**Skill Creations, Inc.**
*Post Office Box 1636*
*Goldsboro, North Carolina 27533-1636*
*Telephone: (919)734-7398 Fax: (919)735-5064*
*"Creating Life Skills With Those We Serve"*

# Fax Transmission

To: Mr. James Silva
Mental Health and Licensure Certification Section
NC Division of Health Service Regulation

919-715- 8078

From: Fontaine Swinson

Date: 4/23/2018



Here is the Plan of Correction for:

SCI Coastal House 1 and 11
Provider Number 34G 173
MHL# 065-028

If you have any questions, do not hesitate to contact me. I can be reached via email

or by telephone at : fontaine.swinson@skillcreations.com; phone number 919-920-4476

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The original is being sent by US Mail.

Thank you,

# DEPARTMENT OF HEALTH AND HUMAN SERVICES
# DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

April 12, 2018

Fontaine Swinson, Chief Operations Office
Skill Creations, Inc.
PO Box 1636
Goldsboro, NC 27533

DHSR - Mental Health
APR 27 2018
Lic. & Cert. Section

Re: Recertification Survey Completed 4/10/18
SCI-Coastal House I and II, 1974 W. Lake Shore Drive, Wilmington, NC 28401
Provider Number 34G173
MHL# 065-028
E-mail Address: fontaine.swinson@skillcreations.com

Dear Ms. Swinson:

Thank you for the cooperation and courtesy extended during the recertification survey completed April 9 - 10, 2018. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

**Type of Deficiencies Found**

- All tags cited are standard level deficiencies.

**Time Frames for Compliance**

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is **June 8, 2018**.

**What to include in the Plan of Correction**

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

**MENTAL HEALTH LICENSURE & CERTIFICATION SECTION**
WWW.NCDHHS.GOV
TEL 919-855-3795 • FAX 919-715-8078
LOCATION: 1800 UMSTEAD DRIVE •WILLIAMS BUILDING • RALEIGH, NC 27603
MAILING ADDRESS: 2718 MAIL SERVICE CENTER • RALEIGH, NC 27699-2718
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Eugina Barnes at 919-819-8182 or eugina.barnes@dhhs.nc.gov.

Sincerely,

Eugina Barnes

Eugina Barnes, BSW/QIDP
Facility Survey Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: Rob Robinson, Director, Alliance Behavioral Health LME/MCO
Wes Knepper, Quality Management Director, Alliance Behavioral Health LME/MCO
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Kim Keehn, Quality Management Director, Trillium Health Resources LME/MCO
Sarah Stroud, Director, Eastpointe LME/MCO
Jeanette Jordan-Huffam, Quality Management Director, Eastpointe LME/MCO
File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G173 | A. BUILDING _____ B. WING _____ | 04/10/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SCI-COASTAL HOUSE I AND II | 1972 &1974 WEST LAKE SHORE DRIVE WILMINGTON, NC 28401 |

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| E 032 | Primary/Alternate Means for Communication<br>CFR(s): 483.475(c)(3)<br><br>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:<br><br>(3) Primary and alternate means for communicating with the following:<br>(i) [Facility] staff.<br>(ii) Federal, State, tribal, regional, and local emergency management agencies.<br><br>*[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.<br>This STANDARD is not met as evidenced by:<br>Based on documentation and interviews, the facility failed to develop an alternate means for communicating with facility staff, regional and local governments during an emergency. The finding is:<br><br>The facility failed to develop an alternate means for communicating with staff, regional and local governments during an emergency.<br><br>Review on 4/9/18 of the facility's emergency preparedness (EP) did not include any information regarding alternate means of communication.<br><br>During an interview on 4/9/18, the qualified intellectual disabilities professional (2) (QIDP) revealed if the land line and cell service were all down there was not another way to | E 032 | The emergency preparedness plan will be reviewed to assure that alternate means for communicating with staff, regional and local government during an emergency is included in the communication plan. The plan will comply with all Federal, State, and local laws by outlining primary and alternate means for communication during an emergency<br>The Quality Management Department will monitor ongoingly and update any needed changes to assure an effective communication plan is in place to assure a safe evacuation during an emergency.<br><br>DHSR - Mental Health<br>APR 27 2018<br>Lic. & Cert. Section | 6-8-18 |

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

Jonathan Simon Chief Operations Officer 4-23-2018

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.

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| E 032 | Continued From page 1<br>communicated during an emergency. | E 032 | | |
| E 036 | EP Training and Testing<br>CFR(s): 483.475(d)<br><br>(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.<br><br>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).<br><br>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at | E 036 | Training and testing will be completed for all staff within the next 30 days on the emergency preparedness plan. Training and testing of the plan will be conducted and updated at least annually for best practice. All emergency preparedness training will be documented for evidence based as well as tracking training for all staff.<br>The Director/QP will monitor the emergency preparedness training at least quarterly to assure that all staff training is current. The assigned Executive Director for the facility will monitor at least quarterly. | 6-8-18 |

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| E 036 | Continued From page 2<br>paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.<br>This STANDARD is not met as evidenced by:<br>Based on document review and interviews, the facility failed to develop a emergency preparedness (EP) training and testing program for House #2. The finding is:<br><br>The facility failed to develop an EP training and testing program.<br><br>Review on 4/9/18 of House #2's EP manual did not include any information on training or testing of the staff.<br><br>During an interview on 4/9/18, staff revealed they had not been tested on the EP. When asked, the staff did not know of an alternate site to evacuate, if the house became uninhabitable for the clients and staff.<br><br>During an interview on 4/9/18, the qualified intellectual disabilities professional (QIDP) confirmed there was no documentation for staff training or tesing regarding the EP for House #2. | E 036 | | |
| W 125 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(3)<br><br>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure 1 of 5 audit | W 125 | | |

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| W 125 | Continued From page 3<br>clients (#8) had the right to be treated with digmity regarding the use of incontinence pads. The finding is:<br><br>Client #8's dignity was not considered regarding the use of incontinence pads.<br><br>During morning observations in the home of 4/10/18, client #8 was seated in a recliner in his bedroom with a large incontinence pad positioned underneath him. The pad was visable to anyone in the home.<br><br>During an interview on 4/10/18, staff revealed the incontinence pad is positioned underneath client #8 due to the fact he will urinate on himself and in the process get the recliner wet. Further interview revealed client #8 wears disposable adult briefs. The staff also stated client #8 is on a "toileting schedule" every two hours.<br><br>Review on 4/10/18 of client #8's individual program plan (IPP) dated 2/13/18 stated, "[Client #8] does not indicate when he has to urinate. He wears adult disapers and will urinate in the diaper but not the toilet".<br><br>During an interview on 4/10/18, the qualified intellectual disabilities professional (QIDP) revealed she was unaware of client #8 having a incontinence pad underneath him while he sat in the recliner in his bedroom. | W 125 | The QP/Director was contacted immediately regarding the use of incontinence pads for client #8. All staff will receive training on client's' right to be treated with dignity and respect. An emphasis will be placed on not placing the incontinence pad in client #8 recliner. Staff will also be retrained on client #8 toileting schedule. Clarification will be provided on staff not initiating procedures/techniques that are not part of client #8 and all clients Person Centered Plans.<br>The Director/QP will monitor at least 2 times a week and follow up on any noted concerns to ensure that all clients' rights are protected and all clients are treated with dignity and respect. | 6-8-18 |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active | W 249 | | |

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| W 249 | Continued From page 4<br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure 3 of 5 audit clients (#1, #7, #8) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of free movement and diet consistency. The findings are:<br><br>1. Clients #8 and #1 were not allowed free movement within their own environment.<br><br>a. During afternoon observations at the day program on 4/9/18, client #8 was verbally prompted to enter a room where other clients were exercising. Client #8 entered the room, stood looking at the staff and then proceeded to exit the room. The staff person, took hold of client #8's right forearm and then pulled him back into the room by holding onto his belt. Further observations revealed the staff person standing in front of client #8 while he again made an attempt to exit the room.<br><br>During an interview on 4/10/18, staff revealed client #8 can have free movement within his environment.<br><br>Review on 4/10/18 of client #8's IPP dated 2/13/18 stated, "He...capable of moving about as he wishes". | W 249 | All staff will receive training in:<br>*ICF-IID Level of Care Basics:*<br>• Active Treatment<br>• Encouraging Independence<br>• Teaching cues<br>• Providing the least assistance necessary<br>• Client #1 and client 8's choices to move around freely within their environment<br>• Respecting Choices for all clients<br>• Client #7 diet consistency<br>The Director/QP will monitor at least three times a week and follow up on any noted concerns. | 6-8-18 |

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| W 249 | Continued From page 5<br><br>During an interview on 4/10/18, the qualified intellectual disabilities professional (QIDP) confirmed staff should have held onto client #8's belt as he was attempting to exit the exercise room at the day program.<br><br>b. During morning observations in House #2 on 4/10/18, client #1 exited her bedroom, came out into the hallway and stood next to the surveyor. A staff person then exited another clients' bedroom, saw client #1 standing in the hallway and called out to another staff (who was in the kitchen) and asked was breakfast ready. The staff in the kitchen replied "No". Client #1 was then physically walked back into her bedroom and told to stay there.<br><br>During an immediate interview, the staff said, "[Client #1] is suppose to be sitting in her room, until staff are ready for her to come up front". When further asked if client #1 can make her own choices, the staff told the surveyor to go ask [QIDP's name].<br><br>Review on 4/10/18 of client #1's IPP dated 11/7/17 revealed, "Enjoys moving around freely...."<br><br>During an interview on 4/10/18, the QIDP revealed client #1 can make her own choices and staff know she can make choices.<br><br>2. Client #7's diet consistency was not follow as written.<br><br>During lunch observations at the day program on 4/9/18, client #7 was observed consuming Cheetos Crunch Cheese flavored snack. Further | W 249 | | |

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| W 249 | Continued From page 6<br>observation revealed the Cheetos ranged in size from 1/2 to 2 inches in length. While consuming the Cheetos client #7 coughed 2 times. At no time where the Cheetos broken into pieces.<br><br>During dinner observations in the home on 4/9/18, client #7 was observed consuming a mixture of rice, mixed vegetables, and chunks of chicken. The mixed vegetables consisted of pieces of baby corn which were 1/2 inch in length. The pieces of chicken ranged in the size from 1/2/ to 2 inches in length. While consuming the mixture client #7 coughed 3 times. At no time was client #7 prompted to cut her food.<br><br>Review on 4/9/18 of the SCI-Coastal House II Diet Chart dated 3/24/18 located on the refrigerator stated, "[Client #7]: consistency: Chopped". Review of client #7's IPP dated 12/5/17 indicated, "...regular chopped diet...." Client #7's nutritional evaluation dated 3/9/18 revealed her diet is chopped. The physician orders signed 3/8/18 revealed, "...Chopped Diet".<br><br>During an interview on 4/10/18, the QIDP reported client #7's food should be the size of a pea. Further interview revealed staff have been "informed" about client #7's diet consistency. | W 249 | | |
| W 322 | PHYSICIAN SERVICES<br>CFR(s): 483.460(a)(3)<br><br>The facility must provide or obtain preventive and general medical care.<br><br>This STANDARD is not met as evidenced by:<br>Based on record reviews and interviews, the | W 322 | | |

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| W 322 | Continued From page 7<br>facility failed to ensure 2 of 5 audit clients (#2, #5) received preventive recommendations. The findings are:<br><br>1. Client #2 has not received her annual mammogram.<br><br>Review on 4/10/18 of client #2's nursing evaulation dated 4/25/17 indicated she received a mammogram on 7/13/16 with the recommendation to return in one year. Further reveiw revealed client #2 had not received a mammogram in 2017.<br><br>During an interview on 4/10/18, the facility's nurse confirmed client #2 did not return in a year for her annual mammogram.<br><br>2. Client #5 was not provided with ACT mouthrinse which was recommended by the dentist.<br><br>Review on 4/10/18 of client #5's dental examination dated 4/9/18 stated, "Fluoride Rinse ACT 1 or 2x day after brushing, especially before bed".<br><br>During an interview on 4/10/18, staff said, "I think [Client #7] uses the rinse during medication pass".<br><br>During an interview on 4/10/18, the facility's nurse revealed client #7 did not have the ACT Rinse. The nurse stated, "Yesterday was busy" and no one was able to purchase the rinse. | W 322 | ---<br>Client's #2 will be scheduled for a mammogram ASAP. Client #5 ACT mouth rinse has been provided. In the future, all recall dates for exams by specialists will become service goals to assure that recommended preventive procedures are completed in a timely manner for client #2 and all clients. This system serves as a "tickler file" and helps keep appointments on schedule. The Director will monitor the service goals at least quarterly when writing the QP note. In the Future, the nurse will establish and maintain a Medical Reminder form that will serve to assure needed examinations are done. Also in the future all recommended "Fluoride Rinse or any other recommended product from a specialist will be provided within a timely manner to avoid any delays with implementation of recommendations from a dentist or any other specialist. The RN Team Lead will monitor recommended procedures at least quarterly. | 6-8-18 |
| W 325 | PHYSICIAN SERVICES<br>CFR(s): 483.460(a)(3)(iii) | W 325 | | |

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| W 325 | Continued From page 8<br>The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure routine screenings were obtained for 1 of 5 audit clients (#8). The finding is:<br><br>A routine screening for client #8 was not obtained.<br><br>Review on 4/19/18 of client #8's record revealed he was scheduled for a colonoscopy on 11/20/17; but it was cancelled to due to him becoming ill and being admitted to the hospital. Further review client #8 was not rescheduled for another colonoscopy. Further review revealed client #8 is 52 years old.<br><br>Review on 4/10/18 of the faclity's policy on diagnostic screening schedules (reviewed 10/2013) revealed, "Colon and Rectal Cancer Screening: 1. Beginning at the age of 50 men...at average risk for developing colorectal cancer should use one of the screening rests below. The tests that are designed to find both early cancer and polyps are preferred of these tests are available: Tests that find both polyps abd cancer:...Colonoscopy every 10 years...."<br><br>During an interview on 4/10/18, the facility's nurse revealed there was no documentation regarding the rescheduling of client #8's colonoscopy or information regarding the guardian declining the procedure. | W 325 | Client #8 will be reassessed by his medical provider and team members for the most appropriate colon/rectal screening due to an adverse reaction previously while being prep for a scheduled colonoscopy. Routine screening for all clients will be assessed to make sure that all laboratory examinations determined necessary by the physician and approved by the guardian has been completed. Any noted outstanding routine screening will be completed as soon as possible for all clients.<br><br>In the future, the Director/QP will monitor at least monthly. The RN Team Lead will monitor ongoingly to assure that physical examinations are completed and include all recommended routine laboratory examinations determined necessary by the physician. | 6-8-18 |

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| SCI-COASTAL HOUSE I AND II | 1972 &1974 WEST LAKE SHORE DRIVE WILMINGTON, NC 28401 |

| (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 |
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| W 331 | NURSING SERVICES<br>CFR(s): 483.460(c)<br><br>The facility must provide clients with nursing services in accordance with their needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure 1 of 5 audit clients (#2) received nursing services in accordance with her medical needs. The finding is:<br><br>Client #2 did not receive nursing services in accordance with her health needs.<br><br>Review on 4/10/18 of client #2's record revealed a "Monthly Breast Exams" sheet. Further review revealed client #2's breasts are to be checked each month for the following: lymph nodules, nipple drainage, inverted nipples and lumps or masses. Client #2's breasts were last checked 2/2018. Further review there was no data for the month of March 2018.<br><br>During an interview on 4/10/18, the facility's nurse confirmed client #2's breast examination had not occured in March 2018. | W 331 | In the future client #2 and all clients will receive nursing services in accordance to their identified needs which will include monthly breast examinations. The RN Team Lead will provide training for the facility nurse on Nursing Policy 205-5 (breast examinations will be provided by the LPN monthly on both female and male clients). The RN Team Lead will monitor the breast examination flow sheet at least monthly as well as all nursing services and follow up with any noted concerns regarding all clients' medical needs.<br><br>The Director/QP will monitor the breast examination flow sheet Quarterly and follow up as needed for completion of breast examinations. | 6-8-18 |
| W 336 | NURSING SERVICES<br>CFR(s): 483.460(c)(3)(iii)<br><br>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility | W 336 | The CNO (Chief Nursing Officer) will worked with the RN Team Lead to develop a clear schedule and assignment sheet for the Quarterly Review of Health Status for client #2 and all clients. The schedule will be posted in the medication room to serve as a visual reminder to prompt the facility LPN with completing the Quarterly Review of Health Status within a timely manner. The facility LPN will be retrained on Nursing Policy 202-2 (Quarterly Review of Health Status). The RN Team Lead will monitor monthly and the CNO will monitor for the next 3 months to assure the QRHS are completed appropriately. The Director / QP will monitor quarterly. | 6-8-18 |

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| | 34G173 | A. BUILDING _____ B. WING _____ | 04/10/2018 |

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| W 336 | Continued From page 10<br>failed to ensure 1 of 5 audit clients (#2) received a review of their health status at least quarterly. The finding is:<br><br>Nursing assessment was not completed at least quarterly for client #2.<br><br>During a review on 4/10/18 of client #2's record revealed her last nursing quarterly was conducted on 3/2016. No other assessments could be located.<br><br>During an interview on 4/10/18, the facility's nurse revealed he was aware of the missing quarterlies for client #2. | W 336 | | |
| W 352 | COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE<br>CFR(s): 483.460(f)(2)<br><br>Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure client #2 received an annual comprehensive dental examination for the maintenance of her oral health. This affected 1 of 5 audit clients. The finding is:<br><br>Client #2 did not have dental cleaning at least annually.<br><br>Review on 4/10/18 revealed client #2 last received a dental cleaning on 8/22/16. Further review indicated client #2 no other dental examinations. | W 352 | Immediate efforts will be made to schedule a dental appointment for client #2 as quickly as possible as well as all clients that has not had an annual comprehensive dental examination. The appointment will be made by the facility nurse. The RN Team lead will assist the facility nurse with developing a grid with dental appointments for all clients noted for tracking and to assure that all clients receive a comprehensive dental examination annually. The Director/QP will be provided a copy of the grid and monitor at least quarterly and follow up on any needed appointments/noted concerns for corrective actions. The RN Team Lead will monitor monthly and initiate corrective actions as warrant. | 6-8-18 |

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| W 352 | Continued From page 11<br><br>During an interview on 4/10/18, the facility's nurse revealed client #2 had two follow-up dental examinations scheduled for 6/28/17 and 8/24/17, but due to client behaviors those examinations were not conducted. The nurse confrmed no other dental appointments had been scheduled. | W 352 | | |
| W 382 | DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(I)(2)<br><br>The facility must keep all drugs and biologicals locked except when being prepared for administration.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, policy review and interview, the facility failed to ensure all drugs and biologicals remained locked. This affected all the clients residing in House #1. The finding is:<br><br>The medications were left unsecured and unsupervised by the facility nurse.<br><br>During morning medication administration in House #1 on 4/10/18 at 7:29am, the facility nurse went around the corner from the medication closet to hand client #2 her medications; which were in a plastic medication cup. The nurse stood there for 5 minutes while client #2 swallowed her pills one at a time. Further observations revealed staff and other clients going up and down the hallway, while the door remained open. Additional observations revealed the cabinets inside of the medication room were unlocked and open. At no time during was the door to the medication room closed. | W 382 | In the future, all drugs and biological will be stored / locked in the medication room except when being prepared and administered. The facility nurse and medication monitors will be re-trained on Nursing Policy 206-1 regarding medication administration with an emphasis on all drugs and biological remaining locked except when being prepared for administration. The RN Team Lead will monitor medication administrations at least quarterly and the Director/QP will monitor at least monthly. | 6-8-18 |

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| W 382 | Continued From page 12<br>Review on 4/10/18 of the facility's medication administration policy (revised 9/17) stated, ..."Procedure: 4. Medication cabinets/clostes are locked at all times except during medication preparation...."<br><br>During an interview on 4/10/18, the facility nurse confirmed the door to medication closet should have been closed, while he observed client #2 consuming her medications. | W 382 | | |
| W 436 | SPACE AND EQUIPMENT<br>CFR(s): 483.470(g)(2)<br><br>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interview, the facility failed to ensure an electric toothbrush was purchased for client #5. The finding is:<br><br>Client #5 was not provided with an electric toothbrush as recommended by the dentist.<br><br>Review on 4/10/18 of client #5's dental examination dated 4/9/18 stated, "...Electric toothbrush would be ideal". Further review revealed client #5's dental rating to be "POOR".<br><br>During an interview on 4/10/18, staff showed the surveyor client #5's manual toothbrush. The staff | W 436 | Client #5 will be provided an electric toothbrush per recommendation of the dentist as soon as possible. In the future, service goals will be developed as soon as a need for equipment is made known. In this way, following-thru with getting needed equipment/items purchased as soon as possible will not be delayed. Further, the QP will maintain a list of needed items/equipment identified by the interdisciplinary team and take all necessary steps with getting equipment and/or maintaining items in good repair. General items such as toothbrushes/electric toothbrushes will be purchased and stocked at the facility to foster a quicker turnaround time in furnishing and/or replacing items such as toothbrushes that are worn etc.<br>The Director/QP will monitor at least 2 times a week to ensure that needed items are provided. | 6-8-18 |

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| W 436 | Continued From page 13<br>revealed the bristles of client #5's toothbrush were worn down.<br><br>During an interview on 4/10/18, the qualified intellectual disabilities professional (QIDP) confirmed client #5's manual toothbrush bristles were worn and needed to be replaced.<br><br>During an interview on 4/10/18, the facility's nurse revealed the electric toothbrush recommended for client #5 should have been purchased. | W 436 | | |