STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G019	A. BUILDING _____ B. WING _____	04/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIGAN STREET HOME	1006 MICHIGAN STREET KANNAPOLIS, NC 28081

(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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 3 audit clients (#4) had the right to have an informed consent obtained from both his legal guardians. The finding is: Client #4's BSP informed consent was not jointly signed by his co-guardians. Review on 4/3/18 of client #4's guardianship papers revealed he has co-guardians. Review on 4/3/18 of client #4's BSP informed consent was not signed by both of his guardians. During an interview on 4/3/18, the qualified intellectual disabilities professional (QIDP) was not aware only one of client #4's guardians had signed his BSP informed consent.	W 125		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G019	A. BUILDING _____ B. WING _____	04/03/2018

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W 249	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 3 audit clients (#4) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of adaptive equipment use. The finding is: Client #4's adaptive curved built-up spoon was not used as indicated. During meal observations in the home through out the survey on 4/2-3/18, client #4 was fed by staff using a small maroon spoon. Review on 4/3/18 of client #4's IPP dated 5/12/17 revealed, "[Client #4] has difficulty maintaining a grasp on utensils but does use a built-up curved spoon with his right hand." Additional review revealed an occupational therapy evaluation dated 12/6/17, with a recommendation for client #4 to use a curved built-up spoon. Interview on 4/3/18 with the QIDP revealed client #4 should use a curved built up spoon hand over hand assist for 3-5 first sccop with all his meals.	W 249		