STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G227	A. BUILDING _____ B. WING _____	04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOWE DRIVE GROUP HOME	628 FLOWE DRIVE CHARLOTTE, NC 28213

(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 289	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: The team failed to ensure techniques to manage inappropriate behaviors were incorporated into the individual support plan (ISP) for 1 of 3 sampled clients (#5) as evidenced by record review and interviews. The findings are: A. Review of facility internal incident reports and investigations for the review year on 4/23/18 revealed an incident of physical aggression on 10/16/17 by client #5 towards staff. Review of the 10/16/17 incident revealed client #5 grabbed a staff by the hair, pulled the staff to the ground and kicked the staff repeatedly. Further review of incident reports for client #5 from the vocational program revealed on 1/8/18 the client was prompted to participate in a vocational activity and hit staff with her lunch bag and threw a trash can at staff. Additional review revealed on 2/26/18 client #5 hit another individual at the vocational program in the head with a chair. Review of client #5's record on 4/24/18 revealed an ISP dated 11/13/17. Further record review revealed a behavior support plan (BSP) dated 10/20/17. Review of the BSP revealed target behaviors of becoming agitated and/or displaying anxiety, leading up to verbal aggression such as	W 289		

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

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W 289	Continued From page 1	W 289		

abusive speech/swearing, clenching her fist and becoming non-compliant. Review of prevention procedures in the BSP revealed client #5 should receive descriptive social praise for cooperation and participation in any activity, provide one on one attention when possible and use preferred activities to reinforce less preferred activities. Review of client #5's psychotropic medications revealed the history of Seroquel, Nuedexta, Lorazepam, Trazedone, Tegretol, Zyprexa and Abilify to address behaviors.

Interview with the facility group home manger (HM) verified client #5 has been physically aggressive and is currently in individual therapy and has had medication changes to address behaviors. Further interview with the facility HM and facility qualified intellectual disabilities professional (QIDP) verified client #5's behavior plan should include physical aggression and should also include prevention strategies to address the identified target behavior.

B. Review of facility investigations for the review year on 4/23/18 revealed an investigation on 10/24/17 due to a verbal allegation of client #5 that staff had sprayed her in the face on 10/16/18. Further review of interviews during the investigation revealed client #5's guardian to report client #5 has a history of making up stories and exaggerating. Continued investigation review revealed the allegation to be unsubstantiated based upon staff and client interviews, nursing assessment of client #5 on the day of event with no skin or eye irritation and statement of the guardian indicating client #5's history of telling stories/exaggerations. Review of incident reports for client #5 at the vocational program revealed various dates the client stated "staff don't like me"

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W 289	Continued From page 2 and "staff don't like anybody here". Review of client #5's record on 4/24/18 revealed an ISP dated 11/13/17. Further record review revealed a BSP dated 10/20/17. Review of the BSP revealed target behaviors of becoming agitated and/or displaying anxiety, leading up to verbal aggression such as abusive speech/swearing, clenching her fist and becoming non-compliant. Review of prevention procedures of the BSP revealed client #5 should receive descriptive social praise for cooperation and participation in any activity, provide one on one attention when possible and use preferred activities to reinforce less preferred activities. Interview with the facility HM verified story telling/exaggerating is a behavior of client #5. Further interview with the facility HM and facility QIDP verified client #5's behavior plan should include telling stories/exaggerations as verified by the guardian to be a behavior history of client #5. Additional interview verified the BSP for client #5 should include prevention strategies to address the identified target behavior.	W 289		
W 356	COMPREHENSIVE DENTAL TREATMENT CFR(s): 483.460(g)(2) The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure comprehensive dental services	W 356		

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W 356	Continued From page 3 relative to restoration of teeth was provided in a timely manner for 1 of 3 sampled clients (#2). The finding is: Review of the record for client #2, conducted on 4/24/18, revealed a dental consultation dated 6/7/17 documenting client #2 would need to have a filling done. Continued review of the 6/7/17 dental consultation revealed documentation stating "she will need to be in a smaller wheelchair for this visit though. Her wheelchair will not fit through the door." Further review of the record for client #2 revealed a subsequent dental consultation dated 12/13/17 stating "she has one cavity noted last time that still needs to be done once she has her smaller chair." Interview conducted with the group home manager on 4/24/18 verified client #2 remained in need of the filling recommended by the dentist on 6/7/17 due to the lack of a smaller wheel chair that could be accommodated in the treatment area of the dental office. It should be noted that the facility is pursuing the provision of an electric wheelchair for client #2. Continued interview with the group home manager and the qualified intellectual disabilities professional revealed the facility could provide the loan of a smaller wheelchair that would allow client #2 access to the treatment area of her dental office. Therefore, the facility failed to provide client #2 with restorative treatment recommended by the dentist for a period of over 10 months.	W 356		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are	W 369		

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W 369	Continued From page 4 self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility's medication administration system failed to assure all medications were delivered without error for 1 of 3 clients observed during medication administration (#6). The finding is: Observations conducted in the group home on 4/24/18 at 6:30 AM revealed client #6 was seated at the dining table eating breakfast. Further observations at 6:50 AM revealed staff prompted client #6 to come into the medication administration area to take her morning medications. Client #6 then arrived in the medication area and was assisted to receive medications including Calcium-Magnesium liquid 10 ml.; Omeprazole 20 mg.; vitamin D-3 2000 units and Zyrtec 10 mg.. Review of the record for client #6, conducted on 4/24/18, revealed physician's orders dated 3/1/18 documenting client #6 was prescribed medications to be taken at 7:00 AM including: Calcium-Magnesium liquid-take 1 Tablespoonful (15 ml.) by mouth twice daily; Omeprazole 20 mg.-take one capsule by mouth every morning before a meal; vitamin D-3 200 units and Zyrtec 10 mg.. Interview conducted with the nurse on 4/24/18 revealed client #6 should have received Calcium-Magnesium liquid 15 ml. as ordered, rather than the 10 ml. which she received, and should have received Omeprazole 20 mg. before a meal as prescribed by the physician.	W 369		

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