

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/10/2018
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HOPE MILLS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 5713 NEWTON STREET 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) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

W 459	<p>DIETETIC SERVICES CFR(s): 483.480</p> <p>The facility must ensure that specific dietetic services requirements are met.</p> <p>This CONDITION is not met as evidenced by: The facility failed to: ensure each client received their modified and specially-prescribed diets (W460).</p> <p>The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated Dietetic Services.</p>	W 459		
W 460	<p>FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure 1 of 4 audit clients (#2) received his modified and specially-prescribed diet as indicated. The findings are:</p> <p>Client #2's appropriate food consistency was not followed at 3 of 3 meals.</p> <p>During lunch observations at the day program on 10/9/18 at 11:29am, client #2 consumed food which was moist, thick and lumpy with visible chunks of food throughout. The client also drank a Boost supplement and Kool-aid.</p>	W 460	<p>DHSR - Mental Health</p> <p>OCT 26 2018</p> <p>Lic. & Cert. Section</p>	<p>11/19/18</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Samantha Sul* TITLE: Administrator (X6) DATE: 10/22/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/10/2018
NAME OF PROVIDER OR SUPPLIER HOPE MILLS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5713 NEWTON STREET 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) COMPLETION DATE
W 460	<p>Continued From page 1</p> <p>During observations in the home on 10/9/18 at 6:02pm, Staff A used a blender to grind up turkey burgers and green beans. The staff added an undetermined amount of water to the burgers. Once completed, the turkey burgers were moist and chunky and resembled a ground consistency. Immediate interview with Staff A revealed the meat was of a pureed consistency.</p> <p>Additional observations of the dinner meal on 10/9/18 at 6:40pm, client #2 was assisted to serve himself the moist, ground turkey meat, mashed potatoes and pureed green beans. As client #2 consumed the food items, he coughed sporadically and was prompted to take a drink.</p> <p>During breakfast observations in the home on 10/10/18 at 7:50am, client #2 was assisted to serve himself moist, finely ground pancakes and moist, thick scrambled eggs. Throughout the meal, the client consistently coughed and was told to "Cover your mouth" by a staff seated next to him. After consuming a serving of the pancakes and eggs, client #2 was offered a second serving of the same food items.</p> <p>Immediate interview with Staff B who had prepared the breakfast meal revealed client #2 consumes a pureed diet which means his food should be ground up in the blender and water, broth or milk would be added to it. When asked what the food would look like after blending, the staff retrieved a jar of baby food from the cabinet and indicated client #2's food should resemble "baby food".</p> <p>After being questioned by the surveyor, Staff B immediately retrieved client #2's plate of food just as he had finished serving himself his second</p>	W 460		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/10/2018
NAME OF PROVIDER OR SUPPLIER HOPE MILLS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5713 NEWTON STREET 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) COMPLETION DATE	
W 460	<p>Continued From page 2</p> <p>serving of finely ground pancakes and eggs. The staff returned the food items to the blender, added an undetermined amount of water, ground them up very briefly and placed the food back on client #2's plate. This time the pancakes and eggs were loose with excess liquid noted on the bottom of the plate. Client #2 consumed this second serving of food with consistent coughing noted.</p> <p>Additional interview with Staff B on 10/10/18 revealed they had worked at the facility for 6 years and had been trained on preparing food consistencies upon hire. During the interview, the staff referred to the home's menu book and papers posted on the inside of the kitchen cabinet which identified each client's diet and instructions for preparing all food consistencies including pureed.</p> <p>Interview on 10/10/18 with Staff C who was seated directly across from client #2 during a portion of the breakfast meal revealed the client's food consistency was incorrect and it should have been blended to "look like baby food".</p> <p>Review on 10/10/18 of each client's diet posted on the door on the inside of the kitchen cabinet revealed client #2 consumes a pureed diet. Additional review of information regarding preparation of food consistencies (posted in the same area) indicated specific instructions for preparing pureed foods such as various meats, grains, cooked vegetables canned fruit and mixed dishes/casseroles. The instructions also identified the specific amount of processing time and liquid needed for each food type.</p> <p>Review on 10/10/18 of client #2's Individual</p>	W 460			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2018
FORM APPROVED
OMB NO. 0938-0391

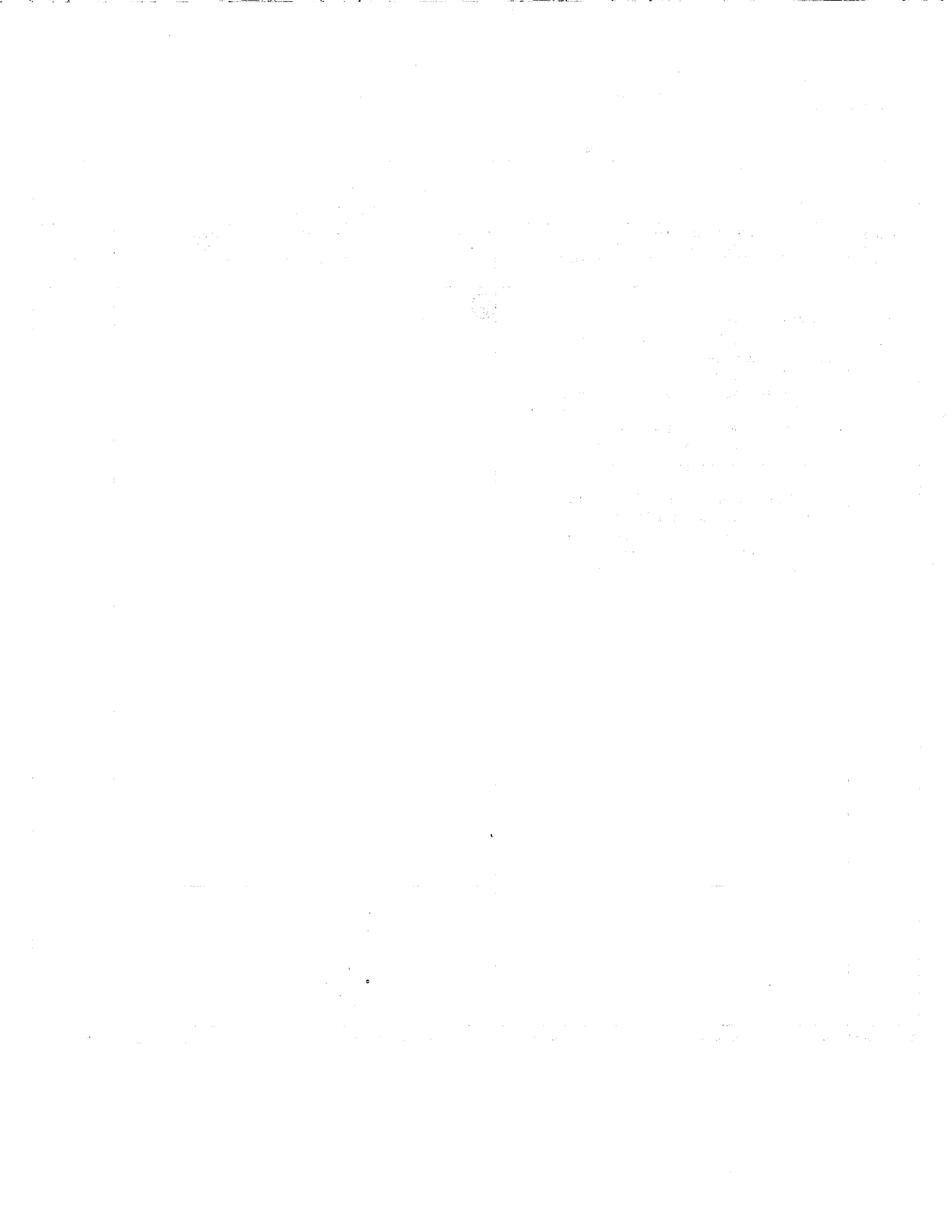
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/10/2018
NAME OF PROVIDER OR SUPPLIER HOPE MILLS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 5713 NEWTON STREET 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) COMPLETION DATE
W 460	<p>Continued From page 3</p> <p>Program Plan (IPP) dated 10/3/18 and current physician's orders revealed client #2 is on a pureed diet. Additional review of the client's meal guidelines (OSG10) dated 10/28/16 noted, "To promote safe oral intake, the following guidelines must be implemented at mealtimes...2) Present appropriate food consistency..." Further review of the record revealed a Health Service Goal (HSG #4) to monitor for choking and/or aspiration. The service goal noted staff should look for difficulty swallowing, coughing while eating and not wanting to eat at meals. Further review of the record indicated client #2 was assessed for his risk for choking on 4/1/18 with interventions to continue under his "choking guidelines" outlined in HSG #4.</p> <p>Further review of client #2's record revealed the client had not had any choking incidents, aspiration or difficulties during eating over the past year.</p> <p>Interview on 10/10/18 with the Home Supervisor confirmed client #2 should consume a pureed food consistency and his food should resemble "baby food or pudding" and not a finely ground texture. Additional interview indicated staff are trained upon hire to prepare each client's food consistency and training is also done throughout the year.</p> <p>Interview on 10/10/18 with the management staff confirmed client #2 consumes a pureed diet; however, he could not be sure of how long the client had been on this consistency but confirmed it had been well over a year and a half based on past physician's orders. Further interview noted the client was most likely provided the pureed consistency due to identified problems with eating</p>	W 460		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/10/2018
NAME OF PROVIDER OR SUPPLIER HOPE MILLS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5713 NEWTON STREET 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) COMPLETION DATE	
W 460	Continued From page 4 a regular food consistency at some point in the past. He stated clients on altered diets are assessed for choking risks each year as a precaution and client #2 was last assessed in April 2018 with interventions under his choking guidelines to continue. Additional interview indicated client #2 has not had any problems with aspiration and/or choking in the past year. Further interview on 10/10/18 with the Facility Administrator confirmed client #2 should be served a pureed diet and staff should be aware of each client's specialized diet and be able to demonstrate how to prepare it. The Administrator acknowledged more staff training needs to be done.	W 460			

11/19/18



W460 The Facility will ensure that all clients receive a nourishing well-balanced diet including modified and specially- prescribed diet.

The Facility Dietician will provide re-inservice training on dietary guidelines for Client #2 and all other Client's diets.

The Dietician will provide training on preparing and providing modified and specially-prescribed diets to Direct Support Staff, RN, QP, Habilitation Specialist, Home Manager, Behavior Specialist, Safety Coordinator, Administrator and LPN.

The Facility will provide increased monitoring at all meals over the next ten days (10/11/2018-10/25/2018). The Qualified Professional, Habilitation Specialist, LPN, and Home Manager will complete meal assessments at each meal.

The Qualified Professional, Habilitation Specialist, Behavior Specialist, Home Managers, and Nursing will increase meal assessments to 4 times a month for 3 consecutive months.

A handwritten signature in cursive script, appearing to read "Diana Lee/AP".

Completion Date: 11/19/18

DHSR - Mental Health

OCT 26 2018

Lic. & Cert. Section

