STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G306	A. BUILDING _____ B. WING _____	04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYDNOR STREET GROUP HOME	134 SYDNOR STREET MOUNT AIRY, NC 27030

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to assure privacy was maintained for 1 non-sampled client (#2). The finding is: Observations in the group home on 4/16/18 at 4:40 PM revealed a staff member assisting client #2 with entering the bathroom for a bath or shower. Continued observations at 5:05 PM revealed a second staff member to enter the bathroom while the client and first staff member were still in the bathroom to assist or check on the client. The second staff member was then observed to exit the bathroom by opening the door wide. Client #2 was observed sitting on the toilet at that time with no clothing or covering. Interview with the qualified intellectual disabilities professional on 4/17/18 at 10:15 AM confirmed that all staff should observe the privacy of clients during the care of personal needs and confirmed staff should have been more discreet when opening the door or should have covered client #2's body before exiting the bathroom.	W 130		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through	W 153		

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

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W 153	Continued From page 1 established procedures. This STANDARD is not met as evidenced by: Based on facility documents and staff interview, the facility failed to ensure an allegation of abuse was immediately reported to the administrator and to other officials in accordance with State law for 1 of 1 investigation reviewed. The finding is: Review of the facility abuse/neglect investigations on 4/16/18 revealed an investigation for an incident which occurred on 1/28/18. Continued review of the investigation documents revealed they included only an Incident Response Improvement System (IRIS) report with a submission date of 4/9/18, and written statements from the three staff working at the time of the incident, all completed on 1/29/18. Review of the 4/9/18 IRIS revealed facility administrative staff became aware of the allegation of abuse on 1/29/18. The allegation description indicated that on 1/28/18 at approximately 10:30 PM, client #3 was agitated and a staff member pushed the client toward the client's bedroom by bumping against the client with his chest and pulling the client's wrists. The staff member was described as shouting at the client and mocking the client. Continued review of the IRIS documentation revealed the alleged staff member was terminated on 1/29/18. Further review of the IRIS documentation revealed the facility qualified intellectual disabilities professional (QIDP) who was employed at the time and who started the investigation, failed to notify the Health Care Personnel Registry (HCPR) within 24 hours and failed to complete an IRIS report. The IRIS report was completed and	W 153		

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W 153	Continued From page 2 the HCPR was notified when the current QIDP became aware these requirements had not been completed. Interview with the current QIDP on 4/17/18 at 10:15 AM revealed she was not sure when administrative staff was notified of the incident/allegation but confirmed the investigation was started the next day on 1/29/18. The QIDP confirmed an IRIS report and HCPR notification were not completed until 4/9/18. The QIDP confirmed the alleged staff member did not work again after 1/28/18, and confirmed the facility did not have evidence the two staff members who were also working at the time of the incident, had been re-trained regarding immediately reporting allegations of abuse/neglect to facility administration.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to assure an allegation of abuse was thoroughly investigated for 1 of 1 investigation reviewed. The finding is: Review of the facility abuse/neglect investigations on 4/16/18 revealed an investigation for an incident which occurred on 1/28/18. Continued review of the investigation documents revealed they included only an Incident Response Improvement System (IRIS) report with a completion date of 4/9/18, and written statements	W 154		

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W 154	Continued From page 3 from the three staff working at the time of the incident, all completed on 1/29/18. Review of the 4/9/18 IRIS revealed facility administrative staff became aware of the allegation of abuse on 1/29/18. The allegation description indicated that on 1/28/18 at approximately 10:30 PM, client #3 was agitated and a staff member pushed the client toward the client's bedroom by bumping against the client with his chest and pulling the client's wrists. The staff member was described as shouting at the client and mocking the client. Continued review of the IRIS documentation revealed the alleged staff member was terminated on 1/29/18. Interview with the qualified intellectual disabilities professional (QIDP) on 4/17/18 at 10:15 AM confirmed the investigation was started on 1/29/18. The QIDP confirmed the alleged staff member did not work again after 1/28/18, and confirmed the facility did not have evidence the two staff members who were also working at the time of the incident, had been re-trained regarding immediately reporting allegations of abuse/neglect to facility administration. Continue interview confirmed the investigation failed to include a summary of the conclusions of the investigation and failed to include any recommendations for training and/or corrective actions for staff beyond the termination of the employee.	W 154		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively,	W 189		

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W 189	Continued From page 4	W 189		

efficiently, and competently.

This STANDARD is not met as evidenced by:
Based on observations an interview, the facility failed to assure each employee was trained to to protect the safety and privacy of 1 sampled client (#1) and 1 non-sampled client (#4) residing in the home. The findings are:

A. Observations conducted in the home on 4/17/18 at 7:30 AM revealed client #4 was being assisted by staff to prepare the breakfast meal. Continued observations revealed client #4 was cooking french toast and sausages on an electric grill. Staff was observed to remind client #4 at frequent intervals to be careful not to burn himself. Further observations revealed the staff assisting client #4 was summoned by another staff to come into the living room of the home to assist with another client. Client #4 was left alone in the kitchen, standing in close proximity to a pot of water heating on the stove as well as the food cooking on the electric griddle. Staff returned to the kitchen after approximately 1 minute and resumed assisting client #4 with meal preparation.

Interview with the consulting qualified intellectual disabilities professional, conducted on 4/17/18 at 10:15 AM revealed staff were expected to remain with clients at all times when food is cooking and/or hot surfaces are within reach of clients.

B. Observations in the group home on 4/17/18 at 6:48 AM and at 6:53 AM revealed a staff member entering client #1's private room without knocking while the client was in the room. Interview with the qualified intellectual disabilities professional

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W 189	Continued From page 5 on 4/17/18 at 10:15 AM confirmed that all staff members should observe and respect client rights to privacy by knocking before entering client bedrooms.	W 189		
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. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure a communication objective was implemented as prescribed in the Plan of Care (POC) for 1 of 3 sampled clients (#3). The finding is: Observations conducted throughout the recertification survey on 4/16/18 and 4/17/18 revealed client #3 did not communicate verbally. Staff was observed to verbally prompt client #3 to choose and engage in leisure activities, wash his hands, eat meals, take medications and load onto the facility van to travel to the day program among other activities. Staff was not observed to utilize manual signs or a picture schedule to communicate with client #3 during survey observations conducted on 4/16/18 and 4/17/18. Review of the record for client #3, conducted on	W 249		

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W 249	Continued From page 6 4/17/18, revealed a POC dated 9/29/17 which included a communication evaluation dated 2/23/18. Continued review of the Communication Evaluation for client #3 revealed staff should use gestures and manual signs when communicating with client #3 as well as a picture schedule in order for client #3 to know what is expected of him throughout the day and be an active participant in knowing completed activities. On-going review of the 9/29/17 POC revealed a communication objective implemented on 9/1/17 stating client #3 would utilize a picture schedule with 80% accuracy for three consecutive months. Interview with the consulting qualified intellectual disabilities professional, conducted on 4/17/18, verified staff should be utilizing a picture schedule as well as gestures and manual signs to communicate with client #3 throughout daily activities as prescribed in his 9/29/17 POC.	W 249		
W 287	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure techniques to manage inappropriate behaviors were not used for the convenience of staff for 1 of 3 sampled clients (#5). The finding is: Observations in the group home on 4/17/18 at 9:12 AM revealed client #5 leaving the bathroom	W 287		

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W 287	Continued From page 7 after brushing her teeth. The client was observed to walk toward a staff member who was in the kitchen area to hand the staff member the toothpaste and toothbrush. The staff member was then observed to open a closet door located next to the kitchen and place the items in the closet. The staff member was then observed locking the closet door. Interview with a direct care staff member at 9:20 AM revealed the toothpaste and toothbrush are stored in a locked closet because the client will eat toothpaste if allowed the opportunity. Review of client #5's record on 4/17/18 revealed a plan of care (POC) dated 11/6/17. The POC contained "Toothpaste Guidelines" dated 3/15/16. The guidelines indicated that staff should monitor client #5 at least every 10 minutes while she is in her room due to a tendency to eat toothpaste. The guidelines did not contain any direction for staff to lock the client's toothpaste in a closet. Interview with with qualified intellectual disabilities professional on 4/17/18 at 10:15 AM confirmed client #5 has guidelines for monitoring the client while she is in her room to assure she is not eating toothpaste, and confirmed staff were locking the toothpaste in the closet as a convenience for staff.	W 287		