

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL081010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/15/2018
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HENDERSON CARE CENTER

**125 HENDERSON CIRCLE
FOREST CITY, NC 28043**

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D 000	Initial Comments The Adult Care Licensure Section and the Rutherford County Department of Social Services conducted an annual survey on February 14-15, 2018.	D 000	RCC went to kitchen and showed staff how to properly mix the powder thickener w/ liquids to make the liquid "nectar" thick.	2/15/18
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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure 1 of 1 sampled residents with an order for thickened liquids (Resident #1) was served nectar thickened liquids as ordered by the resident's physician. The findings are: Observations on 2/14/18 at 10:45am during the initial tour of the kitchen revealed an undated therapeutic diet list posted on a bulletin board. Review of the therapeutic diet list revealed: -Resident #1 was identified as receiving thickened liquids. -The consistency was not specified. Interview on 2/14/18 at 10:50am with the Dietary Manager (DM) revealed Resident #1 received liquids thickened to a honey consistency.	D 310	RCC made an appt with R#1 dr to have a swallow-test done for pt #1 RCC contacted Reliance Pharmacy and set up a class w/ their pharmacist, Leslie C. Corp. for 3/7/18 & 3/8/18. Class will include all employees except house-keeping.	2/15/18 2/15/18

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

G53S11

If continuation sheet 1 of 8

Reviewed and Accepted
Date: 3/9/18
CS

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D 310	Continued From page 1 Interview on 2/14/18 at 11:00am with the DM revealed Resident #1's liquids were to be thickened to a nectar consistency. Review of Resident #1's current FL2 dated 6/1/17 revealed: -Diagnoses included diabetes mellitus, hypertension and traumatic brain injury with seizures. -The resident required total assistance from the staff with all activities of daily living, including eating. -There was a physician's order for a "No concentrated sweets pureed diet with nectar thickened liquids". Review on Resident #1's resident record revealed: -The cause of the traumatic brain injury was unknown. -The resident had aphasia and was unable to speak. -There was no documentation of dysphagia (difficulty swallowing) as a diagnosis. -There was no documentation of a swallow study having been done. -There was no documentation Resident #1 had required speech therapy. -The resident had not been treated and/or hospitalized for choking, aspiration and/or pneumonia. Observations on 2/14/18 at 11:55am of Resident #1 during the lunch meal revealed: -The resident was in a geri-chair with lap tray in place sitting at a table. -A plastic drink container with an extended spout which contained clear brown liquid was sitting on the tray.	D 310	DM ordered prepackaged nectar thickened liquid to be used until 3/7/18 & 3/8/18 to make sure proper thickening is used. R#1 went to Rutherford Regional and had a Swallowing test completed Dr. recommends continuing nectar thickening of all liquids.	2/22/18 3/2/18	

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D 310	Continued From page 2 -The resident picked up the container, put the spout in his mouth, tipped the container and took a drink. -When he returned the drink container to the tray, the container tipped over and the contents were dripping onto the tray. -The contents appeared to be water thin consistency. Interview on 2/14/18 at 12:00pm with Staff A, Personal Care Aide, revealed: -Resident #1's drink container was on his geri-chair lap tray when she entered the dining room. -She had just observed the liquid dripping from Resident #1's drink container. -She had fed Resident #1 his meals on a regular basis for the past four years. -The liquid was more the consistency of water and she had not seen it that thin before. -The Dietary Manager had been immediately notified, observed the liquid was too thin and removed the drink container to the kitchen. Interview on 2/14/18 at 12:05pm with Dietary Manager revealed: -She had prepared the thickened liquids for Resident #1. -The drink container held 8 ounces of liquid. -For several weeks, she had been having difficulty getting Resident #1's liquids to thicken to nectar consistency as ordered by the physician. -For lunch today, she had stirred 3 tablespoons of the thickener (powder) into Resident #1's tea in his drink container. -She did not check to see if it had thickened to nectar consistency before it was given to the resident. Interview on 2/14/18 at 12:07pm with the	D 310		

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D 310	Continued From page 3 Resident Care Coordinator (RCC) revealed: -She stated Resident #1's drink container held 8 ounces of liquid. -She had observed the consistency of Resident #1's thickened tea and stated, "It was too thin". -She had added another tablespoon of thickener and briskly stirred the tea until it was the proper consistency. -She told the DM to use four tablespoons when thickening Resident #1's liquids. Review of the directions on the container of thickener revealed: -Scoop and level off recommended amount of thickener using the enclosed measuring scoop (scoop included teaspoon and tablespoon measurement). -Slowly add the thickener to the liquid while stirring briskly until the thickener has dissolved. Let stand 30 seconds to 1 minute to achieve desired consistency. -You may need to adjust the amount of thickener to suit your requirements. -Note: t = teaspoon, T = tablespoon and 3 teaspoons = 1 tablespoon. Review of the usage chart on the container of thickener revealed for 8 ounces of nectar consistency tea, use 7 - 8 teaspoons of thickener. Observation of the printing on the bottom of Resident #1's drink container revealed the container held 12 ounces or 360ml of liquid. Review of the usage chart on the container of thickener revealed for 12 ounces of nectar consistency tea, use 10 1/2 - 12 teaspoons (3 1/2 - 4 tablespoons) of thickener. Interview on 2/14/18 at 12:45pm with the DM	D 310		

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D 310	Continued From page 4 revealed: -She had not looked closely at Resident #1's drink container. -She did not know the container held 12 ounces of fluid. -She had been thickening the residents liquids according to the directions for 8 ounces of liquid. Interview on 2/14/18 at 12:45pm with the RCC revealed she -She had not looked closely at Resident #1's drink container. -She did not know the container held 12 ounces of fluid. -She had taught the DM to thicken the residents liquids according to the directions on the thickener container for 8 ounces of liquid. Interviews with six staff members regarding Resident #1's thickened liquids revealed: -They had observed Resident #1 with thickened water, orange juice and tea. -They had not observed the consistency of his liquids less than nectar consistency. -They had not observed Resident #1 coughing and/or choking while drinking his thickened liquids. Interview on 2/15/18 at 9:30am with the DM revealed: -She had learned to thicken liquids by following the directions on the thickener container. -Later, the RCC had shown her how to do it. -The DM had shown the first shift Dietary Aide and the second shift cook how to thicken Resident #1's liquids according to the instructions on the thickener container. Interview on 2/15/18 at 11:00am with the second shift cook revealed:	D 310		

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PRINTED: 02/22/2018
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D 310	Continued From page 5 -She had not been taught to thicken liquids. -The dishwasher was responsible for setting up the beverages for each meal and for thickening liquids on the second shift. Interview on 2/15/18 at 11:10am with Resident #1's prescribing practitioner (Family Nurse Practitioner) revealed: - "The resident (Resident #1) receiving water thin liquids is a big concern." - "Resident #1 has dysphagia and is at risk of aspiration." - "His liquids must always be thickened to nectar consistency." - "The facility should be monitoring his fluids to make sure he is getting the proper consistency." - "The resident had not been hospitalized and/or treated for choking, aspiration and/or pneumonia in the past year." Interview on 2/15/18 at 12:05pm with the second shift dishwasher revealed: -He was responsible for thickening Resident #1's liquids on second shift. -The Dietary Aide had showed him how to thicken Resident #1's liquids to a nectar consistency. -The RCC had also shown him how to use the thickener. Interview on 2/16/18 at 12:28pm with the weekend dishwasher revealed: -He was responsible for thickening Resident #1's liquids on the weekend. -The DM and the RCC had shown him how to use the thickener. -He had been responsible for thickening liquids at other facilities. -He knew different liquids required different amounts of thickener -He always made sure Resident #1's liquids were	D 310			

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D 310	Continued From page 6 nectar consistency. The facility failed to assure 1 of 1 sampled residents with an order for thickened liquids (Resident #1) was served nectar thickened liquids as ordered by the resident's physician. The resident had diagnoses which included traumatic brain injury and aphasia, placing him at increased risk of choking (food getting stuck in the upper airway) and/or aspiration (food entering the lungs) if his fluids were not thickened to the proper consistency. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. A Plan of Protection was provided by the facility on 2/15/18 as follows: -The RCC will provide "walk through" training on the proper measurement and the proper mixing (of thickened liquids) to the proper consistency. -The pharmacist from the pharmacy, within the first two weeks of March 2018, will be at the facility to give a class and training to all kitchen staff and administration on properly mixing thickened liquids. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 1, 2018.	D 310			
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912			

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D912	Continued From page 7 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to therapeutic diets with thickened liquids. The findings are: Based on observations, interviews and record reviews, the facility failed to assure 1 of 1 sampled residents with an order for thickened liquids (Resident #1) was served nectar thickened liquids as ordered by the resident's physician. [Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation).]	D912			