PRINTED: 03/29/2018
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G243	A. BUILDING _____ B. WING _____	03/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTSIDE RESIDENTIAL	467 CREEK ROAD ORRUM, NC 28369

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E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop an emergency preparedness (EP) plan including and based upon a community and facility-based risk assessment, utilizing an all-hazards approach. The finding is: The facility did not have an emergency plan	E 006	E 006 – The facility will develop specific policies and procedures to address emergency preparedness specific to including aa facility and community-based risk assessment utilizing all hazards approach. 5-25-18 The team will complete a facility and community based risk assessment to update/revise the emergency preparedness plan to include information specific to the facilities level of risk such as in the case of flood, fire, tornadoes, hurricanes, winter storms and bio terrorism. The team will monitor monthly and make updates/revisions as needed. 5-25-18 DHSR - Mental Health APR 23 2018 Lic. & Cert. Section	

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

Chris Thornhill, ICF Division Director

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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E 006	Continued From page 1 based upon risk assessments. Review on 3/27/18 of the facility's current EP plan dated 2017 revealed the plan did not provide specific information in regards to a facility-based and community-based risk assessment using an all-hazards approach including flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing clients or other emergency types. Interview on 3/27/18 with the qualified intellectual disabilities professional (QIDP) revealed the management team continues to work on a risk assessment for their EP plan; however, it has not been completed as of the date of the survey.	E 006		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the individual program plan (IPP) for 2 of 4 audit clients (#2, #4) included opportunities for choice and self-management. The finding is: Clients (#2, #4) were not encouraged to express their own choice or manage their environment in the home. During morning observations in the home on 3/27/18 at 6:48am, client #2, client #4 and another client left their bedrooms and sat in the living room of the home. The clients watched television or spoke amongst themselves. At this	W 247	W247 – The facility will ensure that all IPP's will include opportunities for choice and self-management. QP will include information regarding choice and self-management in client's #2&#4 IPP. All responsible staff will be inserviced on revision. QP will monitor monthly.	5-25-18

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W 247	Continued From page 2 time, the two staff working in the home were in a back bathroom assisting another client or in a client's bedroom assisting him with the bedroom door opened. When one of the two staff realized the three clients were in the living room, the staff immediately prompted them to return to their bedrooms. The clients were told they needed to remain in their bedrooms until staff were finished getting up other clients. All three clients immediately returned to their bedrooms as instructed. Interview on 3/27/18 with the staff person involved revealed clients cannot be in the living room while staff are in the back getting up other clients. Additional interview indicated clients must "stay in their rooms" and "do activities" until staff "finish with everybody in the back." Review on 3/27/18 of client #2's and client #4's IPP dated 10/19/17 and 3/1/18, respectively, revealed no specific information regarding their choice making skills or how they are able to manage their own environment while in the home. Interview on 3/27/18 with the qualified intellectual disabilities professional (QIDP) revealed all clients in the home are allowed to choose where they want to be in their home and are not required to remain in their bedrooms per staff request. The QIDP acknowledged information regarding choice and self-management was not included in the client's (#2, #4) program plan.	W 247		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan,	W 249		

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W 249	Continued From page 3 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 review and interviews, the facility failed to ensure 1 of 4 audit clients (#5) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the area of meal preparation. The finding is: Client #5 was not prompted or encouraged to participate in meal preparation tasks to her maximum potential. During observations of breakfast preparation in the home on 3/27/18 from 7:05am - 7:27am and 7:48am - 7:55am, staff completed the majority of food preparation tasks without the assistance of client #5. For example, after prompting client #5 to the kitchen to assist with meal preparation, the staff completed tasks such as, making a pot of hot water using the coffee maker, filling pots (2) with water, adding eggs to a pot of water, adding oatmeal to a pot of water and stirring, adding seasoning to the oatmeal, pouring milk into a pitcher, operating oven dials, placing foil and bread on a pan, spreading margarine onto slices of bread, and using a food processor to grind up eggs and toast. During this time, client #5 stood next to the staff or was in the area. Client #5 was observed to make a pitcher of orange juice, stir	W 249	W249 – The facility will ensure a continuous active treatment plan consisting of needed interventions and services as identified in the IPP in the area of meal preparation for all individuals. Habilitation Specialist will inservice all responsible staff on client#5's strengths with meal preparation. Hab. Spec. and manager will monitor weekly and QP will monitor monthly.	5-25-18

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W 249	Continued From page 4 oatmeal briefly, operate the food processor once and periodically obtain necessary items per staff request. Staff interview on 3/27/18 revealed client #5 is a "good helper...anything I need, she gets". The staff indicated the client can make juice and stir food items. Review on 3/27/18 of client #5's IPP dated 1/9/18 revealed strengths to assist with meal preparation and making sandwiches as well as needs to prepare a small meal and to improve meal prep skills. Additional review of client #5's Adaptive Behavior Inventory (ABI) dated 3/1/18 indicated she can independently make desserts, prepare convenience foods, use kitchen equipment, identify fruits/vegetables, breads/cereals, meats, and dairy products. The ABI also noted the client requires partial assistance to bake basic foods, use spoons/cups, make salads and prepare breakfast meals. Further review of the IPP identified an objective to independently prepare her hot lunch plate for 30 out of 30 days (implemented 3/30/17). Interview on 3/27/18 with the qualified intellectual disabilities professional (QIDP) confirmed client #5 was "pretty independent" during meal prep and she has "no issues" with helping in the kitchen.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.	W 252		

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W 252	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations, record/document review and interviews, the facility failed to ensure data was collected in accordance with individual program plan (IPP) objectives. This affected 1 of 4 audit clients (#4). The finding is: Data relative to the accomplishment of 1 of 4 training objectives was not documented for client #4. Review on 3/27/18 of client #4's IPP dated 3/1/18 revealed an objective to be able to correctly recite her personal information for 30 out of 30 days (implemented 3/30/17). Additional review of the objective's March '18 data sheet revealed no documented training for 3/1/18 - 3/27/18. Further review of the objective plan noted, "Data should be collected 5 days a week at the Day Program on Monday - Friday." Interview on 3/27/18 with the habilitation specialist confirmed the objective was current and staff have been trained to document all training on data sheets as well as in the facility's online system.	W 252	W252 – The facility will ensure that data is collected in accordance to the individuals IPP. Habilitation Specialist will inservice all responsible staff on data collection protocol for client #4's objectives. Hab. Spec. and manager will monitor weekly and QP will monitor monthly.	5-25-18
W 253	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by:	W 253		

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W 253	Continued From page 6 Based on record review and interview, the facility failed to ensure a recommendation regarding client #6's guardianship status had been implemented and documented. This affected 1 of 4 audit clients. The finding is: Client #6's record did not include a team discussion of his current guardianship status as recommended. Review on 3/27/18 of client #6's individual program plan (IPP) dated 9/14/17 revealed, "Legal Status: Incompetent Adult...Guardian: Self". The plan also noted a diagnosis of Intermittent Explosive Disorder and Mild Intellectual Disabilities. Additional review of the client's psychological evaluation dated 5/11/17 indicated, "Moderate Intellectual Developmental Disabilities". The psychological evaluation also included the following recommendations: "Given [Client #6's] significant challenges and his levels of functioning, the possibility of having a Legal Guardian should be further explored...Given [Client #6's] behavior challenges, a second opinion concerning his current psychotropic medication regimen should be considered..." Interview on 3/27/18 with the qualified intellectual disabilities professional (QIDP) confirmed client #6 was acting as his own guardian. Additional interview revealed he could not recall the psychologist making the recommendation regarding the client's guardianship and the interdisciplinary team had not discussed client #6's current guardianship status.	W 253	W253 – The facility will ensure that all recommendations regarding guardianship status are discussed by the interdisciplinary team. QP will set up a meeting with the interdisciplinary team to discuss the current guardianship status of client#6. QP will monitor monthly.	5-25-18
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii)	W 257		

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W 257	Continued From page 7 The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the individual program plan (IPP) for 2 of 4 audit clients (#2, #4) was revised after they failed to progress towards identified objectives. The findings are: 1. Client #2's IPP was not revised after she failed to make progress towards 2 of 5 objectives. Review on 3/27/18 of client #2's IPP dated 10/19/17 revealed objectives to clean furniture for 30 out of 30 days (implemented 3/30/17) and to swab her gums for 2 minutes for 30 out of 30 days (implemented 3/31/17). Review of progress notes for the objectives indicated the following: Clean Furniture 08/17 - 100% 09/17 - 94% 10/17 - 33% 11/17 - 46% 12/17 - 16% 01/18 - 15% 02/18 - 34% Swab Gums 08/17 - 100% 09/17 - 88%	W 257	W257- The facility will ensure that all IPP's are reviewed by the QP and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. 1,2 – QP and Habilitation Specialist will ensure that client#2's IPP and client 4's IPP is revised after no progress is noted on objectives. Habilitation Specialist will monitor weekly and QP will monitor monthly.	5-25-18

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W 257	Continued From page 8 10/17 - 79% 11/17 - 57% 12/17 - 33% 01/18 - 32% 02/18 - 30% Interview on 3/27/18 with the habilitation specialist revealed the decrease in client #2's progress may be due to staff errors in documentation; however, the objectives needed to be reviewed. 2. Client #4's IPP was not revised after she failed to make progress towards 1 of 4 objectives. Review on 3/27/18 of client #4's IPP dated 3/1/18 revealed an objective to independently prepare a food item in the microwave oven for 30 out of 30 days (implemented 3/30/17). Additional review of progress notes for the objective indicated the following: 08/17 - 50% 09/17 - 55% 10/17 - 18% 11/17 - 22% 12/17 - 13% 01/18 - 0% 02/18 - 0% Interview on 3/27/18 with the habilitation specialist revealed the decrease in client #4's progress may be due to staff errors in documentation; however, the objective needed to be reviewed.	W 257		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)	W 263		

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W 263	Continued From page 9 The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure written informed consent from the legal guardian was obtained for 2 of 4 audit clients (#2, #4). The findings are: Written informed consent was not obtained for client #2's and client #4's behavior support plan (BSP). a. Review on 3/27/18 of client #2's BSP dated 12/28/17 revealed an objective to exhibit 1 or fewer challenging behaviors per month for 11 consecutive months. The BSP addressed behaviors of self-injurious behavior, severe disruption, aggression and failure to make responsible choices. The plan also included the use of Risperdal, Valium or Vistaril. Additional review of the record did not include a written informed consent for the BSP. b. Review on 3/27/18 of client #4's BSP dated 3/31/17 revealed an objective to have 3 or fewer challenging behaviors per review period for 11 consecutive review periods. The BSP included behaviors of unfounded accusations of abuse/neglect, severe disruption, failure to make responsible choices and property destruction. The plan also included the use of Xanax, Celexa and Seroquel. Additional review of the record did not include a written informed consent for the BSP.	W 263	W263- The facility will ensure that a written informed consent from the legal guardian is obtained for all clients with a BSP. QP will contact guardian and have a written informed consent signed for clients #2&#4's BSP. QP will monitor monthly.	5-25-18

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W 263	Continued From page 10 Interview on 3/27/18 with the qualified intellectual disabilities professional (QIDP) revealed the consents were sent to guardians for client #2 and client #4 but had not been returned.	W 263		