		D HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE SURVEY COMPLETED	
		34G081	B. WING			04/	11/2018
NAME OF PROVIDER OR SUPPLIER FANJOY HOME #2				4	TREET ADDRESS, CITY, STATE, ZIP CODE 50 TWIN OAKS ROAD STATESVILLE, NC 28625		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 104) nust exercise general policy, g direction over the facility.	w	104			
	Based on observatio governing body and r exercise general polic direction over the faci damage to the facility	-					
	Observations conducted of the group home van on 4/11/18 at 8:55 AM revealed damage to the interior ceiling of the van evidenced by the lining hanging down towards the rear of the van with a large hole in the lining above the seat of client #4. Further observation of the damage revealed the presence of the metal top of the van through the interior lining hole. Continued observation of the interior of the facility van revealed 3 of 5 ceiling vents to be missing with holes in the lining where the vents were not present.						
	was a result of behav Further interview with interior had been dam unknown how long. I home qualified intelle (QIDP) revealed she the interior of the grou interview with the QIE currently no current w	he ceiling interior of the van ioral issues of client #4. staff revealed the van haged for a while and it was interview with the group ctual disabilities professional was aware of the damage to up home van. Further					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

TITLE

(X6) DATE

PRINTED: 04/18/2018

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			· ,	CONSTRUCTION	· · /	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING		FLEIEU		
		34G081	B. WING		04	/11/2018	
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
FANJOY I	HOME #2		-	0 TWIN OAKS ROAD ATESVILLE, NC 28625			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 104	Continued From page 1 documentation was unavailable related to the length of time the van had been in the current state of disrepair. The QIDP further indicated maintenance staff was aware of the van's condition although the QIDP was unaware of when or if repairs were scheduled. Therefore, the management failed to assure damage to the group home van was reported, tracked and repaired in a timely manner as indicated by observation and interviews. PROGRAM IMPLEMENTATION		W 104 W 249				
	each client must rece treatment program co interventions and ser and frequency to sup	lisciplinary team has individual program plan, eive a continuous active					
	Based on record rev interview, the team fa support plan (BSP) w	not met as evidenced by: iew, observation and staff ailed to assure the behavior vas implemented as sampled clients (#4). The					
	4/10-11/18 survey re- one to one staff mem engage in self injurio primarily hitting or att lightly or moderately	proup home throughout the vealed client #4 to have a ber and to intermittently us behavior, which was empting to hit his head hard, with a closed fist. The bers were observed to					

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If continuation sheet Page 2 of 8

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/18/2018 / APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT A. BUILDII			(X3) DATE SURVEY COMPLETED		
		34G081	B. WING _				04/ [.]	11/2018
NAME OF PF	ROVIDER OR SUPPLIER		·	ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
FANJOY H	IOME #2				50 TWIN OAKS ROAD TATESVILLE, NC 28625			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
W 249	a protective helmet for Review of the record of revealed a person cer 9/12/17 which include The BSP objective stat tolerate his daily routi rates of target behavior episodes bi-weekly for periods by 9/1/18. Cor revealed client #4 to h member during wakin behavior (SIB), aggre Further review revealed injurious behavior (hit closed fist, biting hand destruction, aggressid disrupted sleep. Con and BSP revealed clien multiple medications for Abilify, Tegretol, Inder Review of the BSP int prompting the client to blocking, toys/reinforce helmet. Documentati indicated that "all epis should be documente sheets and that the bor psychologist would m behavior plan at least review of the BSP did was defined. Review of the Behavior on 4/11/18 for the per	he client during these was observed to be wearing or most of the survey. for client #4 on 4/11/18 intered plan (PCP) dated ed a BSP dated 9/15/17. ated the client's ability to ne will improve so that his ors reduce to 5 or less or 12 consecutive review ontinued review of the BSP have a one to one staff og hours due to self-injurious ission and an unsteady gait. ed target behaviors of self iting forehead or chin with a ds, head banging), property on, non-cooperation and tinued review of the PCP ent #4 to be prescribed for behaviors which included ral and Prozac. terventions for SIB included o put his hands down, cers, and a protective on instructions for staff sodes" of disruptive behavior ed on behavior intervention ehavior analyst (BA) or ionitor the progress of the it bi-weekly. Continued I not reveal how "episodes"	W	249				
		lates for which episodes of						

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If continuation sheet Page 3 of 8

		MEDICAID SERVICES				O. 0938-039	
IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		34G081	B. WING		04	4/11/2018	
NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
FANJOY H	IOME #2			50 TWIN OAKS ROAD STATESVILLE, NC 28625			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
W 249	Continued From page 3 SIB were documented. Review of the documentation for these episodes indicated the SIB occurred throughout the day or several hours throughout a shift, except for one entry which indicated a behavior lasted 5 minutes. Review of the "graphic progress notes" for the period of 10/1/17 through 3/31/18 revealed the following: 10/1/17 - 10/31/17, 0 TB; 11/1/17 - 11/15/17, 0 TB; 11/16 - 11/30/17, 5 TB; 12/1/17 - 12/15/17, 7 TB; 12/6/17 - 12/31/17, 0 TB; 11/1/18 - 1/15/18, 0 TB; 1/16/18 - 1/31/18, 12 TB; 2/1/18 - 2/15/18, 0 TB; 2/16/18 - 2/28/18, 0 TB; 3/1/18 - 3/15/18, 0 TB; 3/16/18 - 3/31/18, 0 TB. Review of the accident/incident reports on 4/10/18 for client #4 for the period of 10/1/17 through 4/10/18 revealed a total of 35 days for which a report was completed. All 7 months reviewed had at least one incident/accident report completed related to client #4's SIB. SIB included the client hitting or attempting to hit himself and banging his head on walls or objects. The majority of the accident/incident reports indicated the client engaged in SIB multiple times, on and off throughout a day or shift.		W 249				
	interpretation of an "e BSP was for each tim SIB, but indicated the figure out how to doc most staff were comp report for each day of SIB and not always c sheet. The BA indica	on 4/11/18 revealed her episode" as stated in the ne client #4 engaged in a team had struggled to ument the episodes and that oleting an accident/incident r shift the client engaged in ompleting a behavior data ted that one TB was being havior data sheet entry for					

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		O. 0938-039	
and plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CON	1PLETED		
		34G081	B. WING		04/11/2018		
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
FANJOY I	HOME #2			50 TWIN OAKS ROAD STATESVILLE, NC 28625			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 249 W 252	client engaged in SIB indicated on the beha with the BA and the q disabilities profession confirmed staff were in data sheets as presci confirmed that becau the BSP objective wa accurately and therefi implemented as presci PROGRAM DOCUMI CFR(s): 483.440(e)(1 Data relative to accorr specified in client indi	during the time period avior data sheet. Interview qualified intellectual al (QIDP) on 4/11/18 not completing the behavior ribed in the BSP and se of this, the progress for s not being measured ore the BSP was not being cribed. ENTATION) mplishment of the criteria	W 249 W 252				
	Based on record revi interview, the team fa to the behavior suppo prescribed for 1 of 3 s finding is: Observations in the g	not met as evidenced by: iew, observation and staff iiled to ensure data relative ort plan (BSP) was taken as sampled clients (#4). The rroup home throughout the					
	one to one staff mem engage in self injuriou primarily hitting or atte lightly or moderately I one to one staff mem prompt and redirect th	vealed client #4 to have a ber and to intermittently us behavior, which was empting to hit his head hard, with a closed fist. The bers were observed to he client during these was observed to be wearing or most of the survey.					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 34G081 B. WING 04/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 450 TWIN OAKS ROAD FANJOY HOME #2 STATESVILLE, NC 28625 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 252 Continued From page 5 W 252 Review of the record for client #4 on 4/11/18 revealed a person centered plan (PCP) dated 9/12/17 which included a BSP dated 9/15/17. The BSP objective stated the client's ability to tolerate his daily routine will improve so that his rates of target behaviors reduce to 5 or less episodes bi-weekly for 12 consecutive review periods by 9/1/18. Continued review of the BSP revealed client #4 to have a one to one staff member during waking hours due to self-injurious behavior (SIB), aggression and an unsteady gait. Further review revealed target behaviors of self injurious behavior (hitting forehead or chin with a closed fist, biting hands, head banging), property destruction, aggression, non-cooperation and disrupted sleep. Continued review of the PCP and BSP revealed client #4 to be prescribed multiple medications for behaviors which included Abilify, Tegretol, Inderal and Prozac. Review of the BSP interventions for SIB included prompting the client to put his hands down. blocking, toys/reinforcers, and a protective helmet. Documentation instructions for staff indicated that "all episodes" of disruptive behavior should be documented on behavior intervention sheets and that the behavior analyst (BA) or psychologist would monitor the progress of the behavior plan at least bi-weekly. Continued review of the BSP did not reveal how "episodes" was defined. Review of the Behavior Data/Intervention Sheets on 4/11/18 for the period of 10/1/17 through 4/10/18 revealed 14 dates for which episodes of SIB were documented. Review of the documentation for these episodes indicated the SIB occurred throughout the day or several hours throughout a shift, except for one entry which

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G081 B. WING 04/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 450 TWIN OAKS ROAD **FANJOY HOME #2** STATESVILLE, NC 28625 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 252 Continued From page 6 W 252 indicated a behavior lasted 5 minutes. Review of the "graphic progress notes" for the period of 10/1/17 through 3/31/18 revealed the following: 10/1/17 - 10/15/17, 13 target behaviors (TB); 10/16/17 - 10/31/17, 0 TB; 11/1/17 - 11/15/17, 0 TB: 11/16 - 11/30/17. 5 TB: 12/1/17 - 12/15/17. 7 TB; 12/6/17 - 12/31/17, 0 TB; 1/1/18 - 1/15/18, 0 TB; 1/16/18 - 1/31/18, 12 TB; 2/1/18 - 2/15/18, 0 TB; 2/16/18 - 2/28/18, 0 TB; 3/1/18 - 3/15/18, 0 TB; 3/16/18 - 3/31/18, 0 TB. Review of the accident/incident reports on 4/10/18 for client #4 for the period of 10/1/18 through 4/10/18 revealed a total of 35 days for which a report was completed. All 7 months reviewed had at least one incident/accident report completed related to client #4's SIB. SIB included the client hitting or attempting to hit himself and banging his head on walls or objects. The majority of the accident incident reports indicated the client engaged in SIB multiple times, on and off throughout a day or shift. Interview with the BA on 4/11/18 revealed her interpretation of an "episode" as stated in the BSP was for each time client #4 engaged in a SIB, but indicated the team had struggled to figure out how to document the episodes and that most staff were completing an accident/incident report for each day or shift the client engaged in SIB and not always completing a behavior data sheet. The BA indicated that one TB was being recorded for each behavior data sheet entry for the purpose of demonstrating client progress, regardless of how many times or how long the client engaged in SIB during the time period indicated on the behavior data sheet. Interview with the gualified intellectual disabilities professional (QIDP) and the BA on 4/11/18,

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM): 04/18/2018 / APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	
		34G081	B. WING		04/	11/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FANJOY H	IOME #2			450 TWIN OAKS ROAD STATESVILLE, NC 28625		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 252	1.0	not completing the behavior	W 252			

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