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
	HAL037001	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATES HOUSE	11 COMMERCE DRIVE GATESVILLE, NC 27938

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D 000	Initial Comments The Adult Care Licensure Section completed an annual survey and complaint investigation on 02/08/23 through 02/10/23.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the primary care provider (PCP) was notified for 2 of 5 sampled residents (#1, #5), related to a resident with a lesion on his scalp and was not referred to a dermatologist (#1) and a resident who had choking episodes with hospitalizations who was not referred for a gastroenterology consultation and had painful toenails that were overgrown and was not referred to a podiatrist (#5). The findings are: 1. Review of Resident #5's current FL-2 dated 08/26/22 revealed diagnoses included dementia without behavioral disturbances, gastroesophageal reflux disease (GERD), hypertension and mood disorder. a. Review of Resident #5's diet order dated 02/06/23 revealed an order for mechanical soft diet with ground meats. Review of a physician order for Resident #5 dated 07/26/22 revealed:	D 273	Gates House shall ensure referral and follow-up to meet the routine and acute health care needs of Residents. Area Clinical Director (ACD) in-serviced Executive Director (ED) and Memory Care Manager (MCM) on the importance of using the Order Processing System to ensure healthcare Referral and Follow-up is managed properly for Residents. ACD in-serviced Med Techs on Timely Documentation related to Acute Changes in Resident's Condition, Requiring Report to PCP for appropriate Follow-Up/ Referrals/ New Orders. ACD in-serviced ED and Care Managers on the importance of reviewing new orders, daily documentation, referrals daily in Management meeting to ensure proper follow-up and interventions have been put in place. Also, in-serviced on the importance of clarifying orders to ensure accuracy and compliance. ACD in-serviced Med Techs on the	2/13/23 2/13/23 2/13/23

Reviewed and Acknowledged 03/28/23:MB

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D 273	Continued From page 1 -Facility staff documented that the resident had been choking when eating breakfast, lunch, and dinner and that he started coughing when he took a bite of his food. -The primary care physician (PCP) ordered the resident a mechanical soft diet and ordered a barium swallow to rule out aspiration due to the resident choking when he ate. Review of Resident #5's barium swallow test dated 08/09/22 revealed his test was within normal limits. Review of a physician order for Resident #5 dated 09/26/22 revealed: -Facility staff documented that the resident had a barium swallow that was within normal limits and patient had choking episodes. -The PCP ordered a gastroenterology consultation due to choking while eating and possible esophageal stricture (an abnormal tightening or narrowing of the esophagus). Review of an incident and accident report for Resident #5 dated 09/30/22 revealed a medication aide (MA) observed the resident in the dining room when he temporarily became unconscious and slid to the floor; the resident was transported by emergency medical services (EMS) to a local hospital. Review of a discharge summary for Resident #5 dated 10/04/22 revealed the resident was hospitalized from 09/30/22 to 10/04/22 with a diagnoses of syncope (loss of consciousness) and collapse. Review of an incident and accident report for Resident #5 dated 10/05/22 revealed: -A MA observed the resident in the dining room	D 273	importance of utilizing the order processing system to ensure proper follow through on physician orders; alert charting to ensure that the Resident's Medical Record reflects orders received, care given, and the Resident's response to treatments/ interventions ordered by the Provider; the importance of completing the 24 Hour communication log for effective shift to shift communication for proper follow-up; the importance of proper completion of Resident incident reports; and appropriate timeframe for notifying PCP as well as Resident's Responsible party. Care Managers will round with in-house Providers on facility's "Doctor Days" whenever possible to ensure Residents of concern are being evaluated, and communication is clear on the plan of care. This will allow for clarification of orders in real time, while the Provider is still present if needed. Care Managers will ensure the Order Processing System is implemented appropriately and is in compliance with it's use. The Order Processing System is instrumental to ensuring appropriate approval, processing, and follow-up on Provider's orders and referrals. Care Managers will follow-up with Med Techs on the appropriate and mandatory use of the 24 hr communication log. They will review the log	2/21/23 3/12/23 3/12/23 3/12/23

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D 273	Continued From page 2 breathing but unresponsive. -The resident was transported by EMS and admitted to a local hospital for seizures. Review of a discharge summary for Resident #5 dated 10/10/22 revealed the resident was hospitalized from 10/05/22 to 10/10/22 with a diagnoses of seizure disorder. Review of an incident and accident report for Resident #5 dated 01/28/23 revealed: -Staff observed the resident in the dining room unresponsive, in a deep stare and drooling. -The resident was transported by EMS to a local hospital. Review of a discharge summary for Resident #5 dated 01/30/23 revealed the resident was hospitalized from 01/28/23 to 01/30/23 with a diagnoses of a transient ischemic attack (TIA). Observation of Resident #5 during lunch on 02/08/23 at 11:34am revealed: -He was served chopped hamburger with gravy, mashed potatoes with gravy, mixed vegetables, a biscuit, ice cream, water, milk, and tea. -The resident coughed 3 times while eating his hamburger and mashed potatoes with gravy. -The resident coughed 3 times after he took a bite of his biscuit. -Resident #5 asked staff to pat his back at 11:57am after he ate a portion of the biscuit because he was coughing and observed with tears down both sides of his face. -A personal care aide (PCA) patted the resident on his back and encouraged him to take his time and take small bites of food. Interview with Resident #5 on 02/10/23 at 12:15pm revealed:	D 273	daily to ensure Med Techs are utilizing this tool correctly for their reporting from shift to shift. Care Managers will review discharge summaries received from Resident's stay in the hospital completely to ensure there are no missed orders or referrals. Care Managers will review the electronic facility documentation daily for any needed follow-up. This documentation will be reviewed daily in management meeting with the ED to ensure follow-up and interventions are appropriate. Care Managers will complete a minimum of 2 chart audits weekly to ensure orders are accurate and have been processed and implemented. completed chart audits will be verified by the ED.	3/12/23 3/12/23 3/12/23

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D 273	Continued From page 3 -He coughed when he ate because food got caught in his mouth and throat. -He choked during most meals and did not understand why. -When he had difficulty swallowing and began to choke, he felt scared and felt like he would vomit. -He did not cough or choke when staff sat with him during meals. Interview with a PCA on 02/08/23 at 12:05pm revealed: -Resident #5 coughed and choked during most meals because he put too much food in his mouth. -She observed him during dinner on 02/04/23 and he had coughing spells and choked because he put too much food in his mouth. -She monitored him during meals because he coughed and became strangled during most meals, and it scared her. -She and the MA had to pat the resident on his back and instruct him to raise his arms above his head when he choked on his food. -She had notified the MA weekly about his coughing and choking episodes during meals. Observation of Resident #5 in the dining room on 02/09/23 at 5:26pm revealed: -The baked potato had butter and was chopped up. -He coughed and began to choke when he attempted to eat his baked potato. -A MA, PCA and a corporate staff member came to his table and reminded him to slow down when eating and to take his time. -When he began to choke the MA and PCA patted him on his back. -Staff were asked to remove the biscuit from Resident #5's plate because it was not soaked.	D 273		

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D 273	Continued From page 4 Interview with a dietary aide on 02/09/23 at 5:28pm revealed: -Resident #5 coughed during most meals. -When the resident coughed; he coughed so hard that "water" came out of his eyes. Interview with a MA on 02/09/23 at 3:00pm revealed: -Resident #5 coughed and choked during most meals. -She observed Resident #5 choke during his dinner meal on 01/30/23, 02/02/23, 02/03/23 and 02/06/23. -He tended to cough and choke even if he ate a small grain. -Staff encouraged him to take bites of his food and to drink in between bites of food. -A MA and PCA observed him at each meal to help remind him to slow down. -She did not realize that the PCP had ordered the resident to have a gastroenterology consultation completed. -The MAs or RCC were responsible for completing referrals and making appointments. Interview with a second MA on 02/10/23 at 10:52am revealed: -Resident #5 choked most times when he was eating. -Staff had to pat the resident on his back during most meals when he started choking and would also remind him to raise his hands above his head. -She had not contacted the resident's PCP to report his choking episodes. -She did not know that the PCP had ordered the resident to be seen for a gastroenterology consultation. -The MAs or RCC completed referrals. -She should have contacted his PCP to ensure	D 273		

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D 273	Continued From page 5 his safety and realized he was at an increased risk of aspirating due to his choking. -It would benefit the resident to contact his PCP to provide an update on his frequent choking Telephone interview with the resident's primary care physician (PCP) on 02/10/23 at 9:00am revealed: -Resident #5 had a history of choking on his food. -She ordered a swallow test that was completed on 08/09/22 and it was normal. -She had not been notified by facility staff that the resident was choking during most of his meals. -She had not been notified by facility staff that the resident was not seen for a gastroenterology consultation. -She would have ordered x-rays periodically to ensure he did not have aspiration pneumonia if staff had notified her of his frequent choking. -She would have changed his diet to pureed and ordered him to have one on one feeding assistance. -Resident #5 should have been referred for a gastroenterology consultation for his safety. -Staff placed Resident #5 at a high risk of being readmitted to the hospital by not notifying her of the increased frequency of his choking episodes. -Failure of staff to notify her of the residents increased choking episodes put the resident at a high risk of a stroke, seizures or passing out in the dining room from choking. -Resident #5 was at risk of the Heimlich maneuver not working if needed due to an esophagus muscle spasm, which put him at a great risk of becoming unconscious. -Resident #5's choking would eventually progress, and she was afraid that without a proper diet order and one on one feeding assistance that he was at risk of choking to death.	D 273		

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D 273	Continued From page 6 Interview with the Administrator on 02/10/23 at 2:02pm revealed: -She was not aware that Resident #5's PCP had ordered a gastroenterology consultation. -The RCC was usually the staff responsible for making referrals; but MAs could also schedule referrals. -She expected the RCC and MAs to make every effort to follow up with any orders from a residents' PCP to ensure their safety. -Staff had placed Resident #5 at a great risk of choking by not ensuring his gastroenterology consultation was completed. -Resident #5 had been in the hospital for seizures and she worried that he could have another seizure or become unconscious from choking. Attempted to interview with RCC on 02/09/23 at 10:45am was unsuccessful. Review of Resident #5's current FL-2 dated 08/26/22 revealed diagnoses included dementia without behavioral disturbances, gastroesophageal reflux disease (GERD), hypertension and mood disorder. b. Review of Resident #5's care plan dated 08/09/22 revealed he required assistance with nail care, bathing, dressing, shaving, and grooming. Review of Resident #5's most recent progress note from the facility's contracted podiatrist dated 06/22/22 revealed: -The resident complained that his toenails were long and thick, and he needed them trimmed. -The resident complained that his feet hurt all over.	D 273		

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D 273	Continued From page 7 Observation of Resident #5 on 02/08/23 at 9:38am revealed: -The resident was lying in bed with his shoes and socks off. -Some of his toenails were overgrown. -The right big toenail was ¼ inch long extended from his toe and pushed against his second toe. -The left big toenail was jagged, ½ inch long extended from the his toe and was curved under his second toe. -His second toenail on his left foot was ½ inch long extended from his toe. Interview with Resident #5 on 02/08/23 at 9:39am revealed: -His toenails were painful and hurt when he walked. -Staff had not trimmed his toenails in the past 3 months and he had not seen the podiatrist since June 2022 or July 2022. -He used a rollator to assist with his walking. -He received showers three times a week and staff applied cream on his feet every day. -He had told a medication aide (MA) and a personal care aide (PCA) that his toenails needed to be cut but no one had cut them. Interview with a PCA on 02/09/23 at 2:45pm revealed: -PCAs were allowed to trim resident toenails if they were not diabetic. -Resident #5 received showers every Monday, Wednesday, and Friday. -PCAs completed shower assessments in the computerized system. -She was expected to report any concerns to the MA or the RCC. -She had not seen the podiatrist at the facility for several months. -She reported Resident #5's toenails were long to	D 273		

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D 273	Continued From page 8 the two MAs and the RCC at least 2 times in January 2023 because she was not comfortable trimming his toenails. Interview with a medication aide (MA) on 02/09/23 at 3:00pm revealed: -Resident #5's toenails were long, and they needed to be trimmed. -A PCA or MA should have trimmed the resident's toenails since he was not a diabetic. -The facility's contracted podiatrist had not visited since June 2022. -Resident #5's toenails could have become infected, he could experience pain, and it increased his risk of a fall. -MAs were expected to report any concerns of resident unmet needs to the RCC. -She reported to the RCC in person, by phone or by texting. -The MAs were also able to contact the PCP regarding any concerns about a resident. -MAs and the RCC were able to reach the PCP by paging her or emailing her. -The MAs and the RCC should have contacted Resident #5's PCP to notify her his toenails were too long. Interview with a second MA on 02/10/23 at 10:52am revealed: -PCAs applied foot cream to the resident's entire foot on Monday, Wednesdays, and Fridays after his showers. -MAs applied the foot cream on his non shower days. -His toenails had been long for approximately 2 months. -The facility's contracted podiatrist had not been to the facility for several months. -The RCC had attempted to get a podiatrist to	D 273		

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D 273	Continued From page 9 come to the facility. Interview with Resident #5's primary care physician (PCP) on 02/10/23 at 9:00am revealed: -Staff had not notified her that the facility's contracted podiatrist had not been to the facility in several months. -Staff had not notified her that Resident #5's toenails had grown so long. -If staff had notified her, she would have ordered a referral for Resident #5 to go to a podiatrist. -She would have cut his toenails herself. -MAs applied a special cream to his feet daily to help with dry skin. -She did not understand why the MAs had not notified her of the excessive growth of his toenails when they applied the special cream to his feet once a day. -Resident #5 had showers every other day by PCAs and she should have been notified of the concern of his long toenails. -The resident suffered pain to his feet that should not have occurred, it was preventable. -The resident was an increased fall risk due to his feet hurting when he walked. -He was at an increased risk of infection and his foot becoming septic. Interview with the Administrator on 02/10/23 at 2:02pm revealed: -PCAs could cut resident toenails if the resident was not a diabetic. -The facility's contracted podiatrist had not been to the facility for at least 2 months. -The MA or RCC should have contacted Resident #5's PCP about his toenails to request a referral to a podiatrist appointment. -Resident #5 was placed at a risk of infection and falls due to his toenails hurting when he walked.	D 273		

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D 273	Continued From page 10 Attempted to interview with RCC on 02/09/23 at 10:45am was unsuccessful. 2. Review of Resident #1's current FL-2 dated 08/26/22 revealed: -Diagnoses included Dementia ad major cognitive disorder. -There was documentation that he was intermittently disoriented. -The level of care was documented as special care unit (SCU). Observation on Resident #1 on 02/08/23 at 8:49am revealed: -There was an open would on the right side of his head approximately the size of a half dollar. -There was dried blood on his pillow and in the hair surrounding the wound. Interview with Resident #1 on 02/08/23 at 8:49am revealed: -He thought he fell and hit his head approximately 3 months prior, hit his head on the night stand and the wound never stopped bleeding. -He was not receiving treatment to the wound and wanted to see a dermatologist. Review of Resident #1's physician's order dated 112/19/22 revealed an order to schedule an appointment with dermatology for lesion to his scalp that was draining. Review of Resident #1's record revealed there was no documentation of contact with a dermatology provider. Interview with a personal care aide (PCA) on 02/08/23 at 9:00am revealed: -The wound had been present on Resident #1's head for a couple of months.	D 273		

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D 273	Continued From page 11 -She was not sure what caused the wound but she did not think it was from a fall. -Resident #1 wound pick at the wound and kept it open. -Resident #1's primary care provider (PCP) was aware of the wound. Interview with the Special Care Coordinator (SCC) on 02/09/23 at 10:10am revealed: -She was responsible for ensuring physician ordered were completed. -She gathered any needed paperwork for referrals and give to transportation staff to schedule the appointment within 48 hours of receiving the order. -She was out sick for 2 weeks in December during the time the dermatology referral was ordered for Resident #1 and the Resident Care Coordinator (RCC) was supposed to cover for her during her absence.. -She found the order incomplete when she returned to work and gave the information to transportation early January 2023 but she did not know the exact date. -She did not know if Resident #1 had been seen by a dermatologist or had an appointment to be seen by dermatology. -She should have followed up with transportation to ensure an appointment was made but she had been busy. Interview with Resident #1's mental health provider on 02/09/23 at 11:01am revealed: -The wound on Resident #1's head had been there for a long time. (Did not quantify length of time) -Resident #1 reported the wound occurred 3 months prior for as long as she could remember. -Resident #1 had an order for a referral to dermatology for suspected skin cancer.	D 273		

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D 273	Continued From page 12 Telephone interview with Resident #1's primary care provider (PCP) on 02/10/23 at 9:00am revealed: -She ordered a dermatology referral for Resident #1 because he had a lesion on the side of his head that was draining and she suspected skin cancer. -The transportation staff told her the previous week that he was having difficulty finding a dermatologist that would take Resident #1's insurance or the appointment was weeks out. -She did not know the order was not processed until January 2023. -She expected orders to be carried out as soon as possible. Telephone interview with the transportation staff on 02/10/23 at 11:04am revealed: -He received the order for Resident #1's referral to dermatology on 01/06/23 from the SCC but could possibly have been 01/08/23. -He began calling dermatology offices to schedule an appointment but was having difficulty because the dermatologist the facility usually used no longer accepted Resident #1's insurance and other offices were not accepting new patients. -Another dermatology office had an appointment at the end of March 2022 and reached out to Resident #1's PCP regarding the appointment being so far out, however an appointment was ultimately scheduled for the end of February 2023. -He should have received the order for dermatology as soon as possible after in was received by the SCC. -He did not know why it took so long for him to receive the order from the SCC.	D 273		

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D 273	Continued From page 13 Interview with the Administrator on 02/10/23 at 2:02pm revealed: -The care managers (RCC and SCC) were responsible for ensuring orders are completed as ordered within 48-72 hours of receiving them. -The SCC was out of work for a couple of weeks in December 2022 and the RCC was expected to cover the SCU while she was out. -She was not aware the dermatology referral was delayed for Resident #1. Attempt to interview with RCC on 02/09/23 was unsuccessful. The facility failed to ensure notification for referral and follow up to the primary care provider (PCP) for 2 of 5 sampled residents (#1, #5) related to Resident #1's lesion on his scalp that was draining and had not been referred to a dermatologist, and a resident (#5) who did not have his toenails trimmed which caused pain and was not referred for a gastroenterology consultation for choking episodes during most meal which could have caused a stroke, seizure, or death. This failure placed the resident at substantial risk of physical harm and constitutes a Type A2 Violation. A plan of protection was submitted by the facility in accordance with G.S. 131D-34 on 02/09/23. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 12, 2023.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 310		

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D 310	Continued From page 14 (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to serve a therapeutic diet as ordered by the primary care provider (PCP) for 1 of 2 sampled residents (#5) with a mechanical soft diet with ground meats. The findings are: Review of Resident #5's current FL-2 dated 08/26/22 revealed diagnoses included dementia without behavioral disturbances, gastroesophageal reflux disease (GERD), hypertension and mood disorder. Review of Resident #5's diet order dated 08/26/22 revealed an order for mechanical soft diet with ground meats. Review of Resident #5's diet order dated 02/06/23 revealed an order for mechanical soft diet with ground meats. Review of a physician's order for Resident #5 dated 07/26/22 revealed: -Facility staff documented that the resident had been choking when eating breakfast, lunch, and dinner and that he started coughing when he took	D 310	Gates House shall ensure that all therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the Resident's physician. ACD in-serviced all staff, including dietary staff, on Therapeutic Diets and the importance of ensuring Residents receive proper diet consistency per MD orders. ACD and Dietary Manager (DM) in-serviced Dietary staff on Rule Area .0904- Nutrition and Food Services, related to updates effective 3/1/23. Local Health Department (LHD) provided food safety refresher in-servicing for Dietary Staff. Care Manager notified PCP of choking episodes x 2 for Resident #5 on 2/9/23. ED/DM will ensure that all newly hired Cooks are trained to understand therapeutic diets, as well as how to review the recipes for the "Special Diet Instructions". DM will ensure updated menus are printed and available for reference to enable cooks to provide appropriate substitutions for mechanically altered diets. ED or Designee will make random observations during meal times to ensure diets are prepared and served	2/9/23 2/10/23 2/21/23 3/2/23 3/8/23 3/12/23 3/12/23 3/12/23

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D 310	Continued From page 15 a bite of his food. -The primary care physician (PCP) ordered the resident a mechanical soft diet with ground meats. -The PCP ordered a barium swallow to rule out aspiration due to the resident choking when he ate. Review of Resident #5's barium swallow test dated 08/09/22 revealed his test was within normal limits. Review of a physician order for Resident #5 dated 09/26/22 revealed: -The facility staff reported to the PCP that the resident continued to have choking episodes when he ate. -The PCP ordered a gastroenterology consultation due to choking while eating and possible esophageal stricture (an esophageal stricture is an abnormal tightening or narrowing of the esophagus). a. Review of the facility's posted menu for lunch on 02/08/23 revealed it included hamburger with gravy, mashed potatoes, grilled asparagus, mixed vegetables, biscuit, strawberry ice cream, water, milk, and tea. Review of the facility's assisted living diet chart on 02/08/23 revealed Resident #5 should be served a mechanical soft diet with ground meats. Review of the facility's diet extensions therapeutic diet menu for lunch dated 02/08/23 revealed: -There was no listing for a mechanical soft diet with ground meats. -There was a listing for mechanical soft diet with chopped meats which included: hamburger with gravy and mixed vegetables should be soft and	D 310	appropriately per Provider orders. Any noted concerns will be addressed with the DM and/or Cook on duty immediately.	

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D 310	Continued From page 16 chopped into bite sized portions, mashed potatoes should be moistened, and the biscuit should be soaked. Observation of Resident #5's during meal service on 02/08/23 from 11:34am to 12:05pm revealed: -He was served chopped hamburger with gravy, mashed potatoes with gravy, mixed vegetables, a biscuit, ice cream, water, milk, and tea. -The resident coughed 3 times while eating his hamburger and mashed potatoes with gravy. -The biscuit he was served had a crispy light brown crust on the top and was not soaked or moist. -Resident #5 picked up the biscuit, took one bite and began to cough. -The resident coughed 3 times after he took a bite of his biscuit. -Resident #5 asked staff to pat his back at 11:57am after he ate a portion of the biscuit because he was coughing and observed with tears down both sides of his face. -A personal care aide (PCA) patted the resident on his back and encouraged him to take his time and take small bites of food. -The resident at 75% of his meal and only ate half of his biscuit. -Resident #5's hamburger steak should have been chopped into bite sized portions and his biscuit should have been soaked. Interview with Resident #5 on 02/10/23 at 12:15pm revealed: -He coughed when he ate because food got caught in his mouth and throat. -He choked during most meals and did not understand why. -When he had difficulty swallowing and began to choke, he felt scared and felt like he would vomit. -Sometimes staff sat with him for a few minutes	D 310		

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D 310	Continued From page 17 when he coughed during meals. -He did not cough or choke when staff sat with him during meals. Interview with a dietary aide on 02/09/23 at 4:17pm revealed: -Resident #5 was on a mechanical soft diet with chopped meats. -The resident's biscuit served at lunch should be soaked. -She thought his biscuit was soaked because it was beside the vegetables on his plate and the juice from the vegetables had soaked the bottom of his biscuit. Interview with a PCA on 02/08/23 at 12:05pm revealed: -Resident #5 received a mechanical soft diet with chopped meats. -He coughed and choked during most meals because he put too much food in his mouth. -The resident had coughed and choked during meals for the past 2 months. -She reminded him to put small amounts in his mouth and take his time. -She observed him during dinner on 02/04/23 and he had coughing spells and choked because he put too much food in his mouth. -She monitored him during meals because he coughed and became strangled during most meals, and it scared her. -She and the MA had to pat the resident on his back and instruct him to raise his arms above his head when he choked on his food. -She had notified the MA weekly about his coughing and choking episodes during meals. Refer to interview with the dietary manager (DM) on 02/08/23 at 12:30pm.	D 310		

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D 310	Continued From page 18 Refer to interview with a medication aide (MA) on 02/09/23 at 3:00pm. Refer to interview with a second MA on 02/10/23 at 10:52am. Refer to interview with the primary care physician (PCP) on 02/10/23 at 9:00am. Refer to interview with the Administrator on 02/10/23 at 2:02pm. b. Review of the facility's posted menu for the dinner meal on 02/09/23 revealed it included beef barley soup, baked potato, caesar salad, garlic bread sticks, chocolate ice cream, water, milk, and tea. Review of the facility's assisted living diet chart on 02/09/23 revealed Resident #5 should be served a mechanical soft diet with ground meats. Review of the facility's diet extensions therapeutic diet menu for dinner dated 02/09/23 revealed: -There was no listing for a mechanical soft diet with ground meats. -There was a listing for mechanical soft diet with chopped meats which included: beef barley soup should have chopped meat, his baked potato should be moistened, caesar salad should be replaced by a soft bite sized vegetable and garlic breadsticks should be soaked. Observation of Resident #5's dinner meal on 02/09/23 at 5:26pm revealed he was served beef barley soup, chopped collards, baked potato with butter, biscuit, ice cream, milk, coffee, and tea. Observation of Resident #5 in the dining room on 02/09/23 at 5:26pm revealed:	D 310		

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D 310	Continued From page 19 -Resident #5 was served a biscuit that was not soaked, and he was able to pick up the biscuit with his hand. -The baked potato had butter and was chopped up. -He coughed and began to choke when he attempted to eat his baked potato. -A MA, PCA and a corporate staff member came to his table and reminded him slow down when eating and to take his time. -When he began to choke the MA and PCA patted him on his back. -Staff intervened and asked staff to remove the biscuit from Resident #5's plate because it was not soaked. Observation of the biscuit that was removed from Resident #5's plate on 02/09/23 at 5:27pm revealed the biscuit had some moisture on the bottom but was able to be cut up and was easily crumbled due to the overall dryness. Interview with a dietary aide on 02/09/23 at 5:28pm revealed: -Almost everything Resident #5 was served caused him to cough. -When the resident coughed; he coughed so hard that "water" came out of his eyes. Interview with a dietary aide on 02/09/23 at 5:30pm revealed: -Resident #5 was on a therapeutic diet that was mechanical soft with ground meats. -She knew to put some "moisture" on his biscuit to soften it to prevent the resident from coughing and choking. -She added a ¼ of a teaspoon of the soup broth on his biscuit to prevent him from coughing and choking. -She had only put ¼ of a teaspoon on the biscuit	D 310		

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D 310	Continued From page 20 because she did not want to get the biscuit too "mushy" but just wanted it moistened. -She did not realize that the biscuit should have been soaked. Refer to interview with the dietary manager (DM) on 02/08/23 at 12:30pm. Refer to interview with a medication aide (MA) on 02/09/23 at 3:00pm. Refer to interview with a second MA on 02/10/23 at 10:52am. Refer to interview with the primary care physician (PCP) on 02/10/23 at 9:00am. Refer to interview with the Administrator on 02/10/23 at 2:02pm. Interview with the Dietary Manager (DM) on 02/08/23 at 12:30pm revealed: -The Resident Care Coordinator (RCC) or MA provided her updated diet orders for residents. -She kept them in a binder. -The RCC provided her with a list that was posted in the kitchen of residents on a therapeutic diet. -She followed the directions on the facility's therapeutic diet menu. -She had not realized that his diet order should have been mechanical soft with ground meats instead of chopped meats. Interview with a MA on 02/09/23 at 3:00pm revealed: -Resident #5 coughed and choked during most meals. -She observed Resident #5 choke during his dinner on 01/30/23, 02/02/23, 02/03/23 and 02/06/23.	D 310		

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D 310	Continued From page 21 -He tended to cough and choke even if he ate a small grain. -He had a tendency to put too much food in his mouth and staff had to remind him to slow down, take his time and take small bites of food. -Staff encouraged him to take small bites of his food and to drink in between bites of food. -A MA and PCA observed him at each meal to help remind him to slow down. Interview with a second MA on 02/10/23 at 10:52am revealed: -Resident #5 choked most times when he was eating. -She and a PCA were in the dining room for meals. -The resident always tried to eat too fast. -When she or the PCA reminded him to slow down and take small bites he did not choke. -Staff had to pat the resident on his back during most meals when he started choking and would also remind him to raise his hands above his head. -She had not contacted the resident's PCP to report his choking episodes, she forgot to send her an update on Resident #5's coughing and choking episodes. -She should have contacted his PCP to ensure his safety and realized he was at an increased risk of aspirating due to his choking. -It would benefit the resident to contact his PCP to provide an update on his frequent choking. Telephone interview with the resident's primary care physician (PCP) on 02/10/23 at 9:00am revealed: -Resident #5 had a history of choking on his food. -She ordered a swallow test that was completed on 08/09/22 and it was normal. -Resident #5's diet order was changed on	D 310		

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D 310	Continued From page 22 08/26/22 to a mechanical soft diet with ground meats. -His most recent diet order was 02/06/23 and continued Resident #5 on a mechanical soft diet with ground meats. -She was not aware that the facility's therapeutic menu listed Resident #5 as a mechanical soft diet with chopped meats instead of ground meats as ordered. -She had not been notified by facility staff that the resident was choking during most of his meals. -She expected staff to follow the diet order for Resident #5; his meats should be ground and not chopped per her order on 08/26/22 and 02/06/22. -Staff placed Resident #5 at a high risk of being readmitted to the hospital by not notifying her of the increased frequency of his choking episodes. -Failure of staff to notify her of the residents increased choking episodes put the resident at a high risk of a stroke, seizures or passing out in the dining room from choking. -Resident #5 was at risk of the Heimlich maneuver not working if needed due to an esophagus muscle spasm, which put him at a great risk of becoming unconscious. -Resident #5's choking would eventually progress, and she was afraid that without a proper diet order and one on one feeding assistance that he was at risk of choking to death. Interview with the Administrator on 02/10/23 at 2:02pm revealed: -She was not aware that dietary staff were not preparing Resident #5's therapeutic diet as ordered. -The dietary staff should have prepared Resident #5's meals per the diet order provided by the PCP and followed directions on how each food item was to be prepared.	D 310		

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D 310	Continued From page 23 -Resident #5 was at risk of choking and aspiration pneumonia due to dietary staff not preparing his meals as ordered. The facility failed to ensure resident (#5) was served a modified diet, mechanical soft with ground meats as ordered, resulting in the resident coughing, and choking during two meals and required assistance from staff to prevent choking, which could have caused a stroke, seizure, or death. This failure placed the resident at substantial risk of physical harm and constitutes a Type A2 Violation. A plan of protection was submitted by the facility in accordance with G.S. 131D-34 on 02/09/23. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 12, 2023.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide feeding assistance to 1 of 2 sampled residents (#5) who required limited assistance with eating due to coughing and choking during meals.	D 312	Gates House shall ensure that Residents needing help in eating shall be assisted upon receipt of the meal, and the assistance shall be unhurried and in a manner that maintains or enhances each Resident's dignity and respect. ACD in-serviced care staff on the importance of observing and assisting Residents per their Care Planned needs during meal consumption. 2/21/23 ACD and DM in-serviced Dietary Staff on Rule Area .0904- Nutrition and Food Services, related to updates effective 3/1/23. 3/2/23	

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D 312	Continued From page 24 The findings are: Review of Resident #5's current FL-2 dated 08/26/22 revealed diagnoses included dementia without behavioral disturbances, gastroesophageal reflux disease (GERD), hypertension and mood disorder. Review of Resident #5's care plan dated 08/09/22 revealed he required limited assistance with eating. Review of Resident #5's diet order dated 02/06/23 revealed an order for mechanical soft diet with ground meats. a. Observation of Resident #5 during lunch on 02/08/23 at 11:34am revealed a medication aide (MA) and personal care aide (PCA) walked around the dining room when residents were eating lunch. Observation of Resident #5 during lunch on 02/08/23 at 11:34am revealed: -A PCA and MA were observed walking around the dining room to check on residents. -He was served chopped hamburger with gravy, mashed potatoes with gravy, mixed vegetables, and a biscuit. -The PCA and MA did not sit with Resident #5 during his meal; they walked by his table and reminded him to slow down and take his time. -The resident coughed 3 times while eating his hamburger and mashed potatoes with gravy. -A PCA came to his table to remind him to slow down and take small bites and then walked to another table in the dining room. -Resident #5 picked up the biscuit, took one bite and began to cough.	D 312	LHD provided food safety refresher in-servicing for Dietary Staff. ED/ Care Managers will continue to in-service staff on the importance of ensuring Residents that require feeding assistance, are assisted with their meals promptly upon meal service. Staff will continue to be in-serviced that Residents are not to have to wait to be served due requiring feeding assistance. ED/ Care Managers/ Designee will complete random rounds during meal times to ensure staff is compliant with assisting Residents with their meals according to their care planned needs, while ensuring Resident dignity is maintained.	3/8/23 3/27/23 3/27/23

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D 312	Continued From page 25 -The resident coughed 3 times after he took a bite of his biscuit. -A MA heard the resident coughing, walked to his table, patted him on the back and instructed him to raise his hands above his head. -Resident #5 coughed again and asked staff to pat his back at 11:57am after he ate a portion of the biscuit because he was coughing and had tears on both sides of his face. -A PCA patted the resident on his back and encouraged him to take his time and take small bites of food. Interview with Resident #5 on 02/10/23 at 12:15pm revealed: -Sometimes staff sat with him for a few minutes when he coughed during meals. -He did not cough or choke when staff sat with him during meals. -He coughed when he ate because food got caught in his mouth and throat. -He choked during most meals and did not understand why. -When he had difficulty swallowing and began to choke, he felt scared and felt like he would vomit. Interview with a PCA on 02/09/23 at 12:05pm revealed: -Resident #5 often coughed and chocked during meals because he put too much food in his mouth and ate too fast. -She reminded him to put small amounts in his mouth and take his time. -She observed the resident during dinner on 02/04/23, he coughed and choked because he put too much food in his mouth. -When she monitored the resident during meals she walked by his table and reminded him to slow down and take his time. -She did not provide one on one feeding	D 312		

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D 312	Continued From page 26 assistance during his meals but did sit with him at times for a few minutes to remind him to slow down. -She and the MA had to pat the resident on his back and instruct him to raise his arms above his head when he choked on his food. -She had notified the MA weekly about his coughing and choking episodes during meals. b. Observation of Resident #5 in the dining room on 02/09/23 at 5:26pm revealed: -A personal care aide (PCA) and medication aide (MA) walked around the dining room during the meal. -The PCA and MA did not sit with Resident #5 during his meal; they walked by his table and reminded him to slow down and take his time. -Resident #5 had eaten approximately half of his baked potato and then coughed and began to choke. -A MA, PCA and a corporate staff member came to his table and reminded him slow down when eating and to take his time. -When he began to choke the MA and PCA patted him on his back. Interview with a dietary aide on 02/09/23 at 5:28pm revealed: -Almost everything Resident #5 was served caused him to cough. -When the resident coughed; he coughed so hard that "water" came out of his eyes. Interview with a MA on 02/09/23 at 3:00pm revealed: -Resident #5 coughed and choked during most meals. -Resident #5 would cough and choke even if he ate a small grain. -The resident would put too much food in his	D 312		

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D 312	Continued From page 27 mouth and staff had to remind him to slow down, take his time and take small bites of food. -She observed Resident #5 choke during his dinner on 01/30/23, 02/02/23, 02/03/23 and 02/06/23. -A MA and PCA walked around the dining room during each meal and reminded him to slow down. -Staff did not sit with him during his meal to provide one on one feeding assistance. Interview with a second MA on 02/10/23 at 10:52am revealed: -Resident #5 coughed and choked frequently when he ate his meals and ate his food too fast. -She and a PCA were in the dining room for meals and walked around to see if residents needed assistance. -Staff had to pat the resident on his back during most meals when he started choking and would remind him to raise his hands above his head. -When she or the PCA reminded him to slow down and take small bites he did not choke. -She had not contacted the resident's PCP to report his choking episodes. -She thought an order by the PCP for one on one feeding assistance would help the resident not choke during meals. -She should have contacted his PCP about his frequent coughing and choking episodes and did not know why she had not contacted the PCP. -She was not aware that the residents care plan listed the resident with limited assistance when eating. -Limited assistance with eating meant that the resident needed a staff person to sit with him during his meals to remind him to eat slowly, take small bites and take sips in between swallowing. Telephone interview with the resident's primary	D 312		

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D 312	Continued From page 28 care physician (PCP) on 02/10/23 at 9:00am revealed: -Resident #5 had a history of choking on his food. -She had not been notified by facility staff that the resident was choking during most of his meals. -If she had been notified by staff that the resident was choking during most meals, she would have ordered the resident to have one on one feeding assistance. -Resident #5 would have benefited from one on one feeding assistance to remind him to eat slower, take smaller bites of food and to drink after he swallowed his food. -Staff placed Resident #5 at a high risk of being readmitted to the hospital by not notifying her of the increased frequency of his choking episodes. -Failure of staff to notify her of the residents increased choking episodes put the resident at a high risk of a stroke, seizures or passing out in the dining room from choking. -Resident #5 was at risk of the Heimlich maneuver not working if needed due to an esophagus muscle spasm, which put him at a great risk of becoming unconscious. -Resident #5's choking would eventually progress, and she was afraid that without a proper diet order and one on one feeding assistance that he was at risk of choking to death. Interview with the Administrator on 02/10/23 at 2:02pm revealed: -She did not know Resident #5's care plan listed him as limited assistance with eating. -Based on his care plan staff should have sat with the resident for all meals. -Staff walked in the dining room and asked residents if they needed assistance but she had not observed one on one feeding assistance for any residents.	D 312		

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D 312	Continued From page 29 -The Resident Care Coordinator (RCC) and medication aide (MA) should have followed the resident's care plan and provided limited assistance with feeding to ensure his safety. -The RCC or MA should have contacted the resident's PCP to notify of his frequency of coughing and choking with meals. -Resident #5 was at risk of additional choking episodes without being provided limited assistance with eating during his meals. -Resident #5 was at an increased risk of additional choking episodes and aspiration pneumonia.	D 312		
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, record reviews, and interviews, the facility failed to administer medication as ordered for 2 of 5 sampled residents (#1, #4) including a medication used to control blood sugar (#4) and a medication used to treat low iron levels in the blood (anemia) (#1). The findings are: Review of the facility's medication administration policy dated September 2021 revealed:	D 358	Gates House shall ensure that the preparation and administration of medications and treatments by staff are according to Providers' orders, which are maintained in the Resident's record, the facility's policies and procedures, and the rules in Section .1004(a). ACD in-serviced Med Techs on the importance of proper medication administration according to MD orders and facility policies and procedures; the importance of following the 6 Rights of Medication Administration; timely reordering of Residents' medications; and the importance of completing weekly cart audits to ensure Residents medications are available. Med Techs will complete MAR to cart audits per facility schedule to ensure availability and accuracy of medications on medication carts. The audits will be reviewed by the Care Managers	2/9/23 2/10/23 3/27/23

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D 358	Continued From page 30 -All orders are reviewed by the Resident Care Coordinator (RCC) or designee. -The RCC, or the medication aide (MA) if after hours/weekends, fax the order to the pharmacy and scan the order into the electronic system. -The RCC or designee will wait for the order to be placed in the electronic medication system for approval and then approve the order for administration and follow the steps in the order process system (bucket system). -The MAs will review the Facility Activity Report at the beginning of each shift for order changes when a new order, or change order is received. -The RCC or designee would follow up timely to receive any necessary clarification for physician's orders. 1. Review of Resident #4's current FL-2 dated 10/20/22 revealed diagnoses included, diabetes mellitus type 2, acute encephalopathy, altered mental status, and major neurocognitive disorder. Review of a physician order dated 10/20/22 revealed an order for Metformin 500mg, 1 tablet daily with food at 8:00am. (Metformin is a medication used to control blood sugar). Review of Resident #4's February 2023 medication administration record (MAR) revealed: -There was an entry for Metformin, 500mg, 1 tablet daily with food to be administered at 8:00am. -There was documentation Metformin 500mg, 1 tablet was administered at 8:00am from 02/01/23 through 02/03/23 and from 02/05/23 through 02/08/23. -There was no documentation that Metformin 500mg, 1 tablet was administered at 8:00am on 02/04/23. -There was documentation Metformin, 500mg, 1	D 358	and ED upon completion for compliance, and to ensure accurate and adequate medications are on hand at all times. Care Managers will complete a minimum of 2 chart audits weekly to ensure that all orders have been processed properly to allow for accurate medication administration. Completed chart audits will be reviewed by the ED for compliance. Care Managers will complete cart audits weekly for overall QA of the medication carts to ensure the cart is stocked with appropriate and accurate medications. ACD will perform random med pass observations at a minimum of 3 observations per month. Observations will be reviewed with the Med Tech for educational feedback, the respective Care Manager, and the ED who will then file in the employee's education folder. Care Managers will ensure accuracy when approving orders, making sure to follow all directions given. Care Managers will be sure to seek order clarification for any unclear or incomplete orders received. Care Managers will pull Medication Compliance Reports daily to ensure medications are administered per MD orders. Reports will be reviewed with	3/27/23 3/27/23 3/27/23 3/27/23 3/27/23

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D 358	Continued From page 31 tablet was not administered on 02/09/23 because it was unavailable. Observation of Resident #4's medications on hand on 09/09/23 at 9:30am revealed Metformin was not in the medication cart. Telephone interview with the facility's contracted pharmacist on 02/09/23 at 9:00am revealed: -Resident #4's Metformin was dispensed on 01/02/23 for a 7-day supply. -Resident #4's Metformin was dispensed on 01/09/23 for a 7-day supply. -Resident #4's Metformin was dispensed on 01/16/23 for a 7-day supply. -Resident #4's Metformin was dispensed on 01/23/23 for a 7-day supply. -Resident #4's Metformin was dispensed on 01/30/23 for a 2 pill. -Resident #4's Metformin was last dispensed on 02/01/23 for 2 pills. -Resident #4's Metformin prescription had expired and he needed a new prescription. -An electronic notification was sent to the facility that a new prescription was needed for Resident #4. Interview with Resident #4 on 02/09/23 at 9:45am revealed: -He did not get his Metformin medication on the morning of 02/09/23. -There were other times he did not get his Metformin but he could not remember when. Interview with the medication aide (MA) on 02/09/23 at 10:00am revealed: -Metformin was not administered to Resident #4 on 02/09/23 because the medication was not on the medication cart. -She would notify the Special Care Coordinator	D 358	the ED during management meeting daily for compliance. Any noted areas of concern will have follow-up as appropriate, including MD notifications, clarifications, and any interventions needed.	

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D 358	Continued From page 32 (SCC) when a medication needed to be re-filled. Interview with the SCC on 02/09/23 at 4:10pm revealed: -Medications were dispensed for a 7-day supply each week. -Medications were delivered by the facility's contracted pharmacy on Wednesday, the night shift (7:00pm-7:00am) placed the medications on the cart Thursday night. -She did not recall receiving a notification from the facility's contracted pharmacy that Resident #4 needed a refilled prescription for Metformin. -She conducted medication cart audits for the special care unit. Interview with the Administrator on 02/09/23 at 4:30pm revealed: -The facility's contracted pharmacist usually notified the facility when a refilled prescription was needed for a resident. -The medication cart audit should be done weekly by the SCC. -The facility should have been aware of a refilled prescription being needed for Resident #4 when the medication cart audit was done. -She expected the SCC to call the primary care provider (PCP) when a prescription needed to be refilled. -She did not know why the PCP was not notified that a refilled prescription was needed for Resident #4. Attempted telephone interview with Resident #4's primary care provider (PCP) on 02/09/23 at 2:30pm was unsuccessful. 2. Review of Resident #1's current FL-2 dated 08/26/22 revealed: -Diagnoses included Dementia ad major cognitive	D 358		

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D 358	Continued From page 33 disorder. -There was documentation that he was intermittently disoriented. -The level of care was documented as special care unit (SCU). -There was an order for ferrous sulfate 325mg to be administered each day. (Ferrous Sulfate is a medication used to treat low iron levels in the blood.) Review of Resident #1's physicians order dated 12/19/22 revealed there was an order to discontinue ferrous sulfate 325mg each day. Review of Resident #1's electronic medication administration record (eMAR) for December 2022 revealed: -There was a computerized entry for ferrous sulfate 325mg to be administered each day. -There was documentation ferrous sulfate 325mg was administered each day at 8:00am from 12/01/22 through 12/31/22. Review of Resident #1's eMAR for January 2023 revealed: -There was a computerized entry for ferrous sulfate 325mg to be administered each day. -There was documentation ferrous sulfate 325mg was administered each day at 8:00am from 01/01/23 through 01/03/23. Telephone interview with Resident #1's primary care provider (PCP) on 02/10/23 at 9:00am revealed: -She discontinued Resident #1's ferrous sulfate in December 2022 because his iron level was within normal range. -She tried to discontinue medications for residents when it was appropriate to decrease medication cost.	D 358		

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D 358	Continued From page 34 -She expected orders to be processes as soon as possible after they are written. Interview with the Special Care Coordinator (SCC) on 02/09/23 at 10:10am revealed: -Medication orders were placed in her box and she was responsible for faxing the order to the pharmacy. -She expected orders to be sent to pharmacy within 48 hours of receiving the order if it is received on a Friday. -She expected the order to be processed by the pharmacy within 24 hour after faxing the order. -She was responsible for ensuring physician ordered were completed. -She was out sick for 2 weeks in December during the time the discontinuation of ferrous sulfate was ordered for Resident #1 and the Resident Care Coordinator (RCC) was supposed to cover for her during her absence.. -She found the order to discontinue Resident #1's ferrous sulfate was not completed when she returned to work and faxed the order to the pharmacy in early January 2023 but she did not know the exact date. Interview with the Administrator on 02/10/23 at 2:02pm revealed: -The care managers (RCC and SCC) were responsible for ensuring orders are completed as ordered within 48-72 hours of receiving them. -The SCC was out of work for a couple of weeks in December 2022 and the RCC was expected to cover the SCU while she was out. -She was not aware Resident #1 continued to receive ferrous sulfate 2-3 weeks after it was discontinued.	D 358		

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D 367	Continued From page 35	D 367	Gates House shall ensure the Resident's MAR is accurate and complete for medication administration, as well as have accurate and complete documentation.	
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the faility failed to ensure the medication administration records (MAR) were accurate for 2 of 5 sampled residentes (#4, #5) including a medication used to control blood sugar (#4) and a medication used as a sleep aide (#5). The findings are: 1. Review of Resident #4's current FL-2 dated 10/20/22 revealed diagnoses included, acute	D 367	ACD in-serviced the ED and Care Managers on the importance of reviewing new orders for accuracy and completion, as well as the importance of clarifying orders that are incomplete or unclear to ensure compliance with proper medication administration. Care Managers will ensure accuracy when approving orders, making sure to follow all directions given, and seeking clarification for any unclear or incomplete orders. Care Managers will complete cart audits weekly for overall QA of the cart is stocked with appropriate and accurate medications. Med Techs will complete MAR to cart audits per facility schedule to ensure availability and accuracy of medications on the med carts. Completed audits will be reviewed by the Care Managers and ED for compliance, and to ensure accurate and adequate medications are on hand at all times. Care Managers will pull medication compliance reports daily to ensure medications are administered per MD orders. Report will be reviewed with	2/13/23 3/27/23 3/27/23 3/27/23 3/27/23

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D 367	Continued From page 36 encephalopathy, altered mental status, major neurocognitive disorder, diabetes mellitus type 2, and dementia. Review of a physician order dated 10/20/22 revealed an order for Metformin 500mg, 1 tablet daily with food at 8:00am. (Metformin is a medication used to control blood sugar). Review of Resident #4's February 2023 medication administration record (MAR) revealed: -There was an entry for Metformin, 500mg, 1 tablet daily with food to be administered at 8:00am. -There was documentation Metformin 500mg, 1 tablet was administered at 8:00am from 02/01/23 through 02/03/23 and from 02/05/23 through 02/08/23. -There was no documentation that Metformin 500mg, 1 tablet was administered at 8:00am on 02/04/23. -There was documentation Metformin, 500mg, 1 tablet was not administered on 02/09/23 because it was unavailable. Observation of Resident #4's medications on hand on 09/09/23 at 9:30am revealed Metformin was not in the medication cart. Telephone interview with the facility's contracted pharmacist on 02/09/23 at 9:00am revealed: -Resident #4's Metformin was dispensed on 01/02/23 for a 7-day supply. -Resident #4's Metformin was dispensed on 01/09/23 for a 7-day supply. -Resident #4's Metformin was dispensed on 01/16/23 for a 7-day supply. -Resident #4's Metformin was dispensed on 01/23/23 for a 7-day supply. -Resident #4's Metformin was dispensed on	D 367	the ED daily during management meeting to ensure compliance. Any noted areas of concern will have follow-up as appropriate, including MD notifications, clarifications, and any interventions needed.	

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D 367	Continued From page 37 01/30/23 for a 2 pill. -Resident #4's Metformin was last dispensed on 02/01/23 for 2 pills. -There should not have been any Metformin in the facility after 02/03/23. -Resident #4's Metformin prescription had expired and he needed a new prescription. -An electronic notification was sent to the facility that a new prescription was needed for Resident #4. Interview with Resident #4 on 02/09/23 at 9:45am revealed: -He did not get his Metformin medication on the morning of 02/09/23. -There were other times he did not get his medication. Interview with the medication aide (MA) on 02/09/23 at 10:00am revealed: -Metformin was not administered to Resident #4 on 02/09/23 because the medication was not on the medication cart. -She would notify the Special Care Coordinator (SCC) when a medication needed to be re-filled. Interview with the SCC on 02/09/23 at 4:10pm revealed -Medications were dispensed for a 7-day supply each week. -Medications were delivered by the facility's contracted pharmacy on Wednesday, the night shift placed the medications on the cart Thursday night. -She did not recall receiving a notification from the facility's contracted pharmacy that Resident #4 needed a new prescription for Metformin. -She conducted medication cart audits for the special care unit. -She did not know why the Metformin was	D 367		

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D 367	Continued From page 38 documented as administered after 02/04/23. Interview with the Administrator on 02/09/23 at 4:30pm revealed: -The facility's contracted pharmacist usually notified the facility when a refilled prescription was needed for a resident. -The medication cart audit should be done weekly by the SCC. -The facility should have been aware of a new prescription being needed for Resident #4 when the medication cart audit was done. -She expected the SCC to cal the primary care provider (PCP) when a prescription needed to be refilled. -She did not know why the PCP was not notified that a refilled prescription was needed for Resident #4. -She did not know why the Metformin was checked off on the MAR as administered after 02/04/23. Attempted telephone interview with Resident #4's primary care provider (PCP) on 02/09/23 at 2:30pm was unsuccessful. 2. Review of Resident #5's current FL-2 dated 08/26/22 revealed diagnoses included dementia without behavioral disturbances, gastroesophageal reflux disease (GERD), hypertension and mood disorder. Review of Resident #5's physician order dated 08/26/22 revealed there was an order for Zolpidem 10mg, with instructions to take 1 tablet at bedtime (Zolpidem is used to treat insomnia). Review of Resident #5's December 2022 electronic medication administration record (eMAR) revealed Zolpidem 10mg was not listed	D 367		

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D 367	Continued From page 39 on the eMAR. Review of Resident #5's January 2023 eMAR revealed: -There was an entry for Zolpidem 10mg, with instructions to take 1 tablet by mouth at bedtime. -Zolpidem 10mg was documented as administered from 01/27/23 to 01/31/23. -There was no documentation that Zolpidem 10mg, 1 tablet was administered from 01/01/23 to 01/26/23. -There was no documentation explaining why the Zolpidem was not administered from 01/01/23 to 01/26/23. Resident #5's February 2023 eMAR revealed: -There was an entry for Zolpidem 10mg, with instructions to take 1 tablet by mouth at bedtime. -Zolpidem 10mg was documented as administered from 02/01/23 to 02/07/23. Review of Resident #5's December 2022 controlled substance log (CSL) on 02/10/23 revealed there was documentation for Zolpidem 10mg, 1 tablet administered at bedtime from 12/01/22 to 12/31/22. Review of Resident #5's January 2023 CSL on 02/10/23 revealed there was documentation for Zolpidem 10mg, 1 tablet administered at bedtime from 01/01/23 to 01/31/23. Review of Resident #5's February 2023 CSL on 02/10/23 revealed there was documentation for Zolpidem 10mg, 1 tablet administered at bedtime from 02/01/23 to 02/09/23. Observation of Resident #5's medications on hand on 02/10/23 revealed: -There was a bubble pack labeled Zolpidem	D 367		

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D 367	Continued From page 40 10mg, take one tablet by mouth at bedtime. -There were 28 tablets remaining out of 30 that were dispensed on 02/03/23. Telephone interview with the facility's contracted pharmacy on 02/09/23 at 3:52pm revealed: -Resident #5's Zolpidem was dispensed on 11/03/22 for a 30-day supply. -Resident #5's Zolpidem was dispensed on 12/01/22 for a 30-day supply. -Resident #5's Zolpidem was dispensed on 01/02/23 for a 30-day supply. -The pharmacy received an order from the facility for Resident #5's Zolpidem 10mg on 01/27/23 for a 3-day supply with two refills. -Resident #5's Zolpidem was dispensed on 01/28/23 for a 3-day supply. -Resident #5's Zolpidem was dispensed on 02/03/23 for a 30-day supply. -The pharmacy entered information on the eMAR and the facility was responsible for approving the eMAR. Interview with Resident #5 on 02/10/23 at 12:15pm revealed he received his Zolpidem every night to help him sleep. Interview with the medication aide (MA) on 02/10/23 at 10:52am revealed: -Medication aides (MAs) were responsible for ordering refills on resident's medications. -MAs checked a box on the computer system to resupply medication when a resident's medications got down to a 10-day supply. Interview with Resident #5's primary care provider (PCP) on 02/10/23 at 9:00am revealed: -Resident #5's should have his Zolpidem 10mg medication available to help with his insomnia. -The MAs should have documented all	D 367		

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D 367	Continued From page 41 administration of the Zolpidem 10mg on the eMAR. Interview with the Administrator on 02/10/23 at 2:02pm revealed: -MAs completed a shift report at the beginning of each shift. -The Resident Care Coordinator (RCC) completed medication cart audits weekly to ensure resident medications were available, there was a 10-day supply of medications, and no medications had expired. -MAs were expected to ensure that documentation on eMARS were accurate. -She expected MAs ensure that residents were administered medications as ordered because they were expected to follow the PCPs orders.	D 367		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for	D 454	Gates House shall ensure that a Resident's responsible person/ contact person as indicated on the Resident Register is notified of any illness or injury requiring medical treatment or referral to Emergency Medical Evaluation no later than 24 hours from time of initial discovery or knowledge, and must be documented in the chart; as well as any fall that doesn't need medical treatment having notification within 48 hrs, and elopement having notification immediately upon discovery. All these situations hold true, unless the Resident/ Responsible Person/ Contact Person object to above notifications. ACD in-serviced Med Techs on the	2/21/23

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D 454	Continued From page 42 emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to notify a resident's power of attorney within 24 hours of being sent out to the local emergency department for evaluation for 1 of 5 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL-2 dated 08/26/22 revealed: -Diagnoses included dementia with behaviors, schizoaffective disorder, major depressive disorder and hypertension. -There was documentation that he was intermittently disoriented. -The level of care was documented as special care unit (SCU). Review of Resident #3's Accident/Incident (A/I) Report dated 01/15/23 revealed: -Resident #3 had an unwitnessed fall at 6:45am in her bedroom. -There was injury to her to her toe on her left foot. -She was transported by emergency management systems (EMS) to the local hospital emergency department (ED)for evaluation. -There was documentation Resident #1's representative was notified on 01/16/23 at 7:45am.	D 454	importance of proper completion of incident reports, as well as appropriate time frames for notifying PCP and Resident's Responsible Party/ Contact Person. ACD in-serviced staff on Resident Rights and Dignity. 2/13/23 Care Managers will review Incident Reports completed on Residents to ensure they are completed accurately and appropriate notifications have occurred within the timeframe set in the Rule area .1212 and facility policies and procedures. Incident Reports will be discussed daily with the ED in management meeting along with any accompanying documentation to ensure appropriate follow-up, notifications, and reporting has occurred. 3/27/23	

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D 454	Continued From page 43 Review of Resident #3's progress note dated 01/15/23 revealed: -The progress note was entered as a late entry on 01/16/23 at 8:22am by the Special Care unit Coordinator (SCC). -Resident #3 was sent to the local hospital via EMS for a laceration of her small toe on the left foot. -The responsible party was named in space provided for notification with no date or time of notification. Telephone interview with Resident #3's Power of Attorney (POA) on 02/10/23 at 8:07am revealed: -He received a call on 01/16/23 at 7:54am from the facility to let him know Resident #3 was sent to the hospital following a fall. -He had no missed calls from 01/15/23. -The facility was aware that another family member was to be called if he was unable to be reached. -He expected the facility to notify one of them immediately following an accident or incident. Telephone interview with the other family member of Resident #3's POA on 02/10/23 at 8:25am revealed: -He did not receive a call from the facility on 01/15/23 and there were no missed calls on his phone. -The facility were aware to contact him if the POA was not available. -He visited 1-2 times weekly and the facility had his contact information. Telephone interview with Resident #3's primary care provider (PCP) on 02/10/23 at 9:00am revealed: -She spoke with Resident #3's family often regarding her care.	D 454		

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D 454	Continued From page 44 -Family was always responsive to calls and texts. -It was unacceptable that her family was not notified for more that 24 hours because they could have provided comfort to her while in the ED. -There could have been safety issue for Resident #3 alone in the ED due to her diagnosis. Telephone interview with the medication aide (MA) on 02/09/23 at 3:12pm revealed: -She found Resident #3 on the floor of her bedroom on 01/15/23 at approximately 4:30am when she went into the room to administer medication to another resident. -She called EMS because Resident #3's little tow was bleeding and she could not get it to stop. -She called Resident #3's POA to tell him Resident #3 was being sent out but there was no answer and she did not remember if she left a message. -She did not make a second attempt or attempt to contact another family member. -She should have made a second attempt and documented that the attempt was not successful. -She reported the incident to the oncoming shift but she did not remember if she told them she had been unable to contact Resident #3's POA. Interview with the SCC on 02/09/23 at 10:10am revealed: -She became aware that the MA had not notified Resident #3's family when she arrived for work on 01/16/23. -The MA told her she tried to call but was unable to reach Resident #3's POA. -She and the MA called Resident #3's POA from her office on 01/16/23 between 7:30am and 8:00am. -The MA should have communicated the information to the on coming shift and	D 454		

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D 454	Continued From page 45 documented the communication in a progress note. Interview with the Administrator on 02/10/23 at 2:02pm revealed: -Resident #3 fell in early morning of 01/15/23 and was sent to the local emergency department for evaluation. -She was aware Resident #3's POA was not notified until the next morning, 01/16/23. -The MA could have contacted another family member listed in contacts or made a second attempt to call the POA. -She expected the responsible person to be notified within 1 hour that an incident had occurred. -The MA should have documented the attempt to contact the POA and relay the information to the oncoming shift if notification could not be made on her shift.	D 454		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed	D 464	Gates House shall ensure that within 30 days of admission to the Special Care Unit and quarterly thereafter, that a written Resident profile containing information that describing the Resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. Gates House will also ensure that the Resident's care plan is developed or updated based on the above stated Resident profile, and will include programming and health care that will help the Resident reach or	

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D 464	Continued From page 46 or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 4 sampled residents (#1,#3, #4) had a special care unit (SCU) pre-screening assessment in place upon admission. The findings are: 1. Review of Resident #1's current FL-2 dated 08/26/22 revealed: -Diagnoses included Dementia ad major cognitive disorder. -There was documentation that he was intermittently disoriented. -The level of care was documented as special care unit (SCU). Review of Resident #1's Resident Register revealed an admission date of 06/06/19. Review of Resident #1's resident record revealed there was no special care unit pre-screening assessment available. Refer to interview with the Administrator on 02/10/23 at 2:02pm. 2. Review of Resident #3's current FL-2 dated 08/26/22 revealed: -Diagnoses included dementia with behaviors, schizoaffective disorder, major depressive disorder and hypertension.	D 464	maintain their maximum level of functioning, as well as making up for lost abilities. Special Care Coordinator (SCC) will ensure that a SCU pre-screening assessment has been completed upon admission to the facility. Also, will ensure that the Resident Profile is completed within 30 days of admission and is used in the development of the Resident's Care Plan, as well as quarterly thereafter. SCC and ED will review new admissions to the Special Care Unit during the weekly At-Risk meeting for the first 4 weeks of admission. This will include review of required documentation, Resident adjustment to the community, and any care needs that need to be addressed. SCC will complete a minimum of 2 chart audits weekly to ensure accuracy and completion of the Resident's medical record. Completed chart audits will be reviewed by the ED to ensure compliance.	3/27/23 3/27/23 3/27/23

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D 464	Continued From page 47 -There was documentation that he was intermittently disoriented. -The level of care was documented as special care unit (SCU). Review of Resident #3's Resident Register revealed an admission date of 07/07/21. Review of Resident #3's resident record revealed there was no special care unit pre-screening assessment available. Refer to interview with the Administrator on 02/10/23 at 2:02pm. 3. Review of Resident #4's current FL-2 dated 10/20/22 revealed: -Diagnoses included cognitive dysfunction, diabetes mellitus type 2, altered mental status, encephalopathy, and dementia. -There was documentation that he was intermittently disoriented. -The level of care was documented as special care unit (SCU). Review of Resident #4's Resident Register revealed an admission date of 06/28/22. Review of Resident #4's record revealed there was no special care unit pre-screening assessment available. Refer to interview with the Administrator on 02/10/23 at 2:02pm. Interview with the Administrator on 02/10/23 at 2:02pm revealed: -She was unable to locate a special care unit pre-screening assessments for Residents #1, #3 and #4.	D 464		

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D 464	Continued From page 48 -The chart system changed in 2022 prior to her employment as the Administrator so she did not know why the pre-screenings were not available. -She and the SCC were responsible for ensuring the pre-screenings were completed. -The SCC was in the process of reviewing all SCU resident charts to ensure all paperwork was completed and on file for each resident.	D 464		