STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL044040	A. BUILDING: _____ B. WING _____	06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPICEWOOD COTTAGES OAKS	67 LOVINGWAY CLYDE, NC 28721

(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 Haywood County Department of Social Services conducted an annual survey on 06/04/19.	D 000		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interview the facility failed to assure foods were stored in a manner to prevent contamination as evidenced by unlabeled and dated food in the facility refrigerators and freezers. The findings are: Observation of the refrigerator in the facility kitchen on 06/04/19 at 8:35am revealed: -A salad on a plate with lettuce and tomato was covered with plastic wrap but not dated or labeled. -A container of orange soup with vegetables was covered but not dated or labeled. -A plastic container with 2 remaining cupcakes was not dated or labeled. -A gallon container of pasta salad was sealed, not dated or labeled. -A six pack of Danish rolls were wrapped in plastic wrap, not dated or labeled. -A 5-pound (lb.) bag of Romano cheese was half full, not dated or labeled. -A gallon freezer bag was half full of cheddar	D 283		

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D 283	Continued From page 1	D 283		

cheese, not dated or labeled.
-A 5 lb. bag of mozzarella cheese had been opened but not dated or labeled.
-A 1 lb. container of barbeque meat had been opened but not dated or labeled.
-A freezer bag with approximately ¼ cup of parmesan cheese remaining not dated or labeled.
-A package of tortillas with 4 remaining tortillas not dated or labeled.
-A plastic bag with 15 ham slices was not dated or labeled.
-A plastic bag with 16 turkey slices was not dated or labeled.
-A plastic bag with approximately 28 slices of cheddar cheese was not dated or labeled.
-A plastic bag with approximately 14 slices of Swiss cheese and 4 slices of cheddar cheese was not dated or labeled.
-Approximately 18 slices of American cheese, wrapped in plastic wrap was not dated or labeled.

Observation of the freezers and refrigerators in the facility storage room for the kitchen on 06/04/19 at 9:05am revealed:
-A gallon freezer bag with 2 holes in the bag contained approximately 14 meatballs not dated or labeled.
-A plastic bag with approximately 16 frozen chicken patties was not dated or labeled.
-A plastic bag with approximately 40 frozen Salisbury steak patties was not dated or labeled.
-A plastic bag with a hole in the bottom of the bag contained approximately 16 frozen chicken patties not dated or labeled.
-A plastic bag, open with 3 frozen chicken patties was not dated or labeled.
-A plastic bag tied closed with 6 frozen chicken patties was not dated or labeled.
-A large plastic bag half full contained frozen yeast roll balls was not dated or labeled.

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D 283	Continued From page 2 -An open bag of 10 frozen cheese omelets was open and not dated. -A container of coleslaw approximately one gallon was not dated or labeled. -A large bag of baby spinach was open and not dated or labeled. -There was a half of a watermelon covered in plastic wrap not dated or labeled. Interview with the Cook on 06/04/19 at 9:17am revealed: -He was aware open items were to be dated and labeled. -He had been "really busy" and had not had time to label and date items as he knew he should. Attempted telephone interview with the Dietary Manager on 06/04/19 at 3:22pm was unsuccessful.	D 283		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would	D 482		

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D 482	Continued From page 3 provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure physical restraints were used only after an assessment and care planning process had been completed	D 482		

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D 482	Continued From page 4	D 482		

through a team process and after alternatives had been tried and documented in the resident's record for 1 of 1 sampled residents (#1) who had a lap buddy (wheelchair cushion device) restraint.

The findings are:

Observation of Resident #1 on 06/04/19 at 8:30am revealed:
-The Resident was seated in a wheelchair (wc) in the living room.
-There was a large lap buddy attached to the wc in front of the Resident.

Review of Resident #1's current FL2 dated 11/05/18 revealed diagnosis included Alzheimer's disease.

Review of signed physician's orders for Resident #1 revealed:
-There was an order dated 08/15/18 for a lap buddy cushion to prevent fall.
-There was an order dated 05/15/19 for a lap buddy cushion to prevent falls.

Review of Resident #1's current care plan dated 10/30/18 revealed:
-There was no assessment documented.
-There was no documentation of alternatives to restraints.
-There was documentation of Licensed Health Professional Support (LHPS) tasks of "wc with restraint and monitor that lap buddy is in place while in wc".

Telephone interview with Resident #1's Power of Attorney (POA) on 06/04/19 at 11:35am revealed:
-Resident #1 was always confused.
-The Resident had multiple falls in the past.
-The lap buddy was used to prevent the Resident

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D 482	Continued From page 5 from getting out of the wc. Interview with the Resident Care Coordinator on 06/04/19 at 2:20pm revealed: -She did not know a restraint assessment needed to be completed for Resident #1. -She did not know there needed to be alternatives to the restraints. Interview with a Medication Aide on 06/04/19 at 2:30pm revealed: -She did not know a restraint assessment needed to be completed for Resident #1. -She did not know there needed to be alternative to the restraints. Telephone interview with Resident #1's Physician's Nurse Practioner (NP) on 06/04/19 at 3:00pm revealed: -Resident #1 had required the lap buddy for "a long time" to prevent falls. -The NP did not know a restraint assessment and alternatives to the restraints needed to be completed. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.	D 482		