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	HAL026058	A. BUILDING: _____ B. WING _____	07/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARC OF HOPE MILLS	4124 PECAN DRIVE HOPE MILLS, NC 28348

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 07/20/16 - 07/22/16.	D 000		
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: Based on observation, interview and record review, the facility failed to assure therapeutic diets were served as ordered for 1 of 3 residents (#2) sampled who had an order for a regular no added salt chopped meats diet and failed to serve thickened liquids for 1 of 1 resident (#3) sampled with an order for nectar thickened liquids. The findings are: 1. Review of Resident #3's current FL-2 dated 04/27/16 revealed: -The resident's diagnoses included Alzheimer's dementia, history of right sacral fracture, history of left femoral neck fracture, and percutaneous stent. -The resident was constantly disoriented and was total care. Review of a physician's order dated 03/21/16 for Resident #3 revealed there was an order for Thick It use as directed for thick liquids. Review of a clarification order dated 07/19/16 for	D 310		

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Resident #3 revealed an order for nectar thickened liquids.

Review of the facility's diet list revealed Resident #3 was on nectar thickened liquids.

Interview with the cook / dietary aide on 07/20/16 at 10:50 a.m. revealed:
-Resident #3 was the only resident receiving thickened liquids.
-They stored the large container of Thick It in the kitchen.
-He thought the resident received nectar thick liquids but he was not sure.
-He did not mix the thickener.
-The nurse aides or medication aides usually mixed the thickener.

Review of the instructions on the label of the Thick-it container revealed:
-The usage chart included amounts of Thick-it to be used per 4 ounces of liquids.
-For water, 3 ½ - 4 teaspoons for each 4 ounces of water, fruit juice, coffee or tea were required for nectar thickened consistency.

Observation and interview of the medication aide (MA) on 07/20/16 at 5:25 p.m. revealed:
-The MA had worked at the facility since the end of February 2016.
-Resident #3 had always gotten nectar thickened liquids since the MA had worked at the facility.
-The MA had 2 cups, one with Kool-Aid and the other with water.
-The Kool-Aid was in a tall green cup the MA described as being 8 ounces.
-The water was in a short, wide transparent amber cup the MA described as being 4 ounces.
-The MA put 2 tablespoons of Thick-It in the Kool-Aid and 1 tablespoon in the water.

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D 310	Continued From page 2 -She stirred the Thick-it in the liquids and served it to Resident #3. -Both liquids appeared to be less than nectar thick. -The MA provided feeding assistance to Resident #3 during the supper meal including the assistance with the liquids. -The resident did not cough or choke when drinking the liquids. Interview and observation with the cook / dietary aide in the kitchen on 07/20/16 at 6:08 p.m. revealed: -He was unsure of the sizes of the cups used to serve the residents. -Using a measuring cup, the tall green cup held 8 ounces of liquid. -Using a measuring cup, the short wide amber colored cup also held 8 ounces of liquid. Interview with the MA on 07/20/16 at 6:13 p.m. revealed: -She thought the shorter amber colored cup was 8 ounces. -She thought 4 teaspoons equaled 1 tablespoon. -When surveyor told her 4 teaspoons was not 1 tablespoon, the MA then said 2 teaspoons was 1 tablespoon. -The surveyor then pointed to the scale on the Thick-it label which noted 3 teaspoons was equal to 1 tablespoon. -She did not realize she was reading the label incorrectly. -The MA had training on thickened liquids at other facilities but not this facility. -She had not observed Resident #3 to cough or choke while eating or drinking. Interview with the Administrator on 07/20/16 at 6:45 p.m. revealed:	D 310		

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D 310	Continued From page 3 -Staff had been trained on mixing the thickened liquids and they should use the instructions on the label for guidance. -She would make sure staff were retrained on how to mix the thickened liquids. Observation of the cook / dietary aide on 07/21/16 at 11:25 a.m. revealed: -The cook was going to mix the thickened liquids for Resident #3. -The cook added 4 teaspoons to an 8 ounce cup of tea. -He stirred the Thick-it in the tea and served it to Resident #3. -The tea appeared to be less than nectar thick. Interview with the cook / dietary aide on 07/21/16 at 11:28 a.m. revealed: -The cook pointed to the top of the instructions beside tea which read 3 ½ - 4 teaspoons. -The surveyor pointed to the top of the instructions above the scale on the Thick-it label which read recommended usage per 4 fluid ounces. -The cook had not noticed the amounts listed on the usage chart were recommended for 4 ounces of liquid instead of 8 ounces. -The cook took back Resident #3 ' s tea and poured it out after realizing he did not add enough Thick-it. -The cook then mixed 8 teaspoons of Thick-it into 8 ounces of tea and served to the resident. -The tea appeared to be nectar consistency. 2. Review of Resident #2's current FL-2 dated 04/20/16 revealed: -The resident's diagnoses included Alzheimer's dementia, hypertension, hyperlipidemia, coronary artery disease, chronic obstructive pulmonary disease, gastroesophageal reflux disease, peptic	D 310		

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ulcer disease, and osteoarthritis.
-The resident was constantly disoriented and required assistance with bathing and dressing.
-There was an order for a regular no added salt chopped meats diet.

Review of the facility's diet list revealed Resident #2 was on a regular no added salt chopped meats diet.

Review of the therapeutic menu revealed the menu included a diet column for a regular / no added salt diet.

Review of the therapeutic menu for supper on 07/20/16 for Resident #2's ordered diet revealed:
-The beverages included 8 ounces of milk and 8 ounces of a beverage of choice.
-The meat to be served was chili dog on a bun.

Interview with the cook / dietary aide on 07/20/16 at 4:50 p.m. revealed he was substituting the hot dogs on the menu with sausage dogs.

Observation of the supper meal on 07/20/16 at 5:27 p.m. revealed:
-Resident #2 was served 8 ounces of water and red Kool-Aid.
-No milk was served to the resident.
-The resident was served sausage dog that was cut into 1 to 2 inch pieces.
-The resident did not have any teeth or dentures and ate the sausage using his gums to chew the sausage.

Interview with Resident #2 on 07/20/16 at 5:49 p.m. revealed:
-He did not have any teeth and he did not like to wear dentures.
-The resident first stated he swallowed the

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D 310	Continued From page 5 sausage pieces whole. -The resident later stated he chewed it with his gums and laughed. -The resident stated he liked milk and he could either "take it or leave it". Interview with the cook / dietary aide on 07/20/16 at 6:04 p.m. revealed: -He usually cut up meats for chopped meats diets. -He first stated he did not have chopper. -He then found a chopper hanging up above the food prep table in front of the stove. Interview with the cook / dietary aide on 07/20/16 at 6:25 p.m. revealed milk was usually served at the breakfast meal. Interview with the Administrator on 07/20/16 at 6:45 p.m. revealed: -Staff should serve beverages according to the menu including milk. -Meats should be chopped not cut up for diets ordered with chopped meats.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interviews, record reviews, and observations, the facility failed to assure 2 residents (#4 and #6) living in the special care unit facility were treated with respect, dignity,	D 338		

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consideration, and full recognition of individuality by 2 staff (A, B) related to one resident requesting meal alternatives (#4) and one resident removing silverware from an unoccupied dining room table (#6).

The findings are:

1. Review of Resident #4's current FL-2 dated 01/06/16 revealed:
-The resident's diagnoses included vascular dementia, end stage renal disease, anxiety, intellect disability, insomnia, degenerative joint disease and gastroparesis.
-The resident was semi-ambulatory and used a wheelchair.
-The resident was intermittently disoriented.
-The resident was a wanderer with no other inappropriate behaviors documented.

Observation of Resident #4 and Staff B (cook / dietary aide) in the dining room on 07/21/16 at lunch revealed:
-At 11:34 a.m. Resident #4 received a plate consisting of country style steak topped with gravy, mashed potatoes topped with gravy, green beans and yellow pudding.
- At 11:44 a.m. Resident #4 verbalized that he was not supposed to eat gravy.
-At 11:44 a.m., a nurse aide (NA) heard the resident comment that he could not eat the food served to him.
-The NA walked to the kitchen door and told Staff B who was in the kitchen that Resident #4 needed a plate with no gravy.
-Staff B sighed and shook his head from side to side while looking downward when told by the NA that Resident #4 did not want gravy.
-At 11:46 a.m., all residents had received their meal and Staff B was refilling beverages to the

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residents.
-Staff B did not acknowledge that Resident #4 had requested a plate with no gravy.
-At 11:47 a.m., Resident #4 started eating the plate of food with gravy but was told by the NA not to eat it.
-The resident responded, "It runs my blood up".
-At 11:49 a.m., Staff B served Resident #4 another plate without gravy.

Confidential interview with a staff member revealed:
-There was an incident that occurred this past weekend on 07/16/16 during the supper meal.
-The residents were served ravioli out of a can with mozzarella cheese poured over it.
-Some of the residents did not want to eat the ravioli and were given a choice of a ham sandwich as an alternative.
-Resident #4 did not want to eat the ravioli but was told by Staff A (medication aide / nurse aide) and Staff B "you are going to eat it, that ravioli".
-Resident #4 was spoke to in a loud and harsh voice by Staff A.
-Resident #4 was told by Staff A to "Get out of here, you know I don't like you anyway".
-Staff B would not give Resident #4 anything else to eat.
-The staff member sent the Director a text and received a text back that somebody better make Resident #4 "a d- - - sandwich".
-The staff member then made a call to the Director from her personal cell.
-The Director told the staff member she would handle the issue on Monday.
-Resident #4 finally got a ham sandwich.

Confidential interview with a former staff member revealed:
-There was "favoritism" shown for some of the

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residents at the facility, especially with food.
-There were some residents that could receive sandwiches when they would ask but there were other residents that could not when they would ask.
-Some of the medication aides yelled at the residents and told the residents they can't sit in the dining room.
- Staff A was the main medication aide who yelled at residents.
-Staff A would yell and tell the residents to get away from the table, it was not time to eat.
-Staff A always had an issue with Resident #4.

Interview with Resident #4 on 07/21/16 at 5:20 p.m. revealed:
-A recent incident occurred with Staff B.
-The resident could not recall the exact day.
-Resident #4 was sitting at his regular table in the dining room.
-A plate of ravioli was placed in front of Resident #4 by Staff B.
-Resident #4 reminded Staff B he did not like beef out of a can that it made him "throw up".
-Staff B told Resident #4 "You are going to eat that ravioli, you can starve, but you are not getting anything else".
-There were other staff members in the dining room that heard the conversation.
-Resident #4 never got anything else to eat, but did eat all the other food on the plate except for the ravioli.
-All other staff members treated him good and he never had an issue with any of the other staff.

Confidential interview with a second staff member revealed:
-There was an incident that occurred in the dining room involving Resident #4.
-The incident occurred on 07/16/16 at the supper

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D 338	Continued From page 9 meal. -Resident #4 received his plate of food (ravioli) and told Staff A and Staff B he did not like it. -Staff A told Resident #4 that he could not have anything else. -Staff B was "adamant" he was not going to give Resident #4 anything else. -Staff A told Resident #4 to "get out of the dining room, you know I don't like you anyway". -Resident #4 became upset and went to his room. -One of the other staff members heard the conversation and called the Director on her personal cell phone. -The other staff person attempted to prepare a sandwich in the kitchen for Resident #4 but was stopped by Staff A and Staff B. - Staff B told the other staff member to get out of the kitchen. -The other staff member told Staff B that the Director had instructed to make Resident #4 a sandwich. -Staff B made Resident #4 two sandwiches. -Resident #4 returned back to the dining room and ate the sandwiches when the supper meal was almost over. - The Resident received his sandwiches, eating them at approximately 6:00 p.m. as the other residents were leaving the dining room. Interview with Staff A on 07/21/16 at 6:15 p.m. revealed: -The residents were served a snack around 2:30 p.m. daily. -Resident #4 was asked around 2:30 p.m. if he wanted a snack on 07/16/16. -The choices for the snack was potato chips, applesauce or a cookie on 07/16/16. -Applesauce was for special diets, Resident #4 was given a choice of potato chips or a cookie.	D 338		

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D 338	Continued From page 10 -Resident #4 told Staff A he was not eating anything unless he got a sandwich. -Staff A gave Resident #4 potato chips and Resident #4 ate the chips for his snack. -Resident #4 wanted milk with his snack, Staff A got the milk, then the resident changed his mind and wanted water which was provided for him. -At supper, Resident #4 was in his room with his roommate. -Staff A went to Resident #4's bedroom about 15 minutes prior to the supper meal and the resident asked what the facility was having for supper. -Resident #4 told Staff A that he was not eating anything unless he got a sandwich. -Staff A encouraged Resident #4 to come to the dining room but he did not get up. -Soon after Staff A left Resident #4's room, another staff member went into Resident #4's room. -The same staff member approached Staff A and reported that Resident #4 was requesting a sandwich. -Resident #4 requested something different to eat quite often. -Staff A told the staff member to " hold on and I will let [name of Staff B] know" that Resident #4 wanted a sandwich. -Staff A was the supervisor on duty and the staff member "goes and calls" the Director and tells her we would not make Resident #4 a sandwich. -Staff A was serving other residents, "It takes us all in the dining room, we are busy". -Staff A went into the kitchen to tell Staff B that Resident #4 wanted a sandwich. -The staff member was already in the kitchen. -Staff B did not realize the other staff member was in the kitchen until Staff A walked in. -Staff B told the staff member to get out of the kitchen. -Staff B made Resident #4 two sandwiches.	D 338		

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-Staff A asked Resident #4 why he did not want to eat the food for supper and Resident #4 responded that his doctor told him he could not have it.
-Staff A reminded Resident #4 he was not supposed to have fried chicken but he ate that.
-Resident #4 got a sandwich between 5:30 p.m. and 6:00 p.m.
-Resident #4 never came to the dining room until he got the sandwiches.
-Resident #4 could get a nasty attitude and she had documented issues she had with him a few months ago.
-Staff A called the Director on 07/16/16 after the staff member left which was around 6:00 p.m.

Review of staff notes for Resident #4 by Staff A revealed:
-05/09/16 (9:23 a.m.): Resident #4 became upset because he stated his spoon was dirty. Staff A checked the spoon and told it was "NOT" dirty. Resident #4 threw his spoon at the Med Tech and left the dining room. Resident #4 did not return to eat dinner then refused nightly medications, The Director would be notified of the situation the next day.
-05/08/16 (9:23 a.m.): Staff A documented that Resident #4 made inappropriate comments and he should "NOT" be making them. Staff A would speak with Director the next day.

Interview with the Administrator on 07/21/16 at 1:30 p.m. revealed:
-The Administrator was not aware of the incident on 07/16/16.
-She expected staff members to report any issues or concerns immediately.
-The staff members were expected to report issues to their immediate supervisor, SCC or Director.

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D 338	Continued From page 12 -She was always available 24 hours a day via phone. -The Administrator's contact number was posted in the front of the facility for all staff members to call if needed regardless of the time of day. Interview with the Director on 07/21/16 at 2:55 p.m. revealed: -The Director received a text from a staff member on 07/16/16 around 5:30 p.m. -The Director told the staff member to make Resident #4 a sandwich. -The Director received a phone call about 20 minutes later from the same staff member that had texted her. -The staff member reported that she was told to get out of the kitchen when she was attempting to make a sandwich for Resident #4. -The Director was told that the staff member told Resident #4 he did not have to eat ravioli and could have a sandwich. -There was a discussion with Staff B and the Director concerning the incident. -Staff B told the Director that the staff person was lying and stirring up something regarding the incident on 07/16/16. -The Director was told by another staff member 07/20/16 that Staff A was loud. -A family member recently reported to the Director that Staff A was loud. -The Director had planned to talk with Staff A about being loud. -Staff B did not get along sometimes with some of the staff. -Staff B was playful and sometimes "picked" at the residents. Interview with the Administrator on 07/21/16 at 2:55 p.m. revealed: -The Administrator advised they would plan to	D 338		

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THE ARC OF HOPE MILLS	4124 PECAN DRIVE HOPE MILLS, NC 28348

(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 338	Continued From page 13	D 338		

meet with the resident.
-The Administrator would plan to have a residents' rights in-service with all staff members.

Interview with Staff B on 07/21/16 at 5:45 p.m. revealed:
-The only resident that usually wanted an alternative meal was Resident #4.
-Staff B stated, "Sometimes he (referring to Resident #4) just does it to mess with me".
-For the incident over the weekend, Resident #4 was served ravioli.
-Staff B was going to give Resident #4 a sandwich after he finished serving all of the other residents.
-One of the staff members came in the kitchen and tried to tell Staff B what to do.
-Resident #4 got two sandwiches for supper that evening.
-Resident #4 told staff what the doctor said the resident can have to eat.
-Staff B told Resident #4 that they had the doctor's orders and they know what not to give the resident.

2. Review of Resident #6's current FL-2 dated 04/27/16 revealed:
-The diagnoses included Alzheimer's dementia, chronic obstructive pulmonary disease, tobacco abuse, and history of alcohol abuse.
-The resident was constantly disoriented and a wanderer.
-The resident required assistance with bathing and dressing.

Observation of Resident #6 on 07/21/16 at 5:08 p.m. revealed:
-Resident #6 was walking around in the dining room.
-The tables had been set with cups and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 338	Continued From page 14 silverware wrapped in a napkin. -Resident #6 walked to one of the tables near the kitchen door and picked up a napkin with silverware (a spoon and a fork) wrapped in it. -Staff B walked up to Resident #6 and grabbed the silverware and tugged back and forth with the resident. -Resident #6 appeared to grip the silverware harder and turned away from Staff B. -Staff B continued to pull on the silverware until Staff B pulled hard enough to get the silverware from Resident #6's hand. -Staff B was telling the resident, "It's not yours, it's not yours", while Staff B was pulling and tugging at the silverware. -Resident #6 then walked away with his head down mumbling. -Staff B put the silverware back on the table. Interview with Staff B on 07/21/16 at 5:45 p.m. revealed: -Resident #6 tried to steal the silverware. -When staff tried to take the silverware, Resident #6 would act like he was going to hit them with it. Interview with the Director on 07/21/16 at 6:00 p.m. revealed: -Resident #6 would steal the silverware and walk up and down the hall holding the silverware. -Resident #6 would hit the end of the table or whatever was nearby with the end of the silverware. -Staff should redirect the resident or supervise him until he put the silverware down.	D 338		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights:	D911		

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D911	Continued From page 15 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure residents were treated with respect, dignity, consideration, and full recognition of individuality as related to the tone and manner in which 2 staff members (A, B) spoke to and treated 2 residents (#4, #6). The findings are: Based on interviews, record reviews, and observations, the facility failed to assure 2 residents (#4 and #6) living in the special care unit facility were treated with respect, dignity, consideration, and full recognition of individuality by 2 staff (A, B) related to one resident requesting meal alternatives (#4) and one resident removing silverware from an unoccupied dining room table (#6). [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights.]	D911		