STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on October 20, 2021-October 21, 2021.	{D 000}		
{D 282}	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the kitchen was clean and protected from contamination related to food particles and a build-up of dirt and grease on the gas stove, double ovens, kitchen floor, unwashed dishes, pots and pans and dirty drain under the dishwasher. The findings are: Review of the local Environmental Health Inspection report for the kitchen dated 09/30/21 revealed: -There was a violation in prevention of food contamination, utensils and equipment. -All physical facilities shall be maintained in good repair and shall be cleaned as often as necessary to keep them clean and by methods that prevent contamination of food products. Clean the floors and walls. This was a repeat violation. -Equipment, food-contact services and utensils shall be clean to sight and touch.	{D 282}		

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{D 282}	Continued From page 1 Review of the "Kitchen Daily Duties" posted in the kitchen revealed: -Clean every dish that had been used throughout meal prep. -Wipe down the serving line. -The food preparation sink was to be wiped out and sanitized. -Sweep and mop the kitchen and dish areas at the end of each shift. -There was to be dietary staff check off sheets after each meal. Observation of the dishwashing area on 10/20/21 at 9:55 am revealed: -On the left side of the dishwashing area was a counter and three-compartment sink that was full of dirty pots, pans, and serving utensils. -There was a two to three counter on both sides of the dishwasher. -The counters were full of dirty pots, pans, utensils and dishes. -Underneath the three-compartment sink and the dishwasher there were multiple food particles and other unidentified items on the floor. -Throughout the kitchen floor there was an unidentified black substance in the cracks of the grout that was between the square tiled flooring. -There was a brown substance on the floor behind the dishwasher drain and covering the lower part of the wall behind the drain and the dishwasher. -Sitting on the counter near the first compartment of the three-compartment sink, there were pans, lids and serving utensils. -In the second compartment of the sink, there was standing water that had particles of food in it. -There was a vent with a drain that was underneath the dishwasher. -The vent was used to catch food particles, so the	{D 282}		

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{D 282}	Continued From page 2	{D 282}		

food particles would not clog the drain.
-The vent had to be manually cleaned and food particles dumped.
-The were massive amounts of food particles on the vent.
-The grout surrounding the square floor tiles throughout the dishwashing area was black and brown in color.
-Flooring in the cooking near the stove and the refrigerator needed to be cleaned and had food and unidentified particles scattered throughout.

Observation of the kitchen food preparation area on 10/20/21 at 9:43am revealed:
-There was a drain on the floor.
-The drain was attached and in the middle of a white square area which was covered in a thick dark brown substance.
-There was a brown substance on the floor behind the drain and covering the lower part of the wall behind the drain and the dishwasher.
-There was a 6-burner gas stove attached to a flat grill. The burners and the flat grill were almost completely covered with a thick brown and black substance.
-There was a serving utensil and light-colored food particles on the flat grill.
-There were two ovens on the front side of the flat grill and stove.
-There was a brown substance on the top part of the right oven doors and between a 1-inch flat area between the oven doors and the stove component.
-The grout surrounding the floor tiles throughout the food preparation areas was black and brown in color.

Interview on 10/20/21 at 11:31am with the cook revealed:
-She had worked at the facility for one day, today

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{D 282}	Continued From page 3 was her second day. -She was the only cook from 6:00am to 6:00pm. -She was busy trying to prepare the meals and there was no staff in the kitchen to help clean up. -She was going to try and wash dishes before she left today. -The other cook was responsible for cleaning the kitchen. Interview on 10/21/21 at 11:35am with the facility's cook revealed: -She had worked at the facility for three weeks. -Each cook was responsible for cleaning the kitchen. -There was need for additional kitchen staff because it was difficult to cook and clean the kitchen during her shift. Interview with the Executive Director on 10/21/21 at 12:10pm revealed: -She had worked at the facility for almost two weeks. -She had realized the kitchen needed staffing help. -She had been trying to help in the kitchen with washing dishes and helping serve the meals. -She had developed a cleaning schedule for the kitchen and was in the process of implementing her schedule.	{D 282}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	{D 310}		

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{D 310}	Continued From page 4	{D 310}		

This Rule is not met as evidenced by:
Based on record review, observation and interviews the facility failed to serve physician ordered diets for 2 of 5 sampled (Residents #2 and #3) with orders for a pureed diet (#3) and a mechanical soft (MS) diet (#2).

The findings are:

1. Review of Resident #3's current FL2 dated 09/28/21 revealed:
-Diagnoses included dementia and dysphagia.
-There was an order for a pureed diet.

Review of the facility's diet list posted in the kitchen revealed Resident #3 was to be served a pureed diet.

Review of the facility's therapeutic diet menu for the lunch meal served on 10/20/21 revealed:
-Residents ordered a pureed diet should be served pureed fried chicken, mashed potatoes with gravy, pureed green beans, pureed wheat roll, margarine, vanilla ice cream and beverage of choice.

Observation on 10/20/21 at 12:10pm revealed:
-Resident #3's pureed meal was not prepared by the cook but by another staff that had previously been serving other residents their plate.
-The staff attempted to puree the fried chicken and mixed greens.
-The pureed fried chicken meat appeared ground with obvious crumbs from the fried breading that was on the chicken.

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{D 310}	Continued From page 5 -The mixed greens were not completely pureed and had obvious stems from the greens and a leaf from the mixed greens. Observation on 10/20/21 from 12:40pm to 1:23pm revealed: -Resident #3 was not eating in the main dining room. -The resident was seated in the parlor at a table. -Resident #3 received feed assistance from the personal care aide (PCA). -The meal served to Resident #3 was ground fried chicken, mixed greens that were not pureed, mashed potatoes, yogurt, and vanilla ice cream. -Resident #3 consumed 100% of the meal without difficulty. Based record review and observation, it was determined Resident #3 was not interviewable. Interview with a personal care aide (PCA) on 10/20/21 at 1:05pm revealed: -Resident #3's meal was usually did not look as good as it did today, but worse. -The facility's cook did not puree the resident's food thoroughly and she usually had to use the spoon to mash and break-up the food before feeding the resident. -The cook working in the kitchen today, did not work for the facility but was from a temporary agency. -The cook in the kitchen today did not know how to prepare Resident #3's pureed meal. -The Transportation Coordinator prepared the resident's pureed meal. Interview with the Transportation Coordinator on 10/20/21 at 1:17pm revealed: -She learned how to puree meals from a previous employer.	{D 310}		

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{D 310}	Continued From page 6 -The cook working in the kitchen today said she did not know how to puree Resident #3's meal. -She tried to pull all the skin off the chicken prior to pureeing placing it in the blender, but she was unable to get all the crunchy floured breading off the chicken. -She did not realize the mixed greens were not completely pureed. -She had not received training on how to puree foods. Refer to interview with the cook on 10/20/21 at 3:00pm. 2. Review of Resident #2's current FL2 dated 08/12/21 revealed: -Diagnoses included dementia and weakness. -There was an order for a mechanical soft diet. Review of the facility's diet list posted in the kitchen on 10/20/21 revealed Resident #2 was to be served a mechanical soft diet. Review of the facility's week at a glance menu revealed the menu for 10/20/21 lunch was for fried chicken, mashed potatoes with brown gravy, mixed vegetables, wheat dinner roll or bread and margarine, vanilla ice cream and beverage of choice.. Review of the facility's mechanical soft menu for the lunch meal served on 10/20/21 revealed residents ordered a mechanical soft diet should be served ground fried chicken, mashed potatoes with gravy, mixed vegetables, wheat roll and beverage of choice. Observation on 10/20/21 from 12:32pm to 12:46pm revealed: -Resident #2 was eating in the main dining room.	{D 310}		

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{D 310}	Continued From page 7 -The resident was seated at the dining room at table. -Resident #2's meal served was a whole fried chicken breast, mixed greens, mashed potatoes, and yogurt. -Resident #2 held the chicken breast with his hands and took small bites from the whole breast or pulled small portions with his fingers from the chicken breast. -Resident #2 consumed 50% of the chicken breast. -Resident #2 consumed 100% of the mixed greens, roll, and mashed potatoes without difficulty. Interview with a personal care aide (PCA) on 10/20/21 at 1:05pm revealed the cook working in the kitchen today did not work for the facility, but was from a temporary agency. Review of the facility's week at a glance menu revealed the menu for 10/21/21 breakfast was eggs, breakfast meat, assorted bread, fruits, beverage of choice, milk, and coffee. Review of the facility's mechanical soft menu for the breakfast meal served on 10/21/21 revealed residents ordered a mechanical soft diet should be served ground breakfast meat, canned fruit of choice, egg, assorted bread, fruits, beverage of choice, milk, and coffee. Observation on 10/21/21 from 7:40am to 7:48am revealed: -Resident #2 was eating in the main dining room. -The resident was seated in the dining room at a table. -Resident #2's meal served was a 4 inch in diameter whole piece of pattied sausage, egg omelette, grits, and an orange slice.	{D 310}		

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{D 310}	Continued From page 8 -Resident #2 held the sausage patties with his hands and took small bites from the whole sausage patties. -Resident #2 consumed 100% of the meal without difficulty. Interview with Resident #2 on 10/21/21 at 9:30am revealed: -He received his meats chopped up sometimes. -He would bite small portions from the whole pieces of meat. -He did not get chocked at meals. Interview with the Compliance Director (CD) on 10/21/21 at 1:30pm revealed: -Resident #2 had a mechanical soft diet ordered because he used to eat so fast he would get chocked. -Resident #2 had a swallow study done 2 to 3 years ago and mechanical soft diet was recommended, but she was not able to locate the results. -The kitchen staff should be serving the mechanical soft diet as ordered. Refer to interview with the cook on 10/20/21 at 3:00pm. _____ Interview with the cook on 10/20/21 at 3:00pm revealed: -She had worked at the facility for one day and today was her second day at the facility. -There was a diet list posted in the kitchen, but she did not review it because she knew nothing about preparing therapeutic diets. -This was her first dietary job and she had no experience preparing special meals or reading menus.	{D 310}		

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{D 358}	Continued From page 9	{D 358}		
{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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure medications were administered as ordered by a licensed prescribed practitioner for 1 of 3 residents (#6) observed during the medication passes. The findings are: The medication error rate was 11% as evidence by the observation of 3 errors out of 22 opportunities during the 8:00am medication pass on 10/21/21. Review of Resident #6's current FL-2 dated 11/02/20 revealed diagnoses included bipolar depression, diabetes and chronic obstructive pulmonary disease (COPD). a. Review of Resident #6's physician's orders dated 07/28/21 revealed an order for Vitamin C (a vitamin supplement) 1000mg once daily. Review of Resident #6's a physician's order dated 10/08/21 revealed to discontinue Vitamin C 1000mg.	{D 358}		

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{D 358}	Continued From page 10 Review of Resident #6's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin C 1000mg daily to be administered at 8:00am. -There was documentation Vitamin C 1000mg was administered at 8:00am at 10/21/21. Observation of medications administered during the medication pass on 10/21/21 at 7:55am revealed Resident #6 was administered 18 oral medications including one Vitamin C 1000mg tablet. Interview with Resident #6 on 10/21/21 at 8:23am revealed she took so many medications that she depended on the facility to keep up with the medications and make sure she received all her medications as ordered. Telephone interview with an order entry staff member for the facility's contracted pharmacy on 10/21/21 at 2:40pm revealed: -The facility was responsible to fax physician's orders to the pharmacy for entering or discontinuing medications. -The facility did not receive the physician's order dated 10/08/21 to discontinue Vitamin C 1000mg. Interview with Resident #6's Primary Care Provider (PCP) on 10/21/21 at 3:15pm revealed: -Resident #6 was ordered Vitamin C 1000mg in July 2021 as part of her standard COVID-19 prevention. -The PCP had begun to discontinue COVID-19 preventive medications to lessen the number of medications some residents were taking since the facility had not had a recent case of COVID-19. -The facility should ensure medications that were	{D 358}		

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{D 358}	Continued From page 11 discontinued were not being administered to residents. Refer to interview with the medication aide (MA) on 10/21/21 at 12:30pm. Refer to interview with the Compliance Director (CD) on 10/21/21 at 11:55am. Refer to interview with the Special Care Unit Coordinator (SCUC) on 10/21/21 at 12:08am. Refer to interview with the Administrator on 10/21/21 at 1:30pm. b. Review of Resident #6's physician's orders dated 07/28/21 revealed an order for Vitamin B complex (a vitamin supplement) take once daily. Review of Resident #6's a physician's order dated 10/08/21 revealed to discontinue Vitamin B complex. Review of Resident #6's October 2021 eMAR revealed: -There was an entry for Vitamin B complex daily to be administered at 8:00am. -There was documentation Vitamin B complex was administered at 8:00am at 10/21/21. Observation of medications administered during the medication pass on 10/21/21 at 7:55am revealed Resident #6 was administered 18 oral medications including one Vitamin B complex. Interview with Resident #6 on 10/21/21 at 8:23am revealed she took so many medications that she depended on the facility to keep up with the medications and make sure she received all her medications as ordered.	{D 358}		

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{D 358}	Continued From page 12 Telephone interview with an order entry staff member for the facility's contracted pharmacy on 10/21/21 at 2:40pm revealed: -The facility was responsible to fax physician's orders to the pharmacy for entering or discontinuing medications. -The facility did not receive the physician's order dated 10/08/21 to discontinue Vitamin B complex. Telephone interview with Resident #6's Primary Care Provider (PCP) on 10/21/21 at 3:15pm revealed: -Resident #6 was ordered Vitamin B complex in July 2021 as part of her standard COVID-19 prevention. -The PCP had begun to discontinue COVID-19 preventive medications to lessen the number of medications some residents were taking since the facility had not had a recent case of COVID-19. -The facility should ensure medications that were discontinued were not being administered to residents. Refer to interview with the medication aide (MA) on 10/21/21 at 12:30pm. Refer to interview with the Compliance Director (CD) on 10/21/21 at 11:55am. Refer to interview with the Special Care Unit Coordinator (SCUC) on 10/21/21 at 12:08am. Refer to interview with the Administrator on 10/21/21 at 1:30pm. c. Review of Resident #6's physician's orders dated 07/28/21 revealed an order for Zinc Sulfate 220mg (a vitamin supplement) take once daily.	{D 358}		

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{D 358}	Continued From page 13 Review of Resident #6's a physician's order dated 10/08/21 revealed to discontinue Zinc Sulfate 220mg. Review of Resident #6's October 2021 eMAR revealed: -There was an entry for Zinc Sulfate 220mg daily to be administered at 8:00am. -There was documentation Zinc Sulfate 220mg was administered at 8:00am at 10/21/21. Observation of medications administered during the medication pass on 10/21/21 at 7:55am revealed Resident #6 was administered 18 oral medications including one Zinc Sulfate 220mg. Interview with Resident #6 on 10/21/21 at 8:23am revealed she took so many medications that she depended on the facility to keep up with the medications and make sure she received all her medications as ordered. Telephone interview with an order entry staff member for the facility's contracted pharmacy on 10/21/21 at 2:40pm revealed: -The facility was responsible to fax physician's orders to the pharmacy for entering or discontinuing medications. -The facility did not receive the physician's order dated 10/08/21 to discontinue Zinc Sulfate 220mg. Telephone interview with Resident #6's Primary Care Provider (PCP) on 10/21/21 at 3:15pm revealed: -Resident #6 was ordered Zinc Sulfate 220mg in July 2021 as part of her standard COVID-19 prevention. -The PCP had begun to discontinue COVID-19	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076032	A. BUILDING: _____ B. WING _____	R-C 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 358}	Continued From page 14 preventive medications to lessen the number of medications some residents were taking since the facility had not had a recent case of COVID-19. -The facility should ensure medications that were discontinued were not being administered to residents. Refer to interview with the medication aide (MA) on 10/21/21 at 12:30pm. Refer to interview with the Compliance Director (CD) on 10/21/21 at 11:55am. Refer to interview with the Special Care Unit Coordinator (SCUC) on 10/21/21 at 12:08am. Refer to interview with the Administrator on 10/21/21 at 1:30pm. _____ Interview with the MA on 10/21/21 at 12:30pm revealed: -She did not know Resident #6 had medications discontinued by the resident's PCP on 10/08/21. -The Resident Care Coordinator (RCC) was responsible to fax orders to the contracted pharmacy and ensure medications appeared on the eMAR for administering as ordered. -She administered medications according to the eMAR and pharmacy's packaging. -Resident #6 received medications as they appeared on the eMAR. Interview with the Compliance Director (CD) on 10/21/21 at 11:55am revealed: -The facility did not currently have a RCC due to staff turnover. -She started working at the facility in August 2021 to assist with medication and health care management.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 358}	Continued From page 15 -The Special Care Unit Coordinator (SCUC) was responsible to ensure medication orders were processed by the contracted pharmacy for the Special Care Unit and the Assisted Living unit until the RCC was replaced. -The SCUC must have overlooked Resident #6's orders dated 10/08/21 to discontinue medications. Interview with the SCUC on 10/21/21 at 12:08am revealed: -She was responsible to ensure all orders were processed by the contracted pharmacy. -There was a third MA that assisted her with sending orders to the pharmacy. -The MA placed orders in a designated spot for the SCUC to double check entry by the pharmacy, approve the orders, and release the orders to appear on the residents' eMARs. -The SCUC did not know how Resident #6's 10/08/21 physician's orders to discontinue medications was overlooked. Interview with the Administrator on 10/21/21 at 1:30pm revealed: -The RCC was responsible to ensure medication orders were processed including discontinuing medications per physician's orders. -The RCC or CD were responsible to ensure the contracted pharmacy was faxed all medication orders. -The Administrator did not routinely monitor medication administration.	{D 358}		