STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G086	A. BUILDING _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAL-WAN HEIGHTS GROUP HOME	748 SHARON DR. STATESVILLE, NC 28677

(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 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure medication to assist in the control of inappropriate behaviors was used only as an integral part of the person centered plan (PCP) for 1 of 3 sampled clients (#2). The finding is: Observation conducted in the group home on 4/4/18 at 8:55 AM revealed staff assisted client #2 to ambulate to the facility vehicle for departure to the day program. Client #2 was observed to cry and vocalize loudly, followed by vomiting on the sidewalk of the home. Staff were then observed to assist client #2 to return to the home and change her clothing, then return to the van. Client #2 was further observed to continue to cry and vocalize loudly as she was loading onto the van, then vomit again after being seated on the van. Interview with staff in the group home at that time revealed client #2 gags and vomits frequently, approximately 2 to 3 times a week when she is crying and loudly vocalizing, often related to getting on the van or during other transitions in the home and/or at the day program. Review of the record for client #2, conducted on 4/4/18 revealed a PCP dated 11/9/17 which	W 312		

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

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W 312	Continued From page 1 contained a behavior support plan (BSP) dated 2/27/17. Further review of the 2/27/17 BSP for client #2 revealed target behaviors were documented to include emotional and physical reactivity defined as sudden and stiff arm and leg movements, non-cooperation, inappropriate vocalizations and tantrum behavior. Continued review of the record for client #2 revealed documentation stating client #2 was seen in Psychiatric Clinic on 10/17/17 related to anxiety with gagging and vomiting resulting in a recommendation to start Lexapro. On-going review of the record for client #2 revealed mini-team meeting minutes dated 3/7/18 documenting client #2 was seen at psychiatric clinic with Klonopin 0.25 mg. in the AM ordered relative to anxiety, especially with transitions. Interview with the nurse, conducted on 4/4/18 at 12:30 PM, verified client #2 had a history of intermittent gagging and vomiting, which had been addressed by the medical team and determined to be caused by anxiety, especially during transitions. Interview conducted on 4/4/18 at 12:45 PM with the qualified intellectual disabilities professional (QIDP) and the behavior analyst verified anxiety was not documented as a target behavior in the current BSP for client #2. These interviews further verified the use of Klonopin for anxiety was not included in the current PCP or BSP, nor was any tracking of client #2's frequent gagging and vomiting as a result of anxiety.	W 312		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing	W 331		

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W 331	Continued From page 2	W 331		

services in accordance with their needs.

This STANDARD is not met as evidenced by:
Based on record review and interview, nursing services failed to assure services were provided in accordance with client needs relative to dental care for 2 of 3 sampled clients (#4 and #5). The findings are:

A. Nursing services failed to conduct a follow-up to address a dental recommendation for a tooth extraction for client #5 as recommended by the dentist.

Review of records for client #5, conducted on 4/4/18, revealed a dental consultation report dated 8/23/17. Further review of the 8/23/17 dental report revealed the need for an extraction of tooth #32 due to decay. Continued review of the record for client #5 revealed no documentation of the extraction. Interview with the nurse, conducted on 4/4/18, revealed the recommended extraction had not been completed due to a delay in getting guardian consent. Further interview with the facility nurse verified the need for follow-up with the guardian and the dental provider to address the recommendation as 7 months delay in addressing the recommendation was to long.

B. Nursing services failed to ensure dental services were provided for client #4 in a timely manner.

Review of records for client #4, conducted on 4/4/18, revealed no documentation of dental services. Interview with the nurse, conducted on 4/4/18, revealed client #4's last appointment for

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W 331	Continued From page 3 dental services might have been in 12/2016 although no documentation was available. Continued interview with the nurse revealed she did not know why client #4 had not received dental services and it was likely related to guardian consent issues. The nurse further verified follow-up with the guardian should have occurred to address dental care for the client and client #4 would be scheduled for a dental exam during the next internal dental clinic on 4/27/18.	W 331		
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observations and interview, staff failed to provide appropriate dining utensils to 1 of 3 sampled clients (#4) and 2 non-sampled clients (#1 and #6) to enable them to eat at their developmental level. The finding is: Observations in the home on 4/3/18 and 4/4/18 during the evening and breakfast meals revealed the place settings for clients #1, #4 and #6 to consist of only a regular spoon. Further observations of the dinner meal on 4/3/18 revealed the meal included fish, green beans and oven browned potatoes. Client #4 was observed to eat a pureed diet consistency. Client #1 was observed to eat a chopped diet with mechanical meats and client #6 was observed to eat a regular dime sized diet consistency. Continued observations revealed clients #1, #4 and #6 to eat	W 488		

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their meal with a regular spoon. At no time did staff offer additional utensils to advance the clients' dining skills. Observation of the breakfast meal on 4/4/18 revealed the meal included scrambled eggs, grits and muffins. All clients were noted to eat the same diet consistency as observed with the evening meal on 4/3/18. Observation of the morning meal revealed clients #1, #4 and #6 to be provided and utilize only a regular spoon with their place setting.

Review of record on 4/4/18 for client #4 revealed a person centered plan (PCP) dated 11/7/17. Review of the PCP revealed a nutritional evaluation recommending a pureed diet with seconds as tolerated. Further review of the nutritional evaluation revealed client #4 to utilize adaptive equipment at meal times to include a small teaspoon. Review of records for client #1 on 4/4/18 revealed a nutritional evaluation dated 3/28/18 recommending a chopped diet with mechanical meats with seconds of fruits and vegetables only. Further review of client #1's record revealed an adaptive behavior inventory (ABI) assessment updated 5/8/17 identifying client #1 to have total independence with eating with a spoon and fork with minimum spillage. Review of records for client #6 on 4/4/18 revealed a nutritional evaluation dated 11/9/17 recommending a regular dime sized diet with no noted adaptive equipment. Further review of client #6's record revealed an ABI assessment dated 12/5/17 identifying client #6 to have partial independence with eating with a spoon and fork with minimum spillage.

Interview with the facility qualified intellectual disabilities professional (QIDP) and habilitation

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W 488	Continued From page 5 specialist revealed client #4 should have been provided a small teaspoon at meal times as ordered in the client's current nutritional assessment. Additional interview revealed client's #1 and #6 should have been provided a fork with their place settings at all meals.	W 488		