PRINTED: 05/24/2018
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
	34G037	A. BUILDING _____ B. WING _____	05/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALLARD LANE CENTER	142 MALLARD LANE ROCKINGHAM, NC 28379

(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 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 interviews, the facility failed to ensure 3 of 4 audit clients (#1, #4, #5) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of following ordered diets and self help skills. The findings are: 1. Staff failed to provide client #3 with her ordered diet. During dinner observations on 5/21/18 at 5:45pm client #3 consumed chicken Alfredo, broccoli, lite yogurt and the food was drenched with ranch dressing. At no time did staff promote client #3 to measure the dressing or remove the excess salad dressing. Review on 5/22/18 of client #3's individual program plan (IPP) dated 12/14/17 revealed her diet was low fat, low sugar no seconds allowed. Further review revealed, "Staff should be assisting [Client #3] with trying to have healthier food choice."	W 249	Program Implementation CFR(s): 483.440(d)(1) 1. By July 20, 2018 all staff will be re-inserviced on all person's supported diet orders and how to use measuring utensils to assist with diet orders 2. By July 20, 2018 all staff will be re-inserviced on all person's supported IDLA's. Specifically, all person's supported assistance needed for self -help skills and serving themselves as independently as possible. 3. Residential Team Leader or designee will completely bi-weekly meal observations to ensure all diet orders are being followed and all IDLA's are being followed specifically with self-help skills during meals. Responsible person: Residential Team Leader or Designee Target Date: July, 20, 2018 DHSR - Mental Health JUN 05 2018 Lic. & Cert. Section	

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

Beth Tyler, RTL, QP, MPA | 6-4-18

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 249	Continued From page 1 Review on 5/22/18 of client #3's physician order dated 5/1/18 revealed "low fat, low sugar diet no seconds allowed. " Review on 5/22/18 of nutrition assessment dated 5/15/18 revealed client weighed 225 pounds and had a body mass index (BMI) of 38.1 "Obese." Client #3 states, "Diet low fat, low sugar and no seconds allowed." Review of the ranch nutrional label revealed 2 table spoons per serving with 14 grams of fat per serving. Interview on 5/22/18 with the qualified intellectual disabilities professional (QIDP) revealed client #3's diet order should be followed. 2. Clients #4 and #5 where not prompted their self-help skills. During dinner meal preparations in the home on 5/21/18, staff removed a prepared serving bowl with a tossed salad in it. Further observations revealed the staff put the salad into individual serving bowls. Additional observations revealed the individual serving bowls being placed at the place setting for clients #4 and #5. Staff did not staff prompt either client #4 or client #5 to prepare their own salads. During an interview on 5/21/18, the staff revealed clients #4 and #5 should have been given the opportunity to prepare their own salads. Review on 5/22/18 of client #1's individual daily living assessment (IDLA) dated 2/2/18 stated,	W 249		

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W 249	Continued From page 2 "can serve self an appropriate serving from a large container with serving spoon/ladle" with gestures or partial physical prompts. Review on 5/22/18 of client #5's IDLA dated (2018) revealed, "Can serve self an appropriate serving from large a container with spoon/ladle" with verbal prompts or cues. During an interview on 5/22/18 the QIDP confirmed staff should have let "the people we support" prepare their own salad.	W 249		
W 273	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(3) Clients must not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 1 of 4 audit clients (#3) did not discipline another client. The finding is: Client #3 was not redirected from disciplining another client. During dinner observations in the home on 5/21/18, client #3 reached across the table and took a bottle of salad dressing from another client's hand. Further observations revealed client #3 saying, "No, no, no" to the other client. The staff then took the bottle of salad dressing from client #3, she put the top on it and placed it at the other end of the table. At no time was client #3 redirected from disciplining the other client.	W 273	Conduct Toward Client CFR(s): 483.450(a)(3) 1. By July 20, 2018 all staff will be re-inserviced on person's supported conduct toward other person's supported and making sure person's supported are not verbally disciplining eachother 2. By July 20, 2018 all staff will be re-inserviced on Monarch's Mission Vision and Values as it relates to dignity and respect for all individuals. 3. Residential Team Leader or designee will complete bi- weekly shift observations to ensure all person's supported dignity and respect is being upheld. Responsible person- Residential Team Leader or designee Target Date- July 20, 2018	

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W 273	Continued From page 3 During an interview on 5/22/18, the qualified intellectual disabilities professional (QIDP) confirmed client #3 should have been redirected by staff when she disciplined the other client.	W 273		
W 324	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(ii) The facility must provide or obtain annual physical examinations of each client that at a minimum includes immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all immunizations were current for 1 of 4 audit clients (#5). The finding is: Client #5 did not receive a tetanus booster as recommended. Review on 5/22/18 of client #5's record revealed he had been admitted to the facility on 12/17/09. Additional review of the client's immunization revealed a tetanus booster had been administered on 8/15/94 Interview on 5/22/18 with the facility's nurse confirmed client #5 had not received a tetanus booster.	W 324	Physician Services CFR(s): 483.460(a)(3)(ii) 1. By July 20, 2018 Residental Team Leader or designee will ensure all person's supported receive all of their required immunizations, including tetanus boosters as recommended. 2. Residential Team Leader or designee will add immunizations to Medical tracking sheet to ensure immunizations are given in recommended time frame. Responsible person: Residential Team Leader or designee Target Date- July 20, 2018	
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure	W 368	Drug Administration CFR(s): 483.460(k)(1) 1. By July 20, 2018 Residential Team	

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W 368	Continued From page 4 that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #3 received all prescribed medications as ordered by the physician. This affected 1 client observed during medication administration. The finding is: Client #1 did not receive his Risperdal as ordered. During observations of medication administration in the home on 5/22/18 at approximately 7:22 am, the medication technician (MT) administered Risperdal 10mg, with 16 other pills to client #1. Client #1 ingested the medication with tomato juice. Review on 5/22/18 of client #1's physician's orders dated 5/1/18 revealed an order for "Risperdal 10mg : take one tablet by mouth twice daily (place on tongue). Interview on 5/22/18 with the MT revealed client #1's Risperdal should be placed on the tongue. Interview on 5/22/18 with the facility's nurse confirmed client #1's Risperdal should be administered as ordered.	W 368	Leader or designee will re-inservice all staff on Monarch's approved Medication Administration policy, specifically the "6 Rights of Administration". 2. By July 20, 2018 Residential Team Leader or designee will complete 3 medication observation passes with the DSR that had the medication error and Monarch's progressive discipline for medication errors will be followed. Responsible person- Residential Team Leader or designee Target Date- July 20, 2018	
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases.	W 455	Infection Control CFR(s): 483.470(l)(1) 1. By July 20, 2018 Residential Team Leader or designee will re-inservice all staff on Monarch's approved Infection Control policy	

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W 455	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control prevention procedures were carried out. This potentially affected all clients residing in the facility. The finding is: Precautions were not taken to promote client health and prevent possible cross-contamination. During evening observations in the facility on 5/21/18, staff (2) went inside of the freezer and removed cubes of ice with their bare hands and placed the cubes of ice into the glasses of two clients. Further observations revealed there was no ice scoop inside of the freezer. At no time did either staff wash their hands prior to touching the ice. During an interview on 5/21/18, staff revealed they should not have used their bare hands when touching the ice. Review on 5/22/18 of the facility's infection control policy dated 9/8/16 stated, "Policy: Monarch promotes hand hygiene as an essential element in safe care for our staff and the people we serve. Procedure:...Hand hygiene includes...washing.... 3. Soap and water should be used...." During an interview on 5/22/18, the qualified intellectual disabilities professional (QIDP) confirmed staff should not have touched the ice with their bare hands. Further interview revealed a ice scoop should have been used.	W 455	2. By July 20, 2018 Residential Team Leader or designee will purchase a scoop for the ice maker. 3. By July 20, 2018 Residental Team Leader or designee will complete monthly hand hygiene observations with all staff. Responsible person- Residential Team Leader or designee Target date- July 20, 2018	