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
	34G260	A. BUILDING _____ B. WING _____	04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCKEEL LOOP ROAD HOME	5910 FARMWOOD LOOP ROAD WILSON, NC 27893

(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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) 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. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 1 audit clients (#5) with an out of state legal guardian had an instate processing/resident agent assigned. The finding is: Client #5 has an out of state legal guardian with no assigned in state processing/resident agent. Review on 4/17/18 of client #5's IPP dated 5/25/17 mentioned her guardian. Further review of the legal section revealed her legal guardian lives out of state. The review of the legal section of the record did not reveal any in state processing or resident agent. Interview with the qualified intellectual disabilities professional (QIDP) on 4/17/18 confirmed client #5 does not have a resident agent assigned to her.	W 125	W 125 The facility will ensure the rights of all clients. To this end, all clients whose legal guardians are from out-of-state will be assigned an instate processing/resident agent. This will be ensured by the QP who will follow guidelines in recent update to LIFE, Inc. QP manual regarding procedure to complete a Resident Process Agent from AOC-E-500. The QP will submit the completed form to the Clerk of Court in the county where the guardianship was appointed. The QP will ensure compliance with this standard on an on-going basis through monthly QP reviews, where any information concerning guardianship would be discussed.	6-15-2018
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record reviews and	W 130	DHSR - Mental Health MAY 14 2018 Lic. & Cert. Section	

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

Barbara W. Parker Dir of Jc F I FED 5-11-18

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 130	Continued From page 1 interviews, the facility failed to assure privacy for 1 of 3 audit clients (#3). The finding is: Client #3 was not consistently afforded privacy during dressing. During observations on 4/17/18, client #3 was observed at 6:30am in only underpants in her bedroom with the door wide open. A peer walked by her room. She remained like this as she put her bra on. During that time, approximately five minutes later a staff came by and told her the door needed to be closed as she closed the door. Review on 4/17/18 of client #3's record revealed an assessment tool dated 9/28/7 indicating she independently observes privacy. Interview with management on 4/17/18 confirmed she should have been assisted in closing the door before dressing.	W 130	W 130 The facility will ensure the rights of all clients, including the right to privacy during treatment and care of personal needs. Staff will be re-inserviced by the QP on strategies to promote and ensure privacy for all clients. Ongoing compliance with this regulation will be ensured by the QP and Hab Coordinator through their QA/QI inspections completed a minimum of three times monthly. Findings regarding privacy will be documented in the Inspection App.	6-15-2018
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 review and interview, the facility failed to assure 1 of 3 audit	W 249	W 249 Each client will receive a continuous active treatment program to support the achievement of objectives identified in the individual program plan. This will include, but not be limited to, the areas of toothbrushing and mealtime. Staff will be re-inserviced on client objectives and recommendations for adaptive mealtime equipment, as well as orders for diet consistencies. Toothbrush and mealtime procedures will be monitored by the QP and the Habilitation Coordinator when they complete QA/QI inspections, a minimum of three times monthly. Findings regarding toothbrushing, adaptive equipment and diet consistencies will be documented in the Inspection App.	6-15-2018

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W 249	Continued From page 2	W 249		

clients (#3) was provided diet consistency and adaptive dining equipment and assisted in goal implementation as per her individual program plan (IPP.) The findings are:

1. Client #3 was not provided the correct diet consistency and adaptive dining equipment as per her IPP.

During observations on 4/17/18 at 8:10am, client #3 independently obtained her toothbrushing items, went into the bathroom alone and brushed her teeth for approximately 30 seconds not covering all surfaces and rinsed with mouthwash. She then returned her items.

Interview with client #3 revealed this is her normal way of doing her teeth. When asked if staff usually goes with her she indicated they do not.

Review of client #3's IPP dated 9/28/17 revealed a formal goal for toothbrushing which focused on flossing teeth. This goal included brushing outer top, inner top, outer bottom and inner bottom teeth.

Interview with management confirmed client #3 should have been assisted in integrating the toothbrushing goal.

2. Client #3 was not consistently provided appropriate diet and dining utensils.

During observations on 4/16/18 and 4/17/18, client #3 ate with a spoon that was the same as others. A regular utensil with a teaspoon. She also received a non cut to 3/4 inch diet consistency. For example, at lunch on 4/16/18, client #3 was served a whole hot dog, chips and

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W 249	Continued From page 3 fig newtons and slaw. Review of client #3's IPP dated 9/28/17 revealed she should receive 3/4 inch size or smaller food pieces. This was documented in the most recent occupational therapy evaluation dated 3/3/18. It further noted she should use a small bowl spoon which was not further defined. Interview with management, agreed that client #3 should have received small pieces of food but was unsure of what "small bowl spoon" client #3 needed.	W 249		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure that one substance prescribed for sleep was incorporated into the active treatment plan for 1 of 3 audit clients (#2). The finding is: Client #2's Melatonin was not incorporated into an active treatment plan. Review on 4/18/18 of client #3's IPP dated 1/11/18 revealed she is prescribed Melatonin for sleep. The physician's order dated 2/1/18 indicated she should receive Melatonin 3 mg. 1 tablet by mouth at bedtime for sleep. Further review revealed there was no active treatment or behavior plan targeting sleep.	W 288	W 288 The facility will ensure that all substances prescribed for sleep are incorporated into the active treatment plans. The QP and Behavior Specialist will meet with the core team to discuss how to incorporate any medication given for sleep into the behavior intervention plan on some active treatment goal or program. Data will be analyzed on a monthly basis by the QP and will be documented in the monthly QP review.	6-15-2018

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W 288	Continued From page 4	W 288		
	Interview with the management staff on 5/18/18 revealed there is no plan to treat the behavior of not sleeping at night. The management staff stated they do take data on sleep but are not monitoring this data with an active treatment goal or program.			
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure all medications were given without error. This affected one of three audit clients (#3). The finding is: Client #3 did not receive her Iron and Zoloft as ordered. During observations of the medication pass on 4/17/18, client #3 punched her Iron and Zoloft from the pill packet. She was assisted crushing her medications and she did not take the cup with these two medications in it. There was no effort by staff to get her to take it when she said she was not going to take that cup. Client #3 was told to throw it away in the trash can and she did. Interview on 4/17/18 with staff indicated this would be a medication error based on client #3's refusal to take the medications. She was asked if she was trained to do anything to get her to take it	W 369	W 369 The facility will ensure that all medications are administered without error. Staff will be re-inserviced by the nurse on strategies to be utilized to encourage clients to take their medications. Additionally, the nurse will post "reminders" for staff in the medication administration area. The QP and Habilitation Coordinator will ensure compliance with this plan of correction through observing a minimum of 3 medication passes per month. Findings will be documented in the Inspection App. If there are no refusals to take medication, this will be noted.	6-15-2018

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W 369	Continued From page 5 she stated she was not. Interview on 4/17/18 with the nurse by phone confirmed this is a medication error.	W 369		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interviews and record reviews the facility failed to assure that fire drills occurred one per shift per quarter. This potentially affected all clients living in the home. The finding is: The fire drills were not conducted one per shift per quarter. Review on 4/17/18 of the fire drill reports revealed there was not one per shift per quarter. Interview with management staff on 4/17/18 confirmed the drills were not conducted one per shift per quarter.	W 440	W 440 The facility will hold evacuation drills at least quarterly for each shift of personnel. The QP will be responsible for scheduling all fire drills and for reviewing the written fire drill report form to ensure that it was held as scheduled, as well as to follow-up on any concerns in reference to the drill. All documentation will be made utilizing the LIFE, Inc. disaster drill report form.	6-15-2018