

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL060093	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/17/2018
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NAME OF PROVIDER OR SUPPLIER

ELLIOTT'S MANOR 1

STREET ADDRESS, CITY, STATE, ZIP CODE

**10201 CONNELL ROAD
CHARLOTTE, NC 28227**

(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
C 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual and follow-up survey on 07/17/18.	C 000	All staff present on the day of survey were addressed immediately. All on coming staff were also addressed.	
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family 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 reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 sampled residents (Resident #1) with physician's orders for nectar thickened liquids. The findings are: Review of Resident #1's current FL2 dated 03/06/18 revealed: -Diagnoses included hypertension, dementia with behaviors, osteoporosis, polymyalgia rheumatica, senile degeneration of brain. -The resident was on a puree diet with nutritional supplements two times daily. Review of Resident #1's subsequent diet order dated and signed by the physician on 05/30/18 revealed a pureed diet order with thickened liquids of nectar consistency. Review of the therapeutic diet orders located in a kitchen drawer on 07/17/18 revealed Resident #1	C 284	Elliott Manor has put a new training program in place to further address the Food & nutrition department. This policy has all training taking place in new hire orientation prior to any new employee serving or assisting to feed any resident. Each new employee will sign off on training to verify understanding and compliance with Elliott Manor's policy Regarding Therapeutic Diets. Supervisors will be in charge of overseeing that all staff remain in compliance. They will check daily for two weeks, then two times weekly for two weeks, then weekly and at Random.	

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

[Signature]

TITLE

[Signature]

(X6) DATE

8/10/18

STATE FORM

6899

H3FV11

If continuation sheet 1 of 5

Reviewed and Accepted *SGR* 10/10/18

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C 284	Continued From page 1 was to be served nectar thickened liquids. Observation of the kitchen area on 07/17/18 at 12:49 pm revealed: -There was a 2 liter bottle of gel thickener with a pump connected to the container. -There were instructions to the side of the container with measurements needed to thicken liquids to the desired consistency. -Review of instructions on how to thicken to the desired consistency revealed: -One stroke of thickener per 4 ounces (oz.) of liquid required to be nectar consistency. -Two strokes of thickener per 8 oz. of liquid required to be nectar consistency. Observation of the lunch meal on 07/17/18 at 1:05pm revealed: -Resident #1's tea, water, and milk were not thickened. -Resident #1's had not drank her tea, water, or milk. Interview with Activity Director (AD) on 07/17/18 at 1:07pm revealed: -She had prepared Resident #1's drink without thickener. -She did not normally prepare drinks for residents. -She was trying to help serve food in the kitchen to get residents served quickly. -She did not know Resident #1 had an order for nectar thick liquids. -She did not refer to Resident #1's diet order located in the kitchen. Observation of the personal care aide (PCA) second preparation of Resident #1's beverages on 07/17/18 at 1:04pm and 1:12pm revealed: -The PCA poured about six ounces of tea directly	C 284			

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C 284	Continued From page 2 from the tea dispenser into a 16 oz. cup without measuring. -She then added 1 stoke of thickener into the same cup. -She then stirred the tea and thickener together for 15 seconds. -The tea was thin consistency and dripped from the spoon. -The PCA poured about eight ounces of milk directly from the container into a cup without measuring. -She then added 1 stroke of thickener into the same cup. -She then stirred the tea and thickener together for 15 seconds. -The milk was thin consistency and dripped from the spoon. Interview with the PCA on 07/17/18 at 1:12pm revealed: -She helped prepare drinks for residents. -She thickened Resident #1 drink with the gel thickener in the kitchen. -She was trained by another staff member on her first day for how to prepare thickened liquids. -She could not remember the staff member who trained her. -She never followed the instructions because she "followed what the other staff member told me to do". -She did not use measuring cups or spoons because no one trained her to use a measuring cup. -She had never paid attention to the instructions on the side of the thickener. -Resident #1 never choked while consuming any of her meal or drinks. -She did not know the consistency of nectar and what the thickened drink was supposed to look like.	C 284		

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C 284	Continued From page 3 Observation of the PCA on 07/17/18 at 1:15pm revealed she removed Resident #1's tea, water, and milk from the table. Interview with a Medication Aide (MA) on 07/17/18 at 4:00pm revealed: -She had not received any training for how to prepare thickened liquids since working. -She prepared thickened drinks for Resident #1 based on the instructions and previous knowledge. -There was no specific staff responsible for preparing thickened liquids, "whoever can get to it first". -She never observed Resident #1 choking on her drink or meal. Interview with Resident #1's responsible person on 07/17/18 at 1:05pm revealed: -Resident #1 was ordered thickened liquids because she had difficulty swallowing. -She never observed or been notified of Resident #1 choking during her meals. Interview with the primary care physician for Resident #1 on 07/17/18 at 3:00pm revealed: -Resident #1 was ordered thickened liquids after a speech evaluation. -Resident #1 would be at risk for choking if she drank thin liquids. -Nectar thick liquids would help prevent Resident #1 from aspiration pneumonia. -The order for nectar thick liquids had not changed. -She expected the order for nectar thick liquids to be followed and no thins liquids were permitted. Interview with Facility Director on 07/17/18 at 3:20pm revealed:	C 284			

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C 284	Continued From page 4 -He was responsible for training staff to prepare thickened liquids. -He trained MAs and expected only MAs to prepare thickened liquids. -He did not know why the PCAs would be preparing thickened liquids. -He provided an initial training to MAs about thickened liquids when they first begin working. -He had not trained the AD to prepare thickened liquids. -He did not know why the AD prepared Resident #1's beverages. -Cups with measurements were supposed to be used, however they cracked and the new cups did not have measurements. -"I dropped the ball, there has been a breakdown in communication". Interview with the Administrator on 07/17/18 at 03:40pm revealed: -She expected the Facility Director to provide training to MAs to properly prepare thickened liquids. -There should have been cups available for MAs to measure liquid prior to thickening. -She expected instructions to be followed on the thickener when preparing the drink. Based on observations and record review Resident #1 was not interviewable.	C 284			