

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026067	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/09/2020
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NAME OF PROVIDER OR SUPPLIER ARC OF HOPE MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 4124 PECAN DRIVE HOPE MILLS, NC 28348
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{D 000}	Initial Comments	{D 000}		
{D 287}	<p>10A NCAC 13F .0904(b)(2) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes:</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observation and interviews the facility failed to ensure all residents were provided with a non-disposable place setting, including a knife.</p> <p>The findings are:</p> <p>Observation of the lunch meal service on 03/09/20 at 11:32am revealed: -There were 22 resident meals that were served in the dining room. -The table setting consisted of a napkin, spoon and fork in addition to the plate and cup. -The meal consisted of seasoned pork, sweet potatoes, boiled squash, a baked roll and a slice of plain yellow cake with no icing.</p> <p>Observation in the kitchen on 03/09/20 at 10:28am revealed the cook was rolling a fork and a spoon in a napkin for the noon meal service.</p>	{D 287}		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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{D 287}	<p>Continued From page 1</p> <p>Interview with a cook on 03/09/20 at 10:28am revealed: -She had been working at the facility for more than 2 years. -The cook was responsible for wrapping the silverware in the napkin. -She had never given residents a knife because the kitchen did not stock knives. -She did not know why the kitchen did not stock knives for resident use. -Kitchen staff were responsible for cutting food when a resident had an order for chopped food.</p> <p>Observation in the kitchen on 03/09/20 at 1:17pm revealed there were three butter knives and a steak knife available to assist staff with cutting food for the residents.</p> <p>Interviewed with another cook on 03/09/20 at 1:17pm revealed: -She had also been employed for about 2 years and the facility had never provided residents a knife for use during a meal during that time. -She could not "wrap the knives" if she did not have the knives in the kitchen to wrap. -No one had ever told her the residents were supposed to have knives for use during their meals.</p> <p>Interview with a Personal Care Assistant (PCA) on 03/09/20 at 1:22pm revealed: -The residents had never received knives for use with their meals. -If she needed to assist a resident to cut something, she would either give the plate back to the kitchen for them to cut it or ask for a knife to cut the item.</p> <p>Interview with the Executive Director (ED) on</p>	{D 287}		

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{D 287}	<p>Continued From page 2</p> <p>10/02/19 at 4:07pm revealed: -They did not currently have knives in the kitchen for resident use nor had they ever in the past. -For safety reasons, he did not think residents that had dementia should be allowed to use a knife. -None of the residents had a physician's order to withhold a knife at mealtimes.</p> <p>Interview with the Administrator on 03/09/20 at 5:00pm revealed: -She was of the understanding all residents in the facility had orders for no knives because they were all dementia patients. -The Resident Care Coordinator (RCC) was responsible for obtaining orders for all residents abstaining from using knives related to their diagnosis of dementia/Alzheimer's disease.</p> <p>Interview with the RCC on 03/09/20 at 5:06pm revealed: -There was only one resident, she was aware of, who was physically unable to use a knife related to the resident's diagnosis of Parkinson's Disease. -She did not have any assessments she could provide that residents were unable to use a knife. -She had some physician orders for residents that all stated to "discontinue the usage of knives due to cognitive disorder/Alzheimer's dementia".</p>	{D 287}		
{D 292}	<p>10A NCAC 13F .0904(c)(3) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the</p>	{D 292}		

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{D 292}	<p>Continued From page 3</p> <p>foods actually served to residents.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to document the foods actually served to residents when substitutions to the menu occurred.</p> <p>The findings are:</p> <p>Review of the facility's lunch menu for 03/09/20 revealed Herb seasoned pork, glazed sweet potatoes, yellow squash with onions, baked roll and caramel apple cake.</p> <p>Observation of the lunch meal service on 03/09/20 at 11:32am revealed seasoned pork roast, sweet potatoes, boiled squash, baked roll, and yellow cake with no icing.</p> <p>Review of the facility's substitution book in the kitchen revealed there was no documentation of any food substitutions since 11/03/19.</p> <p>Interview with the cook on 03/09/20 at 10:20am revealed: -She did not have many substitutions but when she did, she was to fill out a form in substitution book when something was changed on the menu. -She thought she had filed out a form since November 2019 but could not remember for sure. -Several weeks ago, she substituted a chocolate éclair for chocolate pudding but had not put it in the substitution book. -The Executive Director (ED) would check several times during the week to make sure the facility had the items they needed to provide the</p>	{D 292}		

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{D 292}	<p>Continued From page 4</p> <p>resident meals.</p> <ul style="list-style-type: none"> -She spoke with the ED earlier this morning about substitution for the caramel apple cake and he told her to substitute with the plain yellow cake with icing. -She did not have any blank substitution forms in the notebook -She had not placed the substitution in the substitution notebook. <p>Interview with the ED on 03/09/20 at 4:07pm revealed:</p> <ul style="list-style-type: none"> -There was a substitution book in the kitchen with a form to be completed by the cook when substitutions were made. -Since the facility had changed companies and now had different menu's the facility had few substitutions. -He was responsible for ordering items for the menu. -He placed his order based specifically on the items on the menu. -He expected to have few substitutions with the way he was ordering now. -He checked several times a week with the kitchen staff to ensure they had needed items available for each meal. -He had trained the dietary staff to document in the substitutions notebook when any substitutions were made. -He did not know why the substitution forms were not in the notebook. -He did not know why the substitution notebook had not been completed since November 2019. -He expected dietary staff to follow procedures and complete all food substitution documentation as they had been trained. -He had not checked the substitution book to ensure substitutions were being documented. 	{D 292}		

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{D 292}	Continued From page 5 Interview with the Administrator on 03/09/20 at 5:00pm revealed: -She expected dietary staff to follow procedures and complete all food substitution documentation in the "special book" as they had been trained.	{D 292}		
{D 310}	<p>10A NCAC 13F .0904(e)(4) Nutrition and Food Service</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 4 sampled residents (Resident #4) who had physician orders for a No Added Salt (NAS), Low Concentrated Sweets (LCS), and chopped meat diet.</p> <p>The findings are:</p> <p>Review of Resident #4's current FL-2 dated 02/27/20 revealed: -Diagnoses included dementia, hepatic encephalopathy, seizure disorder, schizoaffective disorder, hypertension, schizophrenia, and liver disease. -There was an order for NAS, LCS, and chopped meat diet.</p> <p>Review of the facility's diet list posted in the kitchen on 03/09/20 revealed Resident #4 was to</p>	{D 310}		

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{D 310}	<p>Continued From page 6</p> <p>be served a NAS, LCS, regular texture diet with chopped meats.</p> <p>Review of the lunch menu for 03/09/20 revealed residents were to be served herb seasoned pork, yellow squash and onions, glazed sweet potatoes, a dinner roll, and a slice of caramel apple cake for dessert.</p> <p>Review of the therapeutic diet menus provided by the cook on 03/09/20 at revealed: -The LCS diets were to be served the same menu as the regular diets except for a diet dessert. -The NAS diets were to be served the same items as the regular diets but were not to use a salt shaker at the table.</p> <p>Observation of Resident #4's lunch meal service on 03/09/20 at 12:00pm revealed: -Resident #4 had water and coffee and was served a whole piece of a pork, mashed sweet potatoes, squash and onions, half of a dinner roll, and a slice of yellow cake with no icing. -Resident #4 used a fork to cut pieces into the pork chop and used his fingers to pull the pork chop apart into smaller pieces. -Resident #4 ate 100 percent of his meal. -Resident #4 should have been served chopped-up pork instead of a whole slice.</p> <p>Interview with the cook on 03/09/20 at 12:30pm revealed: -Resident #4's pork was chopped when it was prepared in the kitchen. -She gave Resident #4's plate to a personal care aide (PCA) or a Certified Nursing Assistant (CNA) (she could not remember who she gave the plate to) to serve to Resident #4. -She did not tell the PCA/CNA the plate was for</p>	{D 310}		

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{D 310}	<p>Continued From page 7</p> <p>Resident #4.</p> <ul style="list-style-type: none"> -She handed all the plates to PCA's or CNA's and they served the plates to the residents. -She did not tell the PCA's or CNA's which residents to serve the plates to because they were expected to know all the resident's diets. <p>Interview with Resident #4 on 03/09/20 at 1:45pm revealed:</p> <ul style="list-style-type: none"> -He was served pork, sweet potatoes, squash, and cake for the lunch meal service. -His pork was cold. -He did not have any teeth or dentures to chew his food. -When asked how he chewed the pork chop with no teeth he replied, "I gummed it". -He cut the pork chop using his fork but "it was hard to cut with the fork" so he used his fingers to "pull it apart". <p>Interview with a CNA on 03/09/20 at 2:00pm revealed:</p> <ul style="list-style-type: none"> -The kitchen staff were responsible for telling the CNA's and PCA's which residents received the type of diet ordered for each resident. -The cook would bring the residents plate to the doorway of the kitchen and would hand the PCA's and CNA's the plate, tell them which resident the plate was to be delivered to, and they would take the plate to that resident. -She did not know why Resident #4's pork was not chopped on 03/09/20 or realize that it was supposed to be chopped. -She was told by the cook to give the plate with the whole piece of pork to Resident #4. -She knew there was a diet list in the kitchen with each resident's diet. <p>Interview with a second shift PCA on 03/09/20 at 2:39pm revealed:</p>	{D 310}		

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{D 310}	<p>Continued From page 8</p> <ul style="list-style-type: none"> -Resident #4 was on a regular diet with double portions. -She did not know if Resident #4 had chopped meats ordered for his diet. -She just had to memorize the resident's diets over time. -The cook did not tell her which residents to serve the plates to. -If a resident's diet changed or a new resident was admitted, the cook, Resident Care Coordinator (RCC), or Medication Aide (MA) would tell the PCA's and CNA's of the diet change. -There was a list of each resident's diet posted in the kitchen to use as a reference. <p>Attempted telephone interview with the Primary Care Physician (PCP) for Resident #4 on 03/09/20 at 3:37pm was unsuccessful.</p> <p>Telephone interview with Resident #4's legal guardian on 03/09/20 at 3:40pm revealed:</p> <ul style="list-style-type: none"> -Resident #4 was placed with a guardianship company where she worked about a year ago. -She did not know what type of diet Resident #4 had ordered. -When Resident #4 was in the hospital in November 2019 he was on a cardiac diet with NAS. -Resident #4 did not have any teeth or dentures. -She did not know if Resident #4 had any chewing or swallowing difficulty. <p>Interview with the Executive Director on 03/09/20 at 4:05pm revealed:</p> <ul style="list-style-type: none"> -He did not know why Resident #4 received a whole slice of pork instead of chopped pork for the lunch meal service on 03/09/20. -The cook prepared the plates for the residents and when the PCA retrieved the plate, the cook 	{D 310}		

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{D 310}	<p>Continued From page 9</p> <p>told the PCA what type of diet was on the plate not who the plate was supposed to be served to.</p> <ul style="list-style-type: none"> -The RCC would inform the kitchen staff of diet order changes and she would make corrections to the diet order list posted in the kitchen and a copy was also given to the MA's to be stored on the medication cart. -All staff were trained to reference the diet order sheet for residents' diets. -He was responsible for training the staff in the kitchen. -The MA and kitchen staff should have known Resident #4's meat was supposed to be chopped. -The MA was responsible for monitoring the resident's diets in the dining room and made sure each resident received the correct diet. <p>Interview with the RCC on 03/09/20 at 4:33pm revealed:</p> <ul style="list-style-type: none"> -She was responsible for updating diet orders on the facility diet list in the kitchen and a copy was also provided to the MA's and stored in a notebook on the medication cart. -The MA's were responsible for monitoring the meal services and making sure the residents received the correct diet ordered by the physician. -The cook was responsible for informing the PCA's and CNA's which resident the plate she handed them would go to. -She did not know why Resident #4 did not receive chopped meat on his lunch meal tray on 03/09/20. <p>Interview with the Administrator on 03/09/20 at 4:40pm revealed:</p> <ul style="list-style-type: none"> -The Executive Director was responsible for training all kitchen staff. -The RCC updated all diet orders on the list in the kitchen and in a notebook stored on the 	{D 310}		

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{D 310}	Continued From page 10 medication cart for the MA's. -The cook prepared the meal trays for each resident, hand it to the PCA, and would tell the PCA "this is for resident so-in-so". -The PCA would then deliver the plate to the resident the cook reported it went to. -She did not know why Resident #4's pork was not chopped; "It should have been". -She expected staff to follow the policies and procedures for serving the correct therapeutic diet to the resident the diet was ordered.	{D 310}		