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
	HAL066012	A. BUILDING: _____ B. WING _____	R-C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON MANOR	320 BROUGHTON STREET GASTON, NC 27832

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Northampton County Department of Social Services conducted an annual survey, follow up survey and complaint investigation on 01/14/25 and 01/15/25. The complaint investigation was initiated by the Northampton County Department of Social Services on 11/29/24.	D 000	In response to the cited defeciencies 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 Defeciencies or Corrective Action Report; the Plan of Correction is solely as a matter of compliance with State Law.	Type text her
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure for 1 of 5 sampled residents (#3) received a therapeutic diet as ordered. The findings are: Review of Resident #3's current FL-2 dated 04/24/24 revealed diagnoses included hypertension, ischemic attack, arthritis, pulmonary disease, ataxia, abnormal glucose, and dysphasia. Review of Resident #3's physician order dated 12/04/24 revealed a diet order for mechanical soft entire meal and thickened liquids. Observation of the kitchen on 01/15/25 at 10:05am revealed thickened apple juice, tea and lemon aide in the cooler but there were no	D 310	10A NCAC 13F .0904(e)(4) Hampton Manor shall assure that all residents shall be served a therapeuetic diet, to include nutritional supplements as ordered by physician. The Clinical Nurse Consultant in-serviced all staff to include dietary staff on therapeutic diets and the importance of reporting any issues regarding food and nutrition. Facility Managers will ensure that therapeutic diets are served as ordered by physician during weekly audits and walk through's during meal time. Any concerns identified will be addressed immediately. Facility Managers will discuss any new resident diet orders to include therapeutic diets and any resident diet changes made by physician during daily stand up and ensure dietary staff and faciltiy care staff is aware of changes.	1/27/2025 1/27/2025 1/27/2025

Reviewed and Acknowledged Nola G. Dixon 02/28/25

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D 310	Continued From page 1 thickener pouches. Observation of the breakfast menu on 01/15/25 revealed scrambled eggs, breakfast ham, fresh fruit, juices, and milk. Observation of Resident #3's breakfast meal served on 01/15/25 from 8:30am to 8:48am revealed: -Resident #3's meal was scrambled eggs, grits, ground ham, thickened water, thickened apple juice, and coffee. -He consumed 15% of the scrambled eggs, 15% of the grits, 15% of the ground ham, 10% of the water, 50% of the apple juice, and 100% of the coffee. -The coffee was not thickened. -He drank two cups of coffee during breakfast. -Resident #3 became choked once while drinking his coffee. -A personal care aide (PCA) stood next to Resident #3 and asked if he was okay, and he nodded his head yes. Interview with Resident #3 on 01/15/25 at 8:48am revealed: -His apple juice was thickened. -His coffee was not thickened. -He did not like his coffee to be thickened because he did not like the texture. Interview with the prep cook on 01/15/25 at 8:50am revealed: -He was aware that Resident #3 was on thickened liquids. -He did not thicken Resident #3's coffee because the resident did not like it that way. -He did not know that he had choked on coffee. -He did not tell the lead medication aide (MA) that Resident #3 did not like his coffee thickened or	D 310		

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D 310	Continued From page 2 that he had given him regular coffee without thicker. Interview with the PCA on 01/15/25 at 12:27pm revealed: -She was aware that Resident #3 was on thickened liquids. -She was one of the PCAs in the dining room during meals. -She did not notice that Resident #3s coffee was not thickened. -She had noticed that Resident #3 "strangled" a lot, so she kept an eye on him. -He would strangle two to three times a week. -When he begun to strangle, she asked him to put his arms up and pat him on the back. -She had not mentioned it to the lead MA because everyone knew that he "strangled". -The PCA was responsible for reporting to the lead MA any issues with a resident during meals. Interview with the lead MA on 01/15/25 at 11:05am revealed: -She was aware that Resident #3 was on thickened liquids. -She was not aware that Resident #3's coffee was not being thickened. -She was not aware that Resident #3 would "strangle" when drinking his coffee. -The PCA and kitchen staff were responsible for reporting to her any issues with a resident during meals. -She was responsible for notifying the primary care provider (PCP) of the issue. Interview with the Director of Special Operation on 01/15/25 at 5:00pm revealed: -She was aware that Resident #3 was on thickened liquids. -She was not aware that Resident #3's coffee	D 310		

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D 310	Continued From page 3 was not being thickened. -She was not aware that Resident #3 would "strangle" when drinking his coffee. -The kitchen staff were responsible for reporting to the lead MA any issues with a resident during meals and the lead MA was responsible for notifying the PCP. Attempted telephone interview with Resident #3's PCP on 01/15/25 at 2:30pm was unsuccessful.	D 310		hhhh
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).	D 367	10 NCAC 13F .1004(j) Hampton Manor will assure the Residents EMAR is followed as ordered by physician and administered by certified personnel. The Clinical Nurse Consultant, RN in-serviced Med Techs on Medication Administration to include the importance of accuracy of EMAR's and the 6 Rights of Medication Administration. Facility Care Coordinators will randomly round during medication passes with Medication Techs to ensure all meds are administered according to the 6 Rights of Medication Administration. The Clinical Nurse Consultant, RN will complete Med pass audits with Med Techs randomly to ensure compliance.	1/27/2025 1/27/2025 1/27/2025

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D 367	Continued From page 4 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the documentation on the medication administration records (MARs) included the initials of the medication aide (MA) who administered the nutritional supplement 1 of 3 residents sampled (#3). The findings are: Review of Resident #4's current FL2 dated 08/15/24 revealed diagnoses included Alzheimer's disease and urinary incontinence. Review of Resident #4's physician's orders dated 01/03/25 revealed there was a diet order for a pureed diet and nutritional supplements 3 times a day with meals. Review of the undated therapeutic diet list revealed Resident #4 was not listed to receive a nutritional supplement. Review of Resident #4's electronic medication administration record (eMAR) for January 2025 revealed: -There was an entry for 1 mighty shake three times daily at 8:00am, 2:00pm and 8:00pm. -There was documentation the mighty shake was administered on 01/15/25 at 8:00am by a medication aide (MA). Observation of the breakfast meal served on 01/15/25 between 8:53am and 9:15am revealed: -Resident #4 was served a pureed meal of scrambled eggs, oatmeal, spam and cranberry juice. -Resident #4 consumed about 100% of her meal. -Resident #4 was not offered or served a	D 367	Type text here	

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D 367	Continued From page 5 nutritional supplement. Observation of the kitchen on 01/15/25 at 10:05am revealed there were 2 cases of mighty shakes in the refrigerator. Based on observations and record reviews it was determined that Resident #4 was not interviewable. Interview with the personal care aide (PCA) on 01/15/25 at 1:23pm revealed: -The medication aide (MA) gave her the mighty shake to give to Resident #4 after the breakfast meal. -She documented in the hospice log when she gave Resident #4 a mighty shake with her breakfast meal. -PCAs were allowed to give Resident #4 mighty shakes. -The MA gave the mighty shakes to the PCAs to give to the residents. Review of the hospice log dated 01/15/25 revealed the administering of the mighty shake was not documented. Interview with a MA on 01/15/25 at 12:35pm revealed: -She forgot to give the PCA Resident #4's mighty shake to serve with her breakfast meal on 01/15/25. -She gave the mighty shake to the PCA around 10:00am to serve to Resident #4. -The MAs or PCAs could administer nutritional supplements to residents. -The MA would give the supplement to the PCA who would administer to the residents. -The PCA would inform the MA when the resident received the supplement, the MA would	D 367		

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D 367	Continued From page 6 document on the eMAR. Interview with a second MA on 01/15/25 at 5:26pm revealed: -MAs were to administer all nutritional supplements because it was a physician's order. -MAs were to observe the residents drinking the supplement and document if the resident drank all of the supplement, refused or would not drink all of the supplement. Attempted telephone interview with Resident #4's primary care provider (PCP) on 01/15/25 at 2:30pm was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 01/15/25 at 5:41pm revealed: -MAs were to give the residents mighty shakes but the PCAs could assist in giving the residents mighty shakes. -Mighty shakes were considered an order and only the MAs could document on the eMAR when the shake was given. -The PCAs were to document in the hospice log when they served a resident their mighty shake and would inform the MA so it could be documented on the eMAR. Interview with the Director of Special Operations on 01/15/25 at 6:53pm revealed MAs were to administer all nutritional supplements and document on the eMAR when administered because it was an order.	D 367		