

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011196	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/14/2018
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NAME OF PROVIDER OR SUPPLIER EVERGREEN LIVING HOME #11	STREET ADDRESS, CITY, STATE, ZIP CODE 351 FAMILY RIDGE ROAD LEICESTER, NC 28748
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(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 Buncombe County Department of Social Services conducted an annual survey on June 14, 2018.	C 000		
C 315	<p>10A NCAC 13G .1002(a) Medication Orders</p> <p>10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to clarify an order for 1 of 3 sampled residents (Resident #2) with an order for thickened liquids.</p> <p>The findings are:</p> <p>Review of the current FL2 for Resident #2 dated 04/11/18 revealed: -Diagnoses included senile dementia, dysphagia and transient ischemic attack (TIA). -Documented as non-ambulatory and intermittently disoriented. -An order for a puree diet. -Listed under the medication section of the same</p>	C 315		

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

TITLE

(X6) DATE

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C 315	<p>Continued From page 1</p> <p>FL2 an order for "Thick-It, use as directed."</p> <p>Review of Resident #2's record revealed no documentation or clarification of the thickened liquid order listed on the FL2 and no subsequent orders.</p> <p>Review of the Care Plan for Resident #2 dated 04/11/18 revealed Resident #2 was documented as total care.</p> <p>Review of the Licensed Health Professional Support (LHPS) dated 04/18/18 revealed documentation of Resident #2 having "nectar thickened liquids" with no recommendations.</p> <p>Review of the June 2018 Medication Administration Record (MAR) for Resident #2 revealed an entry for "Thick-It, Use as Directed."</p> <p>Review of the May 2018 MAR revealed no entry for Thick-It.</p> <p>Interviews with the Supervisor-in-Charge (SIC) on 06/14/18 at 9:50am and 10:20am revealed: -The Thick-It was kept in Resident #2's room. -"I use Thick-It" with [Resident #2's] food and liquids. -"I have never observed any complications of choking or coughing while feeding resident her meals with liquids or food." -Resident #2 "primarily only drinks water and maybe juice sometimes." -"I use one large scoop for 4 ounces of liquid, as listed on the Thick-It container." -"I often use a spoon to give the resident her liquids, but sometimes she will drink from the cup." -She stated "another staff showed me to use one scoop".</p>	C 315		

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C 315	<p>Continued From page 2</p> <p>Observation of the Thick-It container in Resident #2's room on 06/14/18 at 10:15am revealed: -A plastic container of Thick-It with a pharmacy computer generated label with Resident #2's name and a dispense date of 04/20/18. -Directions for use on the pharmacy label read, "USE AS DIRECTED."</p> <p>Observation of the SIC on 06/14/18 at 10:16am revealed she used a full scoop in [Resident #2's] liquids (15cc).</p> <p>Review of the Usage Chart on the Thick-It container revealed for water, amount to be used for nectar thickened liquids was 3 ½ -4 t (teaspoons).</p> <p>Telephone interview with the Administrator on 06/14/18 at 10:30am revealed: -She was unsure about the thickened liquid order and would check with the Nurse Practitioner (NP) who comes to the facility monthly to discuss the order.</p> <p>Observation of the lunch preparation and delivery for Resident #2 on 06/14/18 from 11:30am until 12:15pm revealed: -The SIC placed one large scoop of the Thick-It into 4-5 ounces cup of tea and stirred the Thick-It until dissolved in the cup of liquid. -The Relief SIC entered Resident #2's room to assist with the lunch meal. -Resident #2 was asleep and when staff offered her lunch meal was observed to take a couple bites of spooned puree meal and one spoon of the liquid tea. -Resident #2 then shook her head side to side and the staff stated "she does not want to eat right now."</p>	C 315		

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C 315	Continued From page 3 Interview with the Relief SIC on 06/14/18 at 12:20pm revealed: -The SIC always prepared meals and liquids for the resident and he only assisted with feeding. -He would come back later to see if the resident wanted to eat something else. A second telephone interview with the Administrator on 06/14/18 at 12:25pm revealed she had spoken with the NP and she was faxing clarification of the thickened liquid order to her. Review of the faxed order on 06/14/18 at 12:30pm revealed an order signed by the NP dated 06/14/18 for "Thick-It nectar consistency." Telephone interview with the dispensing pharmacy on 06/14/18 at 3:18pm revealed: -The original order for the Thick-It was from an FL2 dated 04/11/18. -The order was "use as directed." -The Thick-It was dispensed to the facility on 04/20/18. Attempted telephone interviews with the NP for Resident #2 on 06/14/18 at 10:45am and 4:00pm was not successful. Based on observations, interview and record review it was determined Resident #2 was not interviewable.	C 315		