

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

PRINTED: 04/26/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2018
NAME OF PROVIDER OR SUPPLIER ASHLEY HEIGHTS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2990 RESERVATION ROAD ABERDEEN, NC 28315		
(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 189	<p>STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1)</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews and record/document review, the facility failed to ensure staff were sufficiently trained to perform their medication technician (MT) duties. The finding is:</p> <p>Proper medication administration procedures were not followed as indicated.</p> <p>During observations of medication administration in the home on 4/24/18 from approximately 8:24am - 8:35am, the MT dispensed medications for two clients. Before the clients consumed their pills, the MT signed their initials on the medication administration record (MAR). Additional observations revealed the staff wore gloves while dispensing medications and completing other tasks. The MT continued to wear the gloves while touching various items in the medication area including an ink pen, keys, various pill cards and the MAR.</p> <p>Immediate interview with the MT revealed they routinely sign the MAR before giving clients their medications. The staff stated, "That's the way I do it." Additional interview indicated they have been trained to wear gloves during medication administration. The staff acknowledged gloves can become contaminated once various items are touched.</p>	W 189			

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.

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W 189	Continued From page 1 Review on 4/24/18 of the facility's guidelines for Medication Administration for Non-Licensed Personnel (no date) revealed, "Never sign off on the MAR prior to giving a medication. Always sign after you observe the individual swallowing the medication." The guidelines encouraged handwashing while dispensing medications. Interview on 4/24/18 with the QIDP confirmed MTs should wait for clients to consume their medications before signing MAR. Additional interview indicated staff have not been trained to wear gloves throughout medication administration.	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 observations, record reviews and staff interviews, the facility failed to ensure a pattern of interactions supported the individual program plans (IPP) for 3 of 3 audit clients (#4, #5, #6), specific to diet consistency and medication administration. The findings are: 1. Client #5's diet consistency was not followed	W 249			

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W 249	<p>Continued From page 2 as written.</p> <p>During lunch observations at the day program on 4/23/18 at 12:45pm, client #5 was assisted to serve herself a ham and cheese sandwich, potato salad and tea to drink. The sandwich was a pureed consistency and the tea was a thin liquid.</p> <p>During dinner observations in the home on 4/23/18 at 5:45pm, client #5 was assisted to pour a cup of juice and milk. The client was assisted to add Thick-it powder to her milk while the juice remained a thin liquid. Client #5 consumed both drinks at the dinner meal.</p> <p>Staff interviews (2) on 4/23 - 4/24/18 revealed client #5 should have Thick-it added to all drinks and her food should be served at a mechanical soft chopped consistency.</p> <p>Review on 4/24/18 of client #5's mini-team meeting dated 2/1/18 indicated, "Aspiration noted with thin/nectar liquids and mixed consistency solids. Weak cough reflex... Diet recommendations: "Mechanical soft chopped honey thickened liquids."</p> <p>Interview on 4/24/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5's diet consistency should be mechanical soft chopped foods with honey thickened liquids.</p> <p>2. Client #4 was not prompted or encouraged to participate with the administration of her medications.</p> <p>During observations of medication administration in the home on 4/24/18 at 8:24am, staff completed all tasks including punching pills,</p>	W 249			

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W 249	<p>Continued From page 3</p> <p>pouring liquids and throwing away trash. During this time, client #4 entered the medication room, consumed her medications and left the area. The client was not prompted or encouraged to participate with the administration of her medications.</p> <p>Immediate interview with the medication technician (MT) revealed client #4 can participate with medication administration by assisting with punching her pills.</p> <p>Review on 4/24/18 of client #4's IPP dated 2/5/18 indicated, "[Client #4] actively participate in medication administration. Can follow directions." Additional review of the client's medication administration assessment dated 4/23/18 revealed she punches pills from the pill card with partial independence. The client's Adaptive Behavior Inventory (ABI) dated 2/5/18 noted the client can pour from a small pitcher and clear dirty dishes with partial assistance.</p> <p>Interview on 4/24/18 with the QIDP confirmed client #4 should have been prompted and assisted to actively participate with the administration of her medications as indicated.</p> <p>3. Client #6 was not prompted or encouraged to participate with the administration of her medications.</p> <p>During observations of medication administration in the home on 4/24/18 at 8:35am, staff completed all tasks including punching pills, pouring liquids and throwing away trash. During this time, client #6 entered the medication room, consumed his medications and left the area. The client was not prompted or encouraged to</p>	W 249			

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W 249	<p>Continued From page 4</p> <p>participate with administration of his medications.</p> <p>Immediate interview with the MT revealed client #6 can participate with medication administration by assisting with punching her pills.</p> <p>Review on 4/24/18 of client #6's IPP dated 4/9/18 revealed, "[Client #6] is able to come to med room when requested. He can punch out his meds with hand over hand assistance due to visual impairment." The plan also indicated he can pour his water and throw away trash.</p> <p>Interview on 4/24/18 with the QIDP confirmed client #6 should have been prompted and assisted to actively participate with the administration of his medications as indicated.</p>	W 249			