagia, and aspiration pneumonia. -Resident #3 was to receive minimum assistance with eating. -A physician's order for a dysphagia mechanical altered and nectar thickened liquids. Review of Resident #3's Care Plan dated 06/05/18 revealed: -This Care Plan was documented as a change of	D 269		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Leah Nash — TITLE: Executive Director — (X6) DATE: 7/3/2018

jeanne S Robinson RN

Reviewed and acknowledged addendum attached 7/191/8

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D 269	Continued From page 1 condition. -Resident #3 required limited assistance with meals. -A diet was documented at a mechanical soft with nectar thickened liquids. -A goal was documented to maintain diet consistency as ordered by the physician. -Resident #3 required limited reminders and cueing assistance during the meals. Interview with Resident #3's family member on 06/06/18 at 11:11 revealed: -Resident #3 was to receive a mechanical soft diet with nectar thickened liquids. -Resident #3 used to get a pureed diet with nectar thickened liquids until 06/05/18. -The staff did not provide cueing or assistance with Resident #3's meals. -The staff would provide a meal and leave the room and pick up the meal about an hour or so later. -Resident #3 eats in her room by herself the majority of the time and had lost "10 pounds in 2 months" so the family hired a companion to sit with her every day 8am-8pm 7 days a week. -The facility would not provide the "extra" meal assistance. Observation of Resident #3 during the initial tour on 06/06/18 at 11:38am revealed: -Resident #3 was served a regular chopped diet of turkey, green beans, white and sweet potatoes, a glass of tea and water, one frozen dietary supplement and a bottle of dietary supplement shake with a straw in each drink. -The medication aide (MA) brought in Residents #3's meal, uncovered the food and left the room. -Resident #3 took a spoon full bite of the turkey, swallowed and began having small gasps of breath, her eyes were wide with fear, and she	D 269		

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D 269	Continued From page 2 could not breathe freely, cough or speak when asked. -Resident #3's family member pressed her call light button. -The MA came to check on Resident #3 who was still having trouble but was able to breathe and swallow. -The Wellness Coordinator (WC) arrived within 2-3 minutes. -Resident #3 was able to state that she "was fine" and her "throat was clear". Interview with Resident #3 on 06/07/18 at 12:29pm revealed: -The staff only set up her food and leaves. -The staff did not come back until 1-2 hours later to retrieve her tray. -She did not received reminders or cues to during her meals. -She eats alone in her room the majority of the time. Telephone interview with a second family member on 06/06/18 at 12:14pm revealed: -Resident #3 was supposed to get a mechanical soft diet with nectar thickened liquids. -She was the one that requested a new care plan because of the decline in Resident #3. -Resident #3 ate all of her meals in her room because she was embarrassed about the Parkinson's tremors. -She requested someone to be in the room with her and to cue and encourage Resident #3 but was charged an "extra fee" so she hired a companion outside of the facility. Interview with a medication aide (MA) on 06/06/18 at 10:47am revealed: -Resident #3's care plan required a mechanical soft diet with thickened liquids.	D 269		

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D 269	Continued From page 3 -She did not give cues or reminders with Resident #3's meals. -She did not know she was to provide cueing and limited reminders with every meal as documented in resident #3's care plan. -She did not know what Resident #3 was served, was not mechanical soft. Interview with a personal care assistant (PCA) on 06/06/18 at 10:47am revealed: -She followed the "document" version of the care plan. -The document version of the care plan was used as a check off for the staff to follow. It was not the actual care plan. -She took meals to Resident #3, set up the meal and leaves the room. -She would go back in after about an hour to pick up the tray. -She did not assist Resident #3 with meals. -She did not thicken liquids because "we are not allowed". Review of Resident #3's documentation care plan dated June 2018 on 06/06/18 at 10:47am revealed: -It was located at the MA station. -This was not the actual care plan, just for "signing off" the completed tasks. -Resident #3 did not receive assistance with her meals or cueing, reminders or set up of the meals. -Resident #3 received a regular diet at regular consistency. Interview with the Wellness Coordinator (WC) on 06/08/18 at 10:15am revealed: -The care plan was updated for Resident #3 on 06/05/18 because of Resident #3's decline in health from not eating.	D 269		

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D 269	Continued From page 4 -A care plan meeting was held on 06/05/18 along with the Administrator and a family member of Resident #3. -She filled out the care plan. -Instructions were given to the staff re: Resident #3 was to receive all meals were to be set up along with reminders and cueing. Interview with the Administrator on 06/08/18 at 10:29 revealed: -A care plan meeting was held concerning Resident #3 on 06/04/18 and a companion service was discussed. -The facility could not provide feeding assistance on the "Assisted Living" side but could in the "Special Care Unit" and Resident #3 was too "independent". -A companion service would not be provided by the facility but would be able to sit with Resident #3 and keep her company. -She did not know the staff was just dropping off the meal tray, uncovering it and leaving the room. -She expected the staff to uncover and set up all meals.	D 269	D273 The Electronic Medication Administration Record (EMAR) will be monitored daily by the Resident Care Manager and Wellness Coordinators who will pull daily compliance reports from our EMAR to assure all medications are administered correctly and any change will be documented accurately in the EMAR. Refusal of medications will be documented and the physician will be notified according to the Waltonwood Policy regarding medication refusals. This will be monitored by the Resident Care Manager, Executive Director and Wellness Coordinators.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to refer to the physician to ensure the acute health care needs were met	D 273		

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D 273	Continued From page 5 for 3 of 5 sampled residents (Resident #3) with a physician order for mechanical soft diet and nectar thickened liquids and (Resident #5) refusals of medications and (Resident #4) with parameters for notifying the physician taking an anti-diarrheal medication. The findings are: 1. Review of Resident #3's current FL2 dated 02/27/18 revealed: -Diagnoses included Parkinson's disease, dementia, dysphagia, and aspiration pneumonia. -A physician's order for a dysphagia mechanical altered and nectar thickened liquids. Review of Resident #3's Care Plan dated 06/05/18 revealed: -This Care Plan was devised due to a change of condition. -A diet was documented as a mechanical soft with nectar thickened liquids. Review of Resident #3's physician's orders revealed: -There was a physician's order dated 03/15/18 for a pureed diet with nectar thickened liquids, a supplement shake and a frozen dietary supplement. -There was a clarification physician's order dated 03/18/18 for a pureed diet with nectar thickened liquids, nutritional supplements, supplement shake three times a day and a frozen dietary supplement three times a day. -There was a physician's order dated 06/01/18 for a mechanical soft diet with nectar thickened liquids. -There was a physician's order dated 06/06/18 for a pureed diet with nectar thickened liquids.	D 273		

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D 273	Continued From page 6 Observation of Resident #3 during the initial tour on 06/06/18 at 11:38am revealed: -Resident #3 was served a chopped breaded turkey cutlet without gravy, chopped white and sweet potatoes, chopped green beans. -Resident #3 was served nectar thick water and tea along with 1 bottle of a dietary supplement shake (non-thickened) and a frozen dietary supplement. -Resident #3 took a spoon full bite of the turkey, swallowed and began having small gasps of breath, her eyes were wide with fear, and she could not breathe freely, cough or speak when asked. -Resident #3's family member pressed her call light button. -The medication aide (MA) came to check on Resident #3 that was still having trouble but was able to breathe and swallow. -The Wellness Coordinator (WC) arrived within 2-3 minutes. -Resident #3 was able to state that she "was fine" and her "throat was clear". Review of a hospital discharge summary dated 02/28/18 revealed: -Speech therapy recommended a mechanical altered chopped diet with nectar thickened liquids. -An order for a dietary supplement shake nectar thick consistency three times a day. Review of Resident #3's Hospice notes revealed: -On 03/09/18, a diet was documented as a pureed diet with thickened liquids. -On 03/22/18, education was provided to the staff in regard to Resident #3 related to swallowing precautions including; feed Resident #3 only when alert, sitting upright for all meals, provide verbal cueing to swallow, offer small bites or sips	D 273		

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D 273	Continued From page 7 and assure each bit or sips were clear prior to offering the next bit or sip, remain in the upright position for 30 after completion of the meal and to avoid straws. -On 04/24/18, it was documented Resident #3 was on a pureed diet and thickened liquids due to swallowing difficulties from the disease progression. Interview with a MA on 06/06/18 at 12:20pm revealed: -She had worked at the facility for two years. -She knew Resident #3's diet used to be pureed with nectar thickened liquids but it was changed on 06/04/18 to a mechanical soft diet with nectar thickened liquids. -The meal "looked mechanical soft". -She did not notify the physician about Resident #3 receiving the wrong diet or the dietary supplement shake was not thickened as ordered. Telephone interview with Resident #3's Hospice Physician on 06/06/18 at 4:27pm revealed: -Resident #3's diet order was changed from pureed to mechanical soft with nectar thickened liquids at the family's request to help Resident #3 eat better. -He did not know Resident #3 received a chopped diet instead of a mechanical soft diet or Resident #3 choked on the chopped diet. -He ordered nectar thickened liquids because of Resident #3's dysphagia. -The physician expected the facility staff to follow the order as written for a mechanical soft diet with nectar thickened liquids and to notify him with any issues or concerns. Interview with the WC on 06/06/18 at 3:45pm revealed she did not notify the physician Resident #3 was drinking the dietary supplement shake	D 273		

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D 273	Continued From page 8 without thickener. Interview with the Administrator on 06/08/18 at 10:29am revealed: -She did not know Resident #3 meal was prepared incorrectly on 06/06/2018. -She did not know Resident #3's dietary supplement shake was not thickened as ordered. -The MAs and WC were responsible for notifying the physician if the diet was not served as written. 2. Review of Resident #5's current FL2 dated 09/07/17 revealed: -Diagnoses included unspecified displaced fracture of cervical vertebrae, syncope/collapse, anemia, muscle weakness, joint pain, and lack of coordination. -There was a physician's order for megestrol 40mg/mL (used to treat loss of appetite), 20mL daily. Review of Resident #5's April 2018 electronic Medication Administration Record (eMAR) revealed megestrol 40mg/mL was documented as refused 18 times. Review of Resident #5's May 2018 eMAR revealed megestrol 40mg/mL was documented as refused 13 times. Review of Resident #5's June 2018 eMAR revealed megestrol 40mg/mL was documented as refused 6 times. Review of Resident #5's progress notes revealed no documentation that the PCP had been notified of Resident #5's medication refusal. Interview on 06/08/18 at 12:00pm with Resident #5 revealed:	D 273		

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D 273	Continued From page 9 -She did not like the taste of megestrol, "sometimes I take it and sometimes I don't". -She did not know why she was prescribed megetrol. -She felt that she had a good appetite and eats when she is hungry. -She did not know if she had experienced any changes in her weight. -She had not discussed megestrol with her physician. Interview on 06/07/18 at 11:30am with a Medication Aide (MA) revealed: -Resident #5 often refused megestrol and she recorded the refusals on the eMAR. -Resident #5 "has her days when she will just refuse megestrol" -She thought Resident #5's physician was aware that resident refused megetrol at times. -She had not notified Resident #5's physician, "he is able to see the eMAR". -She notified the Resident Care Coordinator (RCC) and Wellness Director (WD) that Resident #5 had refused megestrol but could not remember the date. Review of the facility medication refusal policy revealed: -If the resident refused a medication it should be documented on the eMAR. -The MA should inform the RCC. -If a resident refused after 3 dosages the RCC will contact the resident's physician. Interview on 03/05/18 at 12:13 pm with a staff at the contracted pharmacy revealed: -Resident #5's 240 mL of megestrol was filled on 09/28/17, 11/10/17, 01/13/18, and 3/07/18. -One 240 mL bottle should have lasted one month.	D 273		

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D 273	Continued From page 10 Interview with the RCC on 06/08/18 at 11:00am revealed: -She knew Resident #5 refused megestrol at times, "the med techs have told me". -MAs were responsible for notifying the physician via fax if a resident refused medications. -She did not know if Resident #5's physician was not notified about the refusal of megestrol. -She expected MAs to notify the physician for refusals and thought the documentation was in the chart. Interview with the WD on 06/08/18 at 11:15am revealed: -She was not aware that Resident #5 was refusing megestrol. -She reviewed the eMAR twice per week for frequent refusals if notified by the MAs that the resident had refused frequently. -If medications were refused for three doses or a resident continued to refuse a medication, the MAs were supposed to notify the provider. -All MAs had been trained on the administration and documentation of medications. -The physician is also given a copy of the eMAR weekly when he visits the patient to identify refusals. Interview with the Administrator on 06/08/18 at 2:30pm revealed: -She was not aware that Resident #5 was refusing medications and the physician had not been notified. -She expected the physician to be notified by the MA, RCC, or WD when residents had refused their medications. Attempted telephone interview on 06/07/18 at 10:59am, 6/09/18 at 9:30am, and 06/11/18 at	D 273		

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D 273	Continued From page 11 9:38am with the Nurse Practitioner was unsuccessful. 3. Review of Resident #4's current FL2 dated 04/04/2018 revealed diagnoses included coronary artery disease, stage 3 chronic kidney disease, hypertension, gout; carotid aortic stenosis, hypothyroidism, and dyslipidemia. Interview with Resident #4 on 06/06/18 at 10:30am revealed: -She had diarrhea for about 3-weeks. -The facility was administering anti-diarrhea medications to help combat the diarrhea. -She had abdominal pain somedays due to her diarrhea, but she had not told staff. Review of the eMAR for Resident #4 for May 2018 revealed: -An entry for anti-diarrhea 2mg to take 1 tablet as needed for diarrhea with each loose stool not to exceed 8-doses in 24-hours and notify MD if continues for more than 24-hours. -The anti-diarrhea medication was documented as administered on May 21st, 22nd, 23rd, 24th, 26th, 27th, 29th, 30th, and 31st. -There were 2-doses of the anti-diarrhea medication documented as administered on 26th, 27th, and 29th. Review of Resident #4's eMAR revealed the anti-diarrhea medication was documented as administered on June 1st, 2nd, 3rd, 6th, and 7th. Review of Resident #4 record revealed: -There was no documentation that Resident #4's medical doctor was notified she was administered the anti-diarrhea medication for 4-constitutive days (May 21st-24th) and for 3-constitutive days	D 273		

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D 273	Continued From page 12 (May 29th-31st). -There was no documentation that Resident #4 medical doctor was notified that she was administered the anti-diarrhea medication for 2-constitutive days (June 6th-7th). Telephone interview with a representative from Resident #4's primary physician on 06/07/18 at 11:33am revealed: -Resident #4's responsible party e-mailed the physician on 05/21/18 about the resident having diarrhea. -The physician sent the facility an order for Loperamide HCL 2mg (an anti-diarrhea medication). -The physician had never received any notification that Resident #4 continued to have loose stool. -The physician had concerns of Resident #4 getting dehydrated. -The physician was going to send over a referral for Resident #4 to have a consult with a GI doctor. Interview with the Resident Care Coordinator (RCC) on 06/07/18 at 11:50am revealed: -She did not notify Resident #4's primary physician about the continued diarrhea. -She did not know Resident #4 was continuing to have diarrhea. Telephone interview with Resident #4's Responsible Party on 06/07/18 at 12:07pm revealed: -She was concerned about Resident #4 continued diarrhea. -She had e-mailed the primary physician about Resident #4 having diarrhea in May. Interview with a Medication Aide (MA) on	D 273		

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WALTONWOOD COTSWOLD	5215 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 13 06/07/18 at 3:00pm revealed: -Resident #4 had requested Anti-Diarrheal from her about 2 times, but the times were never back to back. -She had not seen or smelled diarrhea associated with Resident #4. -She was not aware that Resident #4 was receiving anti-diarrhea medication for more than 24-hours. -When the anti-diarrhea medication was displayed on the MAR, she was unable to see the entire the month to determine if the medication was administered in consecutive days. - If a pattern was noticed, the doctor should be notified. -Which ever staff person who discovered the pattern would notified the physician. Interview with a second MA on 06/07/18 at 3:08pm revealed: -She was not aware that Resident #4 was having diarrhea. -She did not know Resident #4 was having abdominal pain. -She did not know Resident #4 received the anti-diarrhea medications. Interview with the Executive Director on 06/07/18 at 3:30pm revealed: -She did not know Resident #4 had continued diarrhea. -She did not know the primary physician for Resident #4 was not notified.	D 273	D310 Waltonwood Cotswold responded immediately to the D269 and D310 deficiency by clarifying the care plan to reflect the agreements reached by Waltonwood, the resident and the resident's legal guardian. The care plan was changed on 6/8/18 to clarify the resident's preference of limited cueing at the beginning of meal times only. Waltonwood educated the POA, resident and family on the risks of not having continuous supervision during meal times on Tuesday, June 12th with Novant Hospice present for this care plan meeting.	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes:	D 310		

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D 310	Continued From page 14 (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 sampled resident (Resident #3) with physician orders for a mechanical soft diet with nectar thickened liquids. The findings are: Observation of Resident #3 during the initial tour on 06/06/18 at 11:38am revealed: -Resident #3 was served a chopped breaded turkey cutlet without gravy, chopped white and sweet potatoes, chopped green beans. -Resident #3 was served nectar thick water and tea along with 1 bottle of supplement shake and a frozen dietary supplement. -Resident #3 took a spoon full bite of the turkey, swallowed and began having small gasps of breath, her eyes were wide with fear, and she could not breathe freely, cough or speak when asked. -Resident #3's family member pressed her call light button and I went in the hall to get the medication aide (MA). -The MA came to check on Resident #3 that was still having trouble but was able to breathe and swallow. -The Wellness Coordinator (WC) arrived within 2-3 minutes. -Resident #3 was able to state that she "was fine" and her "throat was clear".	D 310	LPN assessed the resident immediately on 6/6/18 and notified the physician of diet change request. The physician was notified regarding Ensure and a clarification was obtained to approve the Ensure to be given at its original consistency on 6/7/18. The Culinary Service Manager conducted therapeutic diet trainings for all culinary staff immediately on 6/8/2018. The Culinary Service Manager conducted an in-person training with every associate in the culinary department by 6/18/18. The Culinary Service Manager and Wellness Coordinator put in place a quarterly training schedule to train and refresh associates on resident preferences and therapeutic diets. These training were open to all staff and conducted on 7/10 and 7/12.	

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D 310	Continued From page 15 -Resident #3 consumed 10 % of the meal and 100% of the liquids. 1. Review of Resident #3's current FL2 dated 02/27/18 revealed: -Diagnoses included Parkinson's disease, dementia, dysphagia, and aspiration pneumonia. -A physician's order for a dysphagia mechanical altered and nectar thickened liquids. Review of Resident #3's Care Plan dated 06/05/18 revealed: -This Care Plan was for a documented change of condition. -A diet was documented at a mechanical soft with nectar thickened liquids. Review of Resident #3's physician's orders revealed on 06/01/18, a physician's order for a mechanical soft diet with nectar thickened liquids. Review of the therapeutic diet list posted in the kitchen on 06/06/18 revealed Resident #3 was to be served a mechanical soft diet with nectar thickened liquids. Review of the therapeutic diet menu for lunch on 06/06/18 revealed residents on a mechanical soft diet were to be served ground turkey cutlet with picatta sauce, mashed potatoes, whole green beans, a soft choice of bread with margarine, choice of beverage, and a soft and moist mocha brownie. Review of a hospital discharge summary dated 02/28/18 revealed: -A modified barium swallow study was performed and the impression was documented as deep penetration demonstrated with thin liquids with Resident #3 tolerated nectar thick liquids without	D 310	Therapeutic Diet training will be conducted upon onboarding during Waltonwood Orientation. Waltonwood Cotswold make sure all Residents receive the accurate diet for every meal as outline in the Care Plan and signed off by a physician. This will be monitored by the Executive Director, Resident Care Manager and Wellness Coordinators. This plan of correction is in reference to the Type B Violation and D310. Type B Violation and D310 was corrected on June 8, 2018.	

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D 310	Continued From page 16 incident. -Speech therapy recommended a mechanical altered chopped diet with nectar thickened liquids. -An order for supplement shake nectar thick consistency three times a day. Review of Resident #3's Hospice notes revealed: -On 03/06/18 a repetitive saliva swallow test was performed and Resident #3 test was "abnormal". -On 03/09/18, an assessment completed documenting Resident #3 was positive for confusion, tremors, anorexia, dysphagia depressed mood and weakness. -On 03/09/18, a diet was documented as a pureed diet with thickened liquids. -On 04/24/18 documented Resident #3 was on a pureed diet and thickened liquids due to swallowing difficulties from the disease progression. Interview with the WC on 06/06/18 at 11:44am revealed Resident #3 received new diet orders on 06/01/18 for a mechanical soft diet with nectar thickened liquids. Interview with Resident #3 on 06/07/18 at 12:29pm revealed the staff set up her food and leaves every day with every meal. Telephone interview with Resident #3's second family member on 06/06/18 at 12:14pm revealed: -Resident #3 used to be served a pureed diet with thickened liquids. -Resident #3's new diet was a mechanical soft diet with thickened liquids. -The diet was changed from pureed to mechanical soft to "try to see" if Resident #3 would eat better because Resident #3 could recognize the food in the mechanically soft form.	D 310		

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D 310	Continued From page 17 -Resident #3 lost 20 lbs. in two months (April and May 2018). Interview with a MA on 06/06/18 at 12:20pm revealed: -She had worked at the facility for two years. -She knew the Resident #3's diet used to be pureed with nectar thickened liquids but it was changed on 06/04/18 to a mechanical soft diet with nectar thickened liquids. -She got all meals from dietary already prepared. -Dietary was responsible for preparing all meals. -The meal "looked mechanical soft". Telephone interview with Resident #3's Hospice Physician on 06/06/18 at 4:27pm revealed: -Resident #3's diet order was changed from pureed to mechanical soft with nectar thickened liquids at the family's request to help Resident #3 eat better. -He did not know Resident #3 received a chopped diet instead of a mechanical soft diet or Resident #3 chocked on the chopped diet. -He ordered nectar thickened liquids because of Resident #3's dysphagia. -The physician expected the facility staff to follow the order as written. -"Failure to receive the diet as ordered would be detrimental" for Resident #3 because of the "increased risk for aspiration". Interview with the WC on 06/06/18 at 3:45pm revealed: -After notifying the Hospice Physician Resident #3 choked on the mechanical soft diet, the diet order was changed back to puree with nectar thickened liquids. -She was not aware the meal given to Resident #3 was chopped instead of mechanical soft. -She let Resident #3 continue to eat the chopped	D 310		

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D 310	Continued From page 18 diet after the episode because Resident #3 said she was fine. -The dietary staff was responsible for preparing the meals for all of the residents. -When a new diet was ordered, the order was sent to the Dietary Manager for his signature so the order could be filled. Interview with the dietary cook on 06/08/18 at 9:30am revealed: -He had worked in the facility as the cook since November 2016. -He was aware Resident #3's diet was listed as being mechanical soft on the therapeutic diet list. -He prepared Resident #3's lunch meal by using a knife to chop food. -The therapeutic spreadsheet and recipes were available to use in the facility. -He never used the recipe or therapeutic spreadsheet as a guide to prepare a mechanical soft meal. -He did not know the mechanical soft spreadsheet listed ground turkey with a picatta sauce. -He used his prior experience to prepare a mechanical soft diet for residents. -He knew he was supposed to refer to the diet spreadsheet, however "it was more convenient to not look at the spreadsheet". Interview with the Dietary Services Coordinator on 06/08/18 at 9:30am revealed: -He was responsible for the training and oversight of all dietary staff. -He knew Resident #3 was ordered a mechanical soft diet with nectar thickened liquids. -All cooks were oriented when hired and instructed to refer to the therapeutic spreadsheet and recipes when preparing meals. -Cooks were trained for 1 week when hired on	D 310		

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D 310	Continued From page 19 how to prepare therapeutic diets. -We have quarterly trainings on how to prepare therapeutic diets, "the last training was February 2018". -He did not know the cook was not referring to the recipe and therapeutic spreadsheet when preparing the mechanical soft diet. -He expected staff to refer to therapeutic diet spreadsheet and recipes when preparing meals as diets were ordered by the physicians. Interview with the Administrator on 06/08/18 at 10:00am revealed: -She was aware Resident #3 experienced aspiration while eating her lunch on 06/06/18. -She did not know Resident #3 meal was prepared incorrectly on 06/06/2018. -She expected cooks to be trained by the dining service director to prepare meals therapeutic diets according to the recipe. -She expected cooks to refer to therapeutic spreadsheet and recipe when preparing meal. A second interview with the Administrator on 06/08/18 at 10:29am revealed: -Resident #3 was the only resident in the facility that require a therapeutic diet. -Resident #3 did not want to eat in the dining room because she was "embarrassed". -All of the thickened liquids were preordered. -The facility does not "add" thickener to liquids. -There were too many inconsistencies with the staff using thickener, so they only ordered pre thickened liquids. -Dietary was responsible for preparing all diets according to the orders. -Every new order received went to the Dietary Manager on a Dietary Notification sheet with the new order written out.	D 310		

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D 310	Continued From page 20 Interview with the Dietary Manager on 06/08/18 at 2:13pm revealed: -He received Dietary Notification sheets on all residents with their diets on them. -On 06/04/18, he received a new diet notification for Resident #3 for a mechanical soft diet and nectar thickened liquids. -On 06/06/18, the diet sent to Resident #3 was chopped instead of mechanical soft. -Resident #3 was the only resident in the facility that received a textured modified diet. 2. Review of Resident #3's physician's orders revealed: -On 03/15/18, a physician's order for a pureed diet with nectar thickened liquids, a dietary supplement shake and a frozen dietary supplement. -On 03/18/18, a clarification physician's order for a pureed diet with nectar thickened liquids, a dietary supplement shake three times a day and a frozen dietary supplement three times a day. -On 06/01/18, a physician's order for a mechanical soft diet with nectar thickened liquids. Review of Resident #3's Care Plan dated 06/05/18 revealed: -This Care Plan was devised due to change of condition. -A diet was documented at a mechanical soft with nectar thickened liquids. Review of a hospital discharge summary dated 02/28/18 revealed: -A modified barium swallow study was performed and the impression was documented as deep penetration demonstrated with thin liquids with Resident #3 toleration nectar thick liquids without incident. -Speech therapy recommended a mechanical	D 310		

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D 310	Continued From page 21	D 310		

altered chopped diet with nectar thickened liquids.
-An order for a dietary supplement shake nectar thick consistency three times a day.

Review of Resident #3's Hospice notes revealed:
-On 03/06/18 a repetitive saliva swallow test was performed and Resident #3 test was "abnormal".
-On 03/09/18, an assessment completed documenting Resident #3 was positive for confusion, tremors, anorexia, dysphagia depressed mood and weakness.
-On 03/09/18, a diet was documented as a pureed diet with thickened liquids.

Interview with Resident #3's family member on 06/06/18 at 11:45 revealed:
-She was in the room when the aspiration episode occurred.
-Resident #3 was eating chopped turkey, chopped white and sweet potatoes, and chopped green beans.

Observation of Resident #3 on 06/06/18 at 12:05pm revealed a personal care aide (PCA) brought in 6 supplement shakes (not pre-thickened) and put them in Resident #3's refrigerator.

Interview with a PCA on 06/06/18 at 12:05pm revealed:
-She was directed by the MA to put the supplement shakes in Resident #3's refrigerator for easy access.
-She was not told to pre-thicken the shakes.
-Resident #3 received a supplement shake with every meal.

Telephone interview with Resident #3's second family member on 06/06/18 at 12:14pm revealed

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D 310	Continued From page 22 Resident #3 received a supplemental shake three times and day and it was not thickened because the facility staff was "not allowed" to "add" thickener to anything. Interview with a MA on 06/06/18 at 12:20pm revealed: -She had worked at the facility for two years. -She knew the Resident #3's diet used to be pureed with nectar thickened liquids but it was changed on 06/04/18 to a mechanical soft diet with nectar thickened liquids. -Resident #3 received a dietary supplemental shake and a frozen dietary supplement three times and day with meals. -The dietary supplement shake was not thickened because were not not allowed to add thickener to any fluids. -All fluids come pre thickened from dietary. Telephone interview with Resident #3's Hospice Physician on 06/06/18 at 4:27pm revealed: -Resident #3's diet order was changed from pureed to mechanical soft with nectar thickened liquids at the family's request to help Resident #3 eat better. -He did not know the dietary supplement shake was not thickened. -He ordered nectar thickened liquids because of Resident #3's dysphagia. -The dietary supplemental shake was considered a thin liquid. -He did not give the order for the dietary supplement shake. -The physician expected the facility staff to follow the order as written and ticken all liquids including the dietary supplemental shake. -"Failure to receive the diet as ordered would be detrimental" for Resident #3 because of the "increased risk for aspiration".	D 310		

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D 310	Continued From page 23 Interview with the WC on 06/06/18 at 3:45pm revealed: -After notifying the Hospice Physician, the diet order was changed back to puree with nectar thickened liquids. -The dietary supplement shake and frozen dietary supplement were ordered by Resident #3's primary physician. -The facility cannot "add thickener" to anything because of inconsistancies with adding the thickner. -There was too much left up to "interpretation" when adding the thickener so it was the policy of the facility to not add thickener, always order pre thickened. -The dietary staff was responsible for ordering the pre thickened liquids. -She did not notify the Hospice Physician about the dietary supplement shake not given as ordered by making sure it was nectar thick. -When a new diet was ordered by the physician, a change of diet order was sent to the Dietary Manager for his signature so the new order could be provided to the residents. Interview with a dietary server on 06/07/18 at 11:15am revealed: -Resident #3 no longer came to the dining room and prefered to eat in her room. -Thicken liquids were purchased pre-thickened and staff did not thicken liquids for any of the residents in the facility. -The kitchen had never ran out of pre-thickened beverages. -Nectar thickened beverages were always served to Resident #3. -She had served Resident #3 liquids with different consistencies because she had forgotten what his diet order was since it had been "awhile since	D 310		

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D 310	Continued From page 24 they had served him thickened liquids." -She knew of the therapeutic diet list posted in the kitchen indicating Resident #3 was to be served nectar consistency liquids and always referred to it prior to serving his drinks. -Dietary staff were not responsible for serving nutritional supplements. Telephone interview with Resident #3's pharmacy representative on 06/07/18 at 11:37 revealed the only order received for a dietary supplemental shake was on 03/16/18 for dietary supplement shake "1 can three times a day". Interview with Resident #3 on 06/07/18 at 12:29pm revealed the staff set up her food and leaves. Interview with the Dietary Manager on 06/08/18 at 2:13pm revealed: -"We do not thicken anything but soup". -All liquids were ordered "pre-thickened". -He received Dietary Notification sheets on all residents with their diets on them. -On 06/04/18 he received a new diet notification for Resident #3 for a mechanical soft diet and nectar thickened liquids. -On 06/06/18 the diet sent to Resident #3 was chopped instead of mechanical soft. -Resident #3 was the only resident in the facility that received a textured modified diet. Interview with the Administrator on 06/08/18 at 10:29am revealed: -Resident #3 was the only resident in the facility that required a therapeutic diet. -Resident #3 did not want to eat in the dining room because she was "embarrassed". -All of the thickened liquids were preordered. -The facility does not "add" thickener to liquids.	D 310		

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D 310	Continued From page 25 -There were too many inconsistencies with the staff using thickener, so we only ordered pre thickened liquids. -Dietary was responsible for preparing all diets according to the orders. -Every new order received goes to the Dietary Manager on a Dietary Notification sheet with the new order written out. _____ The facility failed to serve Resident #3, who had a history of aspiration pneumonia, a mechanical soft, nectar thickened diet as ordered by his physician. Serving Resident #3 a mechanical soft chopped diet with thin liquids and non-thickened dietary supplemental shake, put her at risk for aspiration pneumonia occurring again. This was detrimental to the health, safety and welfare of the resident which constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/08/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH JULY 27, 2018.	D 310	Waltonwood Cotswold will follow the policies in place to contact the attending physician to clarify all admission and readmission orders. The community will verify the medication list upon move in with the resident and POA to ensure all the medications are accurate. Wellness Coordinators will review resident needs with care staff on a daily basis. The Electronic Medication Administration Record (EMAR) will be monitored daily by the Resident Care Manager and Wellness Coordinators who will pull daily compliance reports from our EMAR to assure all medications are administered correctly and any change will be documented accurately in the EMAR. This will be monitored by the Resident Care Manager, Executive Director and Wellness Coordinators. This is in reference to D358.	
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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D 358	Continued From page 26	D 358		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure Vitamin D was administered as ordered by a licensed prescribing practitioner for 1 of 5 (Resident #4) sampled resident for 65-days.

The findings are:

Review of Resident #4's current FL2 dated 04/04/18 revealed:
-Diagnoses included coronary artery disease; stage 3 chronic kidney disease, hypertension, carotid aortic stenosis; hypothyroidism; and dyslipidemia.
-There was no order for Vitamin D3 400iu.

Review of Resident #4's current Resident's Register dated 03/31/18 revealed Resident #4 was admitted to the facility on 04/04/18.

Review of a facility FL2 verification form for Resident #4 dated on 04/16/18 revealed a signed physician order for Vitamin D3 400iu daily.

Review of the Electronic Medication Administration Record (eMAR) for Resident #4 for April, May and June of 2018 revealed there was no entry for Vitamin D3 400iu to be administered daily.

Interview with Resident #4 on 06/07/18 at 11:01am revealed:
-She had taken Vitamin D3 prior to moving into the facility.
-She had not received Vitamin D3 since moving into the facility on 4/4/18.

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D 358	Continued From page 27 -She was unsure why she was not receiving the Vitamin D3. -She had never ask the staff why she had not received Vitamin D. -She provided a list of medications she received from her primary physician that lists Vitamin D3. Telephone interview with the facility pharmacy on 06/07/18 at 11:16am revealed: -Resident #4 did not have an order for Vitamin D3 listed in her profile. -The pharmacy did not have a copy of the FL2 Verification Form dated 04/16/18 in her profile. Telephone interview with a representative from Resident #4's primary physician office on 06/07/18 at 11:33am revealed Resident #4 was supposed to be on one Vitamin D3 400iu daily. Telephone interview with Resident #4's Responsible Party on 06/07/18 at 12:07pm revealed: -Resident #4 was to take one Vitamin D3 400iu upon admission. -She took a bottle of Vitamin D3 tablets into the facility when Resident #4 moved in. -She was not aware that Resident #4 had not received the Vitamin D3. Interview with the Resident Care Coordinator, RCC, on 06/07/18 at 11:50am revealed: -She was not aware that Resident #4 had not received the Vitamin D3 for 65-days. -She did not fax the FL2 verification form that listed the Vitamin D3 to the pharmacy. -She did not notified Resident #4's primary physician that Resident #4 had not received the Vitamin D3. Interview with the Executive Director on 06/07/18	D 358		

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D 358	Continued From page 28 at 12:30pm revealed she was not aware that Resident #4 had not received the Vitamin D3 as ordered for 65-days. Observation of medications on hand on 06/07/18 for Resident #4 revealed there was no Vitamin D3 available for administration.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding therapeutic diets. 1. Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 sampled resident (Resident #3) with physician orders for a mechanical soft diet with nectar thickened liquids. [Refer to Tag 310, 10A NCAC 13F .0904(e)(4) (Type B Violation).]	D912	In regards to D912: Waltonwood Cotswold will assure all Residents are upheld in compliance with DHSR and Waltonwood policies. This will be monitored by the Executive Director and Resident Care Manager.	
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency	D935		

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D935	Continued From page 29 G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in	D935	D935 was corrected on 6/8. Proper documentation was recieved and filed accordingly. All Waltonwood Medication Technicians will submit the proper documentation before administering medications. Waltonwood will ensure this by conducting bi-weekly audits on new hires. This will be monitored by the Business Office Manager, Resident Care Manager and the Executive Director.	

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D935	Continued From page 30 accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 medication aides sampled (Staff D) completed the 5, 10 or 15 hour medication training or had verification of previous employment before administering medication to residents. The findings are: Review of Staff D's personnel file revealed: -Staff D was hired on 02/13/18 as a Medication Aide (MA). -Documentation Staff D completed a medication clinical skills validation on 03/30/18. -Documentation Staff D successfully passed the medication administration exam on 04/25/17. -There was no documentation of a 5, 10 or 15 hour medication training on file. -There was no documentation of employment verification prior to beginning work as a MA at the facility. Review of the April 2018, May 2018 and June 2018 electronic Medication Administration Records revealed Staff D had administered medications to the residents on a routine basis. Interview with the Health and Wellness Director on 06/08/18 at 1:30pm revealed: -The Business Office Manager (BOM) was responsible for requesting employment verification for all medication aides. -The BOM was on vacation during the survey.	D935		

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D935	Continued From page 31 -The Resident Care Coordinator completed the MA training and competency for all new employees. -She was aware all MAs were required to completed the 5, 10 or 15 hour medication training or obtain a verification of previous employment before administering medication to residents. -She was aware Staff D had administered medications to the residents in the last 3 months. Interview with the Resident Care Coordinator on 06/08/18 at 1:50pm revealed: -The BOM was responsible for completing all new hire staff record. -Staff D had been given the employment verification for completion upon hire. -Staff D had administered medications to the residents since February 2018. Interview with the Memory Care Coordinator (MCC) on 06/08/18 at 2:00pm revealed: -She and the RCC were responsible for reviewing MA training and competency for all new hires. -Staff D must had been missed or overlooked. -Staff D was responsible for administering medications, and Staff D worked 40 hours per week. Interview with the Executive Director on 06/08/18 at 2:08pm revealed she relied on the RCC and the BOM to complete all new staff training and obtain MA verification. Telephone interview on with Staff D (medication aide) on 06/08/18 at 4:00pm revealed: -She had passed the medication aide test in 2017. -She had worked continuously as a MA since passing her test in 2017.	D935		

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D935	Continued From page 32 -She had worked for her previous employer until February 2017. -The facility had given her an employment verification form upon hire to verify her working as a MA with her previous employer, but she had not completed the verification form. -The facility had contacted her on 06/08/18 to obtain the employment verification from her previous employer. -Her responsibilities were to administer medications to the residents in the facility. -She worked in the memory care unit as well as the assisted living community. Review of a faxed document from Staff D previous employer on 06/08/18 revealed Staff D had worked as a MA in a local assisted living facility and was eligible for hire as a MA on 02/22/18.	D935		