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
	34G156	A. BUILDING ______ B. WING ______	05/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN I	3716 WESTWOOD DRIVE HAMPTONVILLE, NC 27020

(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
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 interview and record review, the facility failed to develop specific facility-based strategies as part of their emergency plan. The finding is: Review of the facility's Emergency Program (EP) on 5/1/18 revealed the EP to contain a thorough risk assessment and community-based	E 006		

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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E 006	Continued From page 1 strategies. Further review of the EP, substantiated by interview with the facility administrator, revealed some additional facility-based information needed to be more specific to the needs of the group home and clients in the group home. For example: A. Review of the EP revealed various community evacuation points to include the local fire department, hospital, high school, YMCA and a local hotel. Review of evacuation plans revealed no specific details of routes or directions to the identified destination or evacuation location from the group home. B. Review of the EP revealed the storage of emergency supplies in the group home to include flashlights, radios, food and water with no specifics as to the location of supplies. Observations in the home, substantiated by interview with facility staff on 4/30/18 revealed radios, food, water and one flashlight to be located in the group home. Interview with the group home manager on 5/1/18 revealed the group home to have more than one flash light as additional flashlights were in the group home staff office. C. Review of the EP revealed information regarding the residents of the group home with each residents person centered plan and MAR. Further review of the EP and interview with the facility administrator revealed no information regarding specific communication needs or behavior support plans (BSPs) of the 6 residents of the group home to assist anyone unfamiliar with the residents working with them in an emergency situation. Observation in the group home on 4/30/18 revealed 2 of 6 (#4 and #5)	E 006		

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E 006	Continued From page 2 residents of the group home to utilize a TEACCH schedule for communication and 1 resident (#2) to utilize an augmented communication device. Review of human rights committee minutes for the review year on 4/30/18 revealed 5 of 6 residents (#1, #2, #4, #5 and #6) of the group home to have formal BSP's.	E 006		
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 staff interview, the team failed to assure sufficient interventions to address the communication needs for 1 of 3 sampled clients (#2), and the behavior needs for 1 of 3 sampled clients (#2). The findings are: A. The team failed to assure sufficient interventions to address the communication needs of client #2. For example: Observation in the group home on 4/30/18 revealed client #2 to be mostly non-verbal and staff to prompt the client with verbalizations and gestures. Prompted activities included leisure choices, walking outside, washing hands and	W 249		

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W 249	Continued From page 3 dining. Observation on 5/1/18 at 6:45 AM revealed client #2 to participate in her breakfast meal with staff assistance utilizing an augmented communication device. Client #2 was observed to press with staff assistance, choices of eat, drink and "more." The communication device included pictures and sound that the client used to express preferences during her meal. Further observation of client #2's communication device revealed pictures for brush, drink, eat, toothbrush, "more" and toilet. Observation of client #2 after her breakfast meal did not reveal the client to utilize the communication device at any other time or be prompted by staff to utilize the communication device. Observation from 7:35 AM to 8:45 AM did reveal client #2 to be prompted verbally and with gestures to engage in leisure, brush her teeth, use the restroom, walk or load the van for transport to her day program. Review of the record for client #2 on 5/1/18 revealed a person centered plan (PCP) dated 11/14/17. Review of the PCP revealed a communication objective implemented 3/7/18. Further review of the communication objective revealed client #2 will independently use items on an augmented communication device to communicate wants and needs. Interview with the facility qualified intellectual disabilities professional (QIDP) verified client #2's communication objective is current and was revised in 3/2018 to include more options and choices from a previous objective. Continued interview revealed the communication device for client #2 to include options for leisure, dining and other daily living tasks. The QIDP further verified staff members should have been using the communication device with client #2 in the home	W 249		

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W 249	Continued From page 4 at every opportunity related to activities and tasks, as prescribed in the objective. B. The team failed to assure interventions in sufficient frequency to address the behavior needs of client #2. Observation in the group home on 5/1/18 revealed a pair of gloves to sit near the communication device of client #2. Further observation at 8:45 AM revealed staff to assist all clients to load the facility van for transport to the vocational program. Continued observation revealed staff to load the van and leave the gloves at the group home until interviewed by this surveyor. Interview with group home staff on 5/1/18 at 8:55 AM verified the gloves belong to client #2 for biting behavior. Additional interview with staff revealed the client's gloves are not taken on the van as the client has gloves at the vocational program. Staff further reported if client #2 engages in biting behavior on the van, staff attempt to verbally redirect the client and have nursing to check the client after arriving at the vocational center. It should be noted after the interview with this surveyor, staff were observed to take the gloves for client #2 to the vocational program. Review of facility incident reports on 4/30/18 revealed from 10/2017 through 4/2018 client #2 engaged in three incidents of self injurious behavior (SIB) while on the facility van. Review of the incidents revealed the client bit her left hand during all incidents. Review of records for client #2 on 5/1/18 revealed a PCP dated 11/14/17 that contained a behavior	W 249		

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W 249	Continued From page 5 support plan (BSP) dated 11/15/17. Review of the BSP revealed target behaviors of inappropriate food acquisition, aggression, hyperactivity, wandering, AWOL and SIB: biting self, skin picking or other ways of harming self. When upset client #2 will bite her hand, breaking skin and drawing blood. Review of interventions in the BSP for SIB revealed the use of fingerless gloves to be used to prevent injury noting: when staff observe the client to bite her wrist or hand area they should offer or assist the client with putting on a pair of support gloves. Interview with the facility QIDP verified client #2 should have a pair of gloves on the facility van due to the client's past history of SIB incidents while on the van. Further interview with the QIDP verified client #2's BSP could not be implemented as prescribed without gloves on the facility van when the client has engaged in biting behavior and therefore staff should have access to the client's gloves across all environments.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) 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 review of records and interview, the specially constituted committee, designated as the human rights committee (HRC), failed to ensure written informed consent was obtained from the legal guardian for the use of interventions to address inappropriate behaviors	W 263		

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W 263	Continued From page 6	W 263		

for 1 of 3 sampled clients (#2). The finding is:

Review of records for client #2 on 5/1/18 revealed a behavior support plan (BSP) dated 11/15/17. Review of the BSP revealed target behaviors of inappropriate food acquisition, aggression, hyperactivity, wandering, AWOL and self injurious behavior (SIB): biting self, skin picking or other ways of harming self. When upset, client will bite her hand, breaking skin and drawing blood. Review of BSP interventions to address SIB revealed the use of fingerless gloves to be used to prevent injury. Additional review of the BSP revealed no current guardian consent for the behavior plan although consent had been obtained specific to the client's medications to manage inappropriate behavior.

Interview with the facility qualified intellectual disabilities professional (QIDP) verified a current guardian consent was not available for client #2's BSP. Additional interview with the QIDP revealed client #2 continues to need support gloves to address biting behavior and gloves are utilized per guidelines of the clients BSP.