STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL044039	A. BUILDING: _____ B. WING _____	R 04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPICEWOOD COTTAGES ELMS	39 LOVING WAY 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 completed an annual/follow-up survey on 04/14/21.	D 000		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure all residents were provided with a non-disposable place setting, including a knife. The findings are: Observation of the noon meal on 04/14/21 from 12:00pm - 12:20pm revealed: -There were 8 residents seated at tables in the dining room. -There was 1 personal care aide (PCA) seated at a table. -Seven residents were served a whole pork chop with sauce, potatoes and cabbage, and 1 resident was served a chopped pork chop, potatoes and cabbage.	D 287		

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D 287	Continued From page 1	D 287		

-Each resident had a napkin, spoon, fork and no knife.
-Two residents requested knives to cut their pork chops and staff gave the two residents a knife.
-One resident was using his fingers and a spoon to tear bite sized pieces of the pork chop.
-One resident was using his fingers and a fork to tear bite sized pieces of the pork chop.
-Three residents made no attempt to eat their pork chops.
-Staff never offered to cut up the residents' pork chop.

Interview with the PCA in the dining room on 04/14/21 at 12:08pm revealed:
-Knives were not given out to the residents because the facility was a "lockdown unit".
-Residents should ask for a knife if they needed one.
-The PCA should have offered to cut up the pork chop but she had forgotten to.

Interview with the Medication Aide (MA) on 04/14/21 at 12:10pm revealed that knives were not given to the residents because the facility was a "locked unit".

Interview with two residents on 04/14/21 at 12:15pm revealed:
-They never received a knife.
-Sometimes they would like a knife to cut up their meal.

Telephone interview with the Dietary Manager on 04/14/21 at 12:45pm revealed:
-The food and utencils were prepared and brought to the facility from a sister facility for each meal service.
-There were enough knives for each resident.
-Staff had not given knives out to the residents

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D 287	Continued From page 2 because the residents all had a diagnosis of dementia. -The residents never received a knife. Interview with the Administrator on 04/14/21 at 2:28pm revealed: -There had been concerns about a couple of residents in the past having knives so none of the residents were given knives. -Staff should have assisted the residents with cutting up their pork chops.	D 287		
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). This Rule is not met as evidenced by:	D 367		

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D 367	Continued From page 3	D 367		

Based on observations, interviews and record reviews, the facility failed to ensure the electronic Medication Administration Record (eMAR) was accurate for 1 of 3 sampled residents (#1) related to Thromo-Embolus Deterrent (TED) Hose.

The findings are:

Review of Resident #1's current FL2 dated 11/23/20 revealed diagnoses included dementia and hypertension.

Review of the Resident Register for Resident #1 revealed an admission date of 11/16/20.

Review of a physician's order dated 02/01/21 for Resident #1 revealed Thrombo-Embolus Deterrent (TED) Hose (helps to prevent blood clots), on in the morning and off in the evening.

Review of Resident #1's electronic Medication Administration Record (eMAR) for February 2021, March 2021, and April 1 - 14, 2021 revealed:
-There was an entry for Jobst Knee High (TED hose) put on in the morning with an application time of 8:00am.
-There was documentation the TED hose were applied at 8:00am February, March, and April 1 - 14, 2021 at 8:00am.
-There was an entry for Jobst Knee High (TED hose) remove at bedtime with a removal time of 8:00pm.
-There was documentation the TED hose were removed at 8:00pm February, March, and April 1 - 13, 2021 at 8:00pm.

Observation of Resident #1 on 04/14/21 at 11:51am revealed she did not have any TED hose on.

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D 367	Continued From page 4	D 367		

Interview with Resident #1 on 04/14/21 at 11:52am revealed:
-She had not worn TED hose "in long while".
-She thought they were somewhere in her room.
-She had not had any edema in her legs.

Interview with a Personal Care Aide (PCA) on 04/14/21 at 11:53am revealed:
-She did not know Resident #1 should TED hose.
-If she had known that Resident #1 was to wear TED hose she would have applied them.

Interview with the Medication Aide (MA) on 04/14/21 at 11:55am revealed:
-Resident #1 would not wear the TED hose.
-She only wore them for a couple of days.
-He did not know why he documented on the eMAR that he had applied the Ted hose when he had not.

Interview with the Resident Care Coordinator (RCC) on 04/14/21 at 12:25pm revealed:
-The MAs should have informed the Nurse Practitioner (NP) that Resident #1 would not wear the TED hose.
-The MAs should not have documented they had applied and removed the TED hose when they had not.

Telephone interview with a second MA on 04/14/21 at 2:41pm revealed:
-She had documented she had applied the TED hose on the eMAR when she had not because sometimes Resident #1 would apply the TED hose herself.
-She had thought the socks that Resident #1 wore were the TED hose.

Interview with the Nurse Practitioner (NP) on 04/14/21 at 1:30pm revealed:

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D 367	Continued From page 5 -She had ordered the TED hose for Resident #1 due to edema in her legs. -Resident #1 would not wear the TED hose. -She had not discontinued the TED hose because she had "hoped" the resident would wear them. Interview with the Administrator on 04/14/21 at 2:28pm revealed: -Resident #1 would sometimes take off her TED hose. -The MAs should not have documented the application and removal of the hose if they had not done so.	D 367		