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| EAST TOWNE | 4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey and complaint investigation on 06/20/23- 06/22/23. | D 000 | **"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law."** | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record review, the facility failed to ensure timely follow up for 1 of 1 sampled Resident (#2) related to notifying the Primary Care Provider (PCP) of weight gain of three pounds or greater in a 24-hour period.<br><br>The findings are:<br><br>Review of Resident #2's current FL-2 dated 04/05/23 revealed diagnoses included heart failure, diabetes, chronic lung disease and chronic kidney failure.<br><br>Review of physician's orders dated 07/20/21 revealed:<br>-An order to check and record weight daily.<br>-An order to notify the primary care provider (PCP) if there was a weight gain of three pounds (lbs.) or greater in a 24-hour period.<br><br>Review of the April 2023 daily weight record for Resident #2 revealed:<br>-There was a documented weight gain of 3 lbs. (183.0 # - 186.0 #) from 04/03/23 -04/04/23.<br>-There was a documented weight gain of 3.2 lbs. (183.8 # - 187.0 #) from 04/06/23 - 04/07/23.<br>-There was a documented weight gain of 4.8 lbs. | D 273 | **10A NCAC 13F .0902 (b) Health Care:**<br>1.Facility Executive Director and Director of Resident Care Services/ Resident Care Coordinator will train all supervisors in charge and Medication Aides on the above rule area and specifically in the area of following orders placed on the MAR written and ordered by the residents Provider to include documentation of notifications of weight loss ordered by the provider and general requirements for notification set by parameters.<br>2.Facility Director of Resident Care Services and RCC will be responsible for auditing SIC/Medication Aides progress notes on a weekly basis to ensure documentation of all follow up needs per physician orders have been met. Any missing documentation or follow up needs will be conducted upon review and awareness of need.<br>3.Facility Director of Resident Care Services and RCC will document and retrain any SIC/Medication Aide that requires additional training upon findings of staff to be non-compliant with rule area stated above. | **8/06/23** |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Kristi Evans, Administrator | (X6) DATE: 7/26/2023



Reviewed and acknowledged.
Brianna Jameson 08/04/23

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(187.0 # - 191.8 #) from 04/10/23 - 04/11/23.
-There was a documented weight gain of 6 lbs.
(194.0 # - 200.0 #) from 04/14/23 - 04/15/23.
-There was a documented weight gain of 6.7 lbs.
(192.3 # - 199.0 #) from 04/19/23 - 04/20/23.
-There was a documented weight gain of 3.4 lbs.
(191.6 # - 195.0 #) from 04/25/23 - 04/26/23.
-There was a documented weight gain of 3 lbs.
(191.0 # - 194.0 #) from 04/29/23 - 04/30/23.
-There was no documentation the PCP had been notified of the weight gain for each occurrence in April 2023.

Review of the May 2023 daily weight record for Resident #2 revealed:
-There was a documented weight gain of 5 lbs.
(195.0 # - 200.0 #) from 05/03/23 - 05/04/23.
-There was a documented weight gain of 3 lbs.
(194.0 # - 197.0 #) from 05/06/23 - 05/07/23.
-There was a documented weight gain of 4 lbs.
(198.0 # - 202.0 #) from 05/09/23 - 05/10/23.
-There was a documented weight gain of 5 lbs.
(193.0 # - 198.0 #) from 05/15/23 - 05/16/23.
-There was a documented weight gain of 3 lbs.
(195.0 # - 198.0 #) from 05/19/23 - 05/20/23.
-There was a documented weight gain of 3.8 lbs.
(194.0 # - 197.8 #) from 05/25/23 - 05/26/23.
-There was no documentation the PCP had been notified of the weight gain for each occurrence in May 2023.

Interview with a medication aide (MA) on 06/22/23 at 8:03am revealed:
-Resident #2 was weighed daily.
-Resident #2's weight was documented on the electron medication administration record (eMAR).
-She called the PCP office to let them know of the weight gain of 3 lbs. or more in a 24-hour period.
-She documented the weights on Resident #2's

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| D 273 | Continued From page 2<br>eMAR but did not document that she contacted the PCP about the weight gain for each occurrence.<br><br>Telephone interview with a Registered Nurse (RN) at Resident #2's PCP office on 06/22/23 at 8:24am revealed:<br>-If the PCP office had been notified by staff from the facility by telephone, the triage nurse would have sent a message to the PCP and documented there was a telephone encounter from the staff member who contacted the office.<br>-Review of their electronic telephone communication log revealed they had not received notification of weight gain of three lbs. or more daily for Resident #2 during the months of April 2023 and May 2023.<br><br>Interview with the Administrator on 06/21/23 at 1:15pm revealed:<br>-She expected the staff to follow parameters and notify the PCP for weights of 3 lbs. or more in a 24-hour period.<br>-Some staff documented contacting the PCP on the electronic Medication Administration Record (MAR).<br>-Some staff sent a text message to the PCP to notify them about Resident #1's weight gain, but they should have been documenting they notified the PCP.<br>-Some staff called the PCP to notify them about Resident #2's weight gain, but they should also be documenting they notified the PCP.<br>-All staff should have been documenting on the eMAR or in the progress notes when they contacted the PCP about the weight gain for Resident #2. | D 273 | | |

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| D 309 | Continued From page 3 | D 309 | **"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law."** | |
| D 309 | 10A NCAC 13F .0904(e)(3) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record review and interviews the facility failed to maintain an accurate and current listing of residents with physician ordered therapeutic diets for guidance of food service staff.<br><br>The findings are:<br><br>Observation of the kitchen on 06/20/23 at 10:25am revealed there was not a list of physician ordered therapeutic diets posted for staff to reference.<br><br>Review of the facility's therapeutic diet orders revealed:<br>-Individual diet order sheets for residents on therapeutic diets were provided to the surveyor at the beginning of survey on 06/20/23.<br>-One resident was on a chopped diet with nectar thick liquids, one resident was on a chopped meat diet with nectar thick liquids, one resident was on a pureed diet with nectar thick liquids, four residents were on a chopped diet and one | D 309 | **10A NCAC 13F .0904 (e)(3) Nutrition and Food Service:**<br>1.Facility Executive Director will train the Dietary Manager on the above rule area.<br>2.Facility Dietary Manager will be responsible for working with Resident Care Coordinator, Director of Resident Care Services and Executive Director on ensuring an updated list of current Physician-ordered therapeutic diets are placed in a Diet Notebook and posted on the community board inside of the dining area on a weekly basis for care staff to utilize.<br>3.All current staff will be trained on where they can locate specific diets for individuals inside of the community and dining area.<br>4.Executive Director and Dietary Manager will audit during daily walk through for compliance of current diet orders inside the dining area. If further non-compliance is found requirements for compliance will be immediately corrected and necessary trainings on the above rule area will be conducted. | 8/06/23 |

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resident was on a chopped diet with no added table salt.

Interview with the Dietary Manager (DM) on 06/20/23 at 10:25am revealed there was not a list of residents on therapeutic diets posted in the kitchen, but he did have a book that all of the diet orders were kept in.

Interview with a personal care aide (PCA) on 06/22/23 at 11:05am revealed:
-Before serving a meal, she asked the DM if any of the residents had new diet orders.
-She knew the DM kept a copy of each diet order in a book.

Interview with a second PCA on 06/22/23 at 11:06am revealed:
-The DM was responsible for knowing all of the residents' diet orders.
-When she served meals, she walked into the kitchen and told the DM which resident she needed a meal for then the DM would plate the meal.
-There was a list of the residents' diet orders on snack cart but she was not sure if it was still posted.

Observation of the snack cart on 06/22/23 at 11:20am revealed a list residents' diet orders was not present.

Interview with the DM on 06/22/23 at 11:20am revealed:
-The Administrator or Resident Care Coordinator (RCC) gave him copies of new diet orders and he communicated any changes to the PCAs.
-He kept all of the diet orders in a book in his office.
-The previous RCC printed a list of all residents

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| D 309 | Continued From page 5<br>and their diet orders on a weekly basis, which he posted in the kitchen as well as on the snack cart.<br>-The current RCC had not printed an updated list of residents' diet orders.<br><br>Interview with the RCC on 06/22/23 at 4:27pm revealed she put new diet orders in the DM's mailbox and had not been asked to create a list of residents on a therapeutic diet.<br><br>Interview with the Administrator on 06/22/23 at 4:28pm revealed:<br>-No one was responsible for creating a therapeutic diet list.<br>-New diet orders were given to the DM and he kept them in a book.<br>-The DM was responsible for knowing each residents' diet order and to plate the correct meal.<br>-If there was a question about a resident's diet then staff should have referenced the diet order book. | D 309 | **"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law."**<br><br>**10A NCAC 13F .0904 (e)(4) Nutrition and Food Service:**<br>1.Facility Executive Director will conduct training with all staff on the above rule area and the importance of following therapeutic diets ordered by the resident's physician and how any non-compliance in following a therapeutic diet according to ordered can be detrimental to the residents' health and safety.<br>2.Facility Dietary Manager will be responsible for following diet extensions and recipes assigned by the company's dietician/third-party vendor generated to follow recommended diet orders if any non-compliance is noted Facility Dietary Manager will work with the Executive Director and team on retraining food service staff on following all therapeutic diets as ordered. | **8/6/23** |
| D 310 | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews the facility failed to ensure 2 of 3 sampled residents (Resident #6 and #7) were served physician ordered therapeutic diets related to a chopped meat diet with nectar thick liquids (#6) | D 310 | | |

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| D 310 | Continued From page 6<br>and a chopped diet with nectar thick liquids (#7).<br><br>The findings are:<br><br>Review of the diet extension sheet for the lunch meal service on 06/21/23 revealed:<br>-The diet extension sheet consolidated the therapeutic diet menus for the lunch meal service on 06/21/23 into one document.<br>-The mechanical soft, chopped diet should be served Brunswick stew with chopped meat, mechanically soft balsamic roasted vegetables, soft and bite sized gourmet green salad, moistened buttermilk biscuits, milk at ordered thickness and mechanical soft ice cream.<br>-There was not a diet extension for nectar thick liquids for the lunch meal service on 06/21/23.<br><br>1. Review of Resident #7's current FL2 dated 05/04/23 revealed diagnoses included malignant neoplasm of the esophagus, epidural hemorrhage and muscle weakness.<br><br>Review of Resident #7's signed diet order dated 05/17/23 revealed an order for a chopped diet with nectar thick liquids.<br><br>Interview with Resident #7 on 06/21/23 at 11:56am and 06/21/23 at 1:27pm revealed:<br>-He had trouble swallowing some food but was unable to state what was difficult for him to swallow.<br>-He did not think he needed to drink thickened liquids.<br><br>Observation of Resident #7's lunch meal service on 06/21/23 from 1:16pm to 1:27pm revealed:<br>-Resident #7's lunch tray had Brunswick stew with chopped meat and a thin broth, steamed green beans, bite sized green salad, a moistened | D 310 | 3.Facility Executive Director will work with Director of Resident Care Services and Resident Care Coordinator to ensure compliance in serving therapeutic diets according to Physicians order through monitoring weekly residents who are on a therapeutic diet serving plates/drinks/ snacks. If any noncompliance is noted Facility Executive Director will work with Dietary Manager, Director of Resident Care Services and Resident Care Coordinator on additional training needed for care staff and food service staff.<br>4.Director of Resident Care Services and Resident Care Coordinator will ensure a current list of residents that are on therapeutic diet order are readily available and accessible for all care staff to view and confirm compliance in what food items they would be distributing to a resident.<br>5.Dietary Manager and food staff will be trained on the importance of confirming the therapeutic plate that they are preparing aligns with the diet extensions and recipes for substitutions needed to follow ordered therapeutic diet. | |

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buttermilk biscuit, orange juice drink and chocolate ice cream.
-A personal care aid (PCA) delivered the lunch tray to Resident #7's room and placed it on the seat of his walker.
-The PCA was asked if the items on Resident #7's tray were appropriate for his diet.
-Resident #7 grabbed the lunch tray and said, "don't take it, I want it".
-The PCA did not attempt to remove any of the items from Resident #7's lunch tray or explain to Resident #7 she needed to make some changes to the items on his lunch tray.
-Resident #7 ate several spoonsful of the Brunswick stew and did not cough.
-Resident #7 took a sip of the orange juice drink and coughed three times.
-Resident #7 did not eat the chocolate ice cream.

Interview with a PCA on 06/21/23 at 1:15pm revealed:
-She delivered Resident #7's lunch tray today (06/21/23).
-The Dietary Manager (DM) told her Resident #7 was on a regular diet.
-She was not aware Resident #7 was on a chopped diet with nectar thick liquids and should not have the orange juice drink, the Brunswick stew with thin broth or the chocolate ice cream.

Telephone interview with a Registered Dietitian (RD) at the facility's contracted menu company on 06/21/23 at 4:11pm revealed:
-The orange juice drink should have been served at a nectar thick consistency for Resident #7.
-The diet extension sheet stated all beverages should be served at ordered thickness.

Interview with the DM on 06/21/23 at 1:40pm and 4:40pm revealed:

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-He was not aware a PCA put the orange juice drink and ice cream on Resident #7's lunch meal tray.
-Resident #7 should have received a nectar thick beverage and pudding instead of the orange juice drink and ice cream.
-He typically told the staff what the residents' diet orders were but Resident #7 had been on a chopped diet with nectar thick liquids for a while, so he did not repeat Resident #7's diet order on 06/21/23.

Telephone interview with Resident #7's Primary Care Provider on 06/21/23 at 4:23pm revealed:
-Resident #7 had a history of a stroke and a malignant tumor in his esophagus which could make it difficult for him to swallow.
-He was ordered a chopped diet with nectar thick liquids on 05/17/23 and advised to continue to follow up with Speech Therapy.
-Resident #7's medical history could put him at risk for aspiration (the accidental inhalation of food, drink, saliva, or vomit into the lungs instead of swallowing it through the food pipe and into the stomach) which could be observed by choking after drinking a thin liquid.

Review of Resident #7's therapy service screening guide revealed Resident #7 declined speech therapy services on 06/09/23 and 06/19/23.

Refer to telephone interview with a RD at the facility's contracted menu company on 06/21/23 at 4:11pm.

Refer to interview with the DM on 06/21/23 at 1:40pm and 4:40pm.

Refer to interview with the Administrator on

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06/22/23 at 4:28pm.

2. Review of Resident #6's current FL2 dated 12/13/22 revealed diagnoses included history of a stroke with right sided weakness.

Review of Resident #6's diet order signed 02/15/23 revealed an order for chopped meats and nectar thick liquids.

Observation of Resident #6's lunch meal service on 06/21/23 from 12:45pm to 1:10pm revealed:
-Resident #6 was served Brunswick stew with chopped meat with a thin broth, steamed green beans, bite sized green salad, a moistened buttermilk biscuit, nectar thick water and nectar thick iced tea.
-Resident #6 refused to eat the Brunswick stew so it was taken away and he was served Salisbury steak that was chopped.
-A dietary aide placed ice cream on the table in front of Resident #6.
-Resident #6 asked a medication aide (MA) to open the ice cream, the MA took the lid off the ice cream then placed the ice cream on the table in front of him.
-The MA picked up Resident #6's ice cream before he was able to eat it when asked if ice cream was on his diet.

Interview with a MA on 06/21/23 at 1:10pm revealed:
-She opened the ice cream for Resident #6.
-She knew Resident #6 received nectar thick liquids but was not sure if ice cream was allowed on his diet, so she went to ask another MA.

Interview with a second MA on 06/21/23 at 1:30pm revealed:
-Ice cream was technically not allowed on

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Resident #6's diet and they were supposed to serve pudding or applesauce instead.
-Resident #6 really enjoyed eating ice cream and would take it from other residents, so they served it to him.

Interview with the DM on 06/21/23 at 1:40pm revealed ice cream is not allowed for residents on nectar thick liquid diets and Resident #6 should have received pudding.

Based on record review, observations and interviews on 06/22/23 at 3:22pm revealed Resident #6 was uninterviewable.

Refer to interview with the DM on 06/21/23 at 1:40pm and 4:40pm.

Refer to telephone interview with a RD at the facility's contracted menu company on 06/21/23 at 4:11pm.

Refer to interview with the Administrator on 06/22/23 at 4:28pm.

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Telephone interview with a RD at the facility's contracted menu company on 06/21/23 at 4:11pm revealed:
-She expected the facility to print out the diet extension sheets and recipes for every item to know what foods and beverages were appropriate for each diet texture.
-There was not a diet extension for thickened liquids, but the recipes would state "serve at ordered thickness" or suggest an alternative item for foods or beverages that had thin liquids.
-Brunswick stew with thin broth would not be appropriate for a resident who required nectar thick liquids and the recipe instructed to serve at ordered thickness.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL060149 | A. BUILDING: _____ B. WING _____ | 06/22/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAST TOWNE | 4815 NORTH SHARON AMITY ROAD CHARLOTTE, NC 28205 |

| (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 310 | Continued From page 11<br>-Ice cream was not allowed for a resident that required nectar thick liquids and the recipe for ice cream advised to serve pudding instead.<br><br>Interview with the DM on 06/21/23 at 1:40pm and 4:40pm revealed:<br>-He did not thicken the Brunswick stew because the diet extension sheet only instructed to chop the meat in the stew.<br>-He did not print all of the recipes for this week and was not aware that the recipes and diet extension sheets should be compared with each other.<br><br>Interview with the Administrator on 06/22/23 at 4:28pm revealed:<br>-The DM was expected to know all the residents' diet orders and plate the correct food.<br>-The PCA or dietary aide was expected to tell the DM who needed a meal, and the DM would hand them the correct plate.<br>-She expected the DM to put nectar thick beverages on the beverage cart and provide desserts that were appropriate for Resident #6 and #7 for the staff to distribute.<br>-If staff were unsure of a resident's diet order, then they should have looked at the diet order book.<br>-The DM had access to all the contracted menu provider's materials and was expected to print out all recipes and reference the texture modifications at the end of the recipe.<br><br>The facility failed to serve therapeutic diets as ordered including a chopped diet with nectar thick liquids to Resident #7 resulting in coughing after ingesting a thin liquid which could have resulted in aspiration. This failure was detrimental to the resident's health and safety and constitutes an Type B Violation. | D 310 | | |

| 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 310 | Continued From page 12<br><br>The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 06/21/23.<br><br>THE CORRECTION DATE FOR THE TYPE UNABATED B VIOLATION SHALL NOT EXCEED AUGUST 06, 2023 | D 310 | | |