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
	34G041	A. BUILDING _____ B. WING _____	06/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR GROUP HOME	1070 PACKING PLANT ROAD SMITHFIELD, NC 27577

(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 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(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: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[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. This STANDARD is not met as evidenced by: Based on observations, interview and document review, the facility failed to ensure a communication plan was developed to include alternative means of communicating with facility staff, federal, state, regional and local emergency management agencies. The finding is: An alternative means of communication was not provided. During morning observations in the home on 6/5/18 at approximately 7:30am, the land line phone in the home shut down abruptly, leaving the home without phone service for approximately 15 minutes. Additional observations revealed staff using their personal cell phone to call management staff regarding the outage. Staff interviews (2) on 6/4 - 6/5/18 revealed only	E 032	DHSR - Mental Health JUN 19 2018 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Fred Hudson, Jr.	Administrator	6/15/18

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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E 032	Continued From page 1 land line phones are available for use in the home. The staff acknowledged another means of communication would be needed if the land line went down or the home was without power. Review on 6/4/18 of the facility's emergency preparedness (EP) plan dated 9/8/17 did not include alternative means of communication in the event of a power failure. Interview on 6/5/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed all of the phones in the home were on land lines and there is currently no alternative means of communication during a power failure.	E 032		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under	E 037		

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E 037		E 037		
	Continued From page 2 arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training.(iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency			

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E 037	Continued From page 3 preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training.(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:	E 037		

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E 037	Continued From page 4 (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training.(iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure direct care staff were adequately trained regarding the facility's current emergency preparedness (EP) plan. The finding is: Staff had not received EP training as indicated. Review on 6/4/18 of the facility's EP plan dated 9/8/17 revealed no specific training for direct care staff.	E 037		

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	34G041	A. BUILDING _____ B. WING _____	06/05/2018

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E 037	Continued From page 5 Staff interviews (3) on 6/4 - 6/5/18 revealed the staff could not provide specific details regarding the facility's EP program. Additional interview on 6/5/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed they have had discussions with staff regarding the EP plan; however, no training documentation was provided. The QIDP further revealed he could not be sure if direct care staff had been formally trained on the facility's most current emergency plan since the training would have been completed by someone else.	E 037		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure client #5 had the right to access grooming supplies in the home. This affected 1 of 3 audit clients. The finding is: Client #5 did not have access to his grooming supplies. During morning observations in the home throughout the survey on 6/4 - 6/5/18, staff repeatedly and consistently used a key to unlock a closet located adjacent to the kitchen to obtain various items. Additional observations of the	W 137		

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W 137	Continued From page 6 locked closet revealed cleaning supplies, paper products and grooming supplies (i.e. soap, razors, shaving cream, toothpaste, etc.). Further observations of client #5's bedroom wardrobe revealed only a toothbrush and a tub of toothpaste (recently placed in his bedroom that morning). No other personal hygiene items were noted. Staff interview on 6/5/18 revealed client #5 will misuse his grooming items if left in his bedroom. Additional interview indicated staff usually get the items they need for his grooming activities from the locked closet each time they need them. Review on 6/5/18 of client #5's individual program plan (IPP) dated 9/26/17 revealed, "[Client #5] can access his toileting items independently. [Client #5] has full access to toileting items." Additional review of the plan revealed a service goal (OSG #9) for Client's Rights. Further review of a note regarding the service goal (dated 10/26/17) indicated, "...QP spoke to [Client #5] about the right to have access to his personal property..." Interview on 6/5/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the supply closet in the home should not have been locked and client #5 should have grooming items in his bedroom.	W 137		
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	W 249		

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W 249		W 249		

Continued From page 7 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, interviews and record reviews, the facility failed to ensure 3 of 3 audit clients (#2, #4, #5) received an active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of following prescribed diets, toothbrushing, communication and sensory stimulation programs. The findings are:

1. Staff did not follow the sensory stimulation program using a weighted backpack for client #4 as described in his IPP.

During observations at the vocational center on 6/4/18 at 1:05pm client #4 returned from a community outing. He was not wearing a weighted backpack when he walked into the vocational center.

During observations at the facility on 6/4/18 from 3:55pm until 6pm, client #4 was not seen with his weighted backpack. None of the 3 direct care staff staff working mentioned the backpack.

During observations at the facility on 6/5/18 from 6am-8:25am, client #4 was not seen with a weighted backpack nor did staff refer to him wearing it. He left the facility with the other clients on the van around 8:25am for the vocational center. He was not wearing the backpack.

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COUNTRY MANOR GROUP HOME	1070 PACKING PLANT ROAD SMITHFIELD, NC 27577

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W 249		W 249		

Continued From page 8

Review on 6/5/18 of client #4's IPP dated 3/23/18 revealed, "He wears a weighted backpack during transitioning and staff use a corn brush for sensory stimulation."

Review on 6/5/18 of client #4's guidelines for his weighted backpack dated 6/24/14 revealed the following:
Use: The weighted backpack will be used during transitions during activities at the vocational center, community activities and van rides. "The backpack will be applied and worn for approximately 30-35 minutes for the best affect. Check to make sure the appropriate books are in the backpack, as they total the correct weight which is approximately 7 pounds." "During community outings, apply it prior to the event, using the van riding time as part of the wearing time needed. Remove the backpack when you arrive at the outing."

Interview on 6/5/18 with direct care staff at the vocational center revealed client #4 sometimes puts the backpack in another classroom because he does not prefer to wear it. Direct care staff was trying to locate it at the vocational center when they were interviewed.

Interview on 6/5/18 with the QIDP revealed this program was developed by the occupational therapist (OT) for any time client #4 transitions from one activity to another and for van rides because he can sometimes become anxious. He confirmed the program is still current.

2. Staff did not consistently implement client #4's communication guidelines.

During observations at the facility on 6/4/18 at

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	34G041	A. BUILDING _____ B. WING _____	06/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR GROUP HOME	1070 PACKING PLANT ROAD SMITHFIELD, NC 27577

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W 249		W 249		
	Continued From page 9 4:55pm, client #4 came to the dining room table while staff and client #2 were in the kitchen completing meal preparation, staff walked by and asked client #4, " It is not time for supper, what do you want?" Client #4 got up from the table and walked away. During observations on 6/5/18, client #4 got up from the living room and was pacing in the facility and humming . He walked back and forth into and out of the dining room. Staff asked him, " What do you want?" He walked out of the dining room and slammed the door. Review on 6/5/18 of client #4's IPP dated 3/23/18 revealed he uses gestures, manual signs and a communication book to communicate with others. Further review of the IPP revealed, " [Client #4] uses a picture book to communicate about activities which he performs part of the day. He uses manual signs, gestures and facial expressions to communicate." Review on 6/5/18 of client #4's functional communication guidelines revealed, "Has worked on a formal goal to use pictures in his communication book . Book should be used when staff are not certain what [client #4's name] is trying to communicate."' Interview on 6/5/18 with the QIDP revealed client #4 has a communication book with signs and pictures that client #4 is familiar with so staff can communicate more effectively with him. The QIDP confirmed direct care staff should integrate these pictures and signs with client #4 as often as possible. 3. Direct care staff did not implement client #2's			

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COUNTRY MANOR GROUP HOME	1070 PACKING PLANT ROAD SMITHFIELD, NC 27577

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W 249		W 249		

Continued From page 10

toothbrushing program using a timer.

During observations on 6/5/18 at 6:53am, after breakfast, direct care staff took client #2 to the bathroom to brush his teeth. Staff assisted him in getting his toothbrush and toothpaste from his grooming basket in his room.

During observations of toothbrushing at 6:55am, client #2 was verbally cued and assisted to brush for 55 seconds. No timer was used.

Review on 6/5/18 of client #2's IPP dated 3/23/18 revealed a formal program for toothbrushing. Further review of the program revealed, "A timer should be set for 2 minutes to ensure he brushes for at least 2 minutes."

Interview on 6/5/18 with the habilitation specialist at the vocational center revealed this program is current and direct care staff should use a timer when client #2 is brushing his teeth.

4. Staff did not implement a communication program for client #2.

Review of client #2's IPP dated 6/15/17 revealed he had completed a communication program on 4/1/18 to make 4-5 word simple word statements and questions following a verbal model with 80% independence.

Review on 6/5/18 of a note dated 4/1/18 by the Speech Pathologist revealed, "Will implement a follow up goal."

Interview on 6/5/18 with the habilitation specialist and the QIDP revealed a formal communication goal had not yet been implemented.

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	34G041	A. BUILDING _____ B. WING _____	06/05/2018

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W 249		W 249		

Continued From page 11

5. Direct care staff did not integrate strengths as identified in client #2's IPP for meal preparation.

Observations on 6/4/18 at 4:43pm revealed client #2 was assigned to work in the kitchen to assist with meal preparation. Staff took frozen chicken, frozen vegetables out of the freezer while client #2 stood nearby ready to assist. After client #2 put chicken on the baking pan, staff added vegetables to the baking sheet. Staff then put the baking sheet into the oven. Staff retrieved a bag of shredded lettuce out of the refrigerator and put it in a bowl. Staff got a bag of fajitas out of the pantry and put them into a bowl. Staff put rice into a pot of boiling water. Staff stirred the rice and then poured the rice into a bowl.

Observations of meal preparation on 6/5/18 at 6:25am revealed staff putting bread onto a baking pan and buttering the bread while client #2 stood nearby ready to assist. Staff took the baking pan and put it in the oven while client #2 stood in the kitchen. Staff took the pan out of the oven using oven mitts. Client #2 went to a drawer, retrieved oven mitts and took the pan over to the sink to rinse it for staff.

During observations at the facility on 6/5/18 at 6:50am, direct care staff emptied the entire dishwasher putting silverware, plates and cups away while client #2 stood nearby in the kitchen.

Review on 6/5/18 of client #2's adaptive behavior inventory (ABI) dated 4/28/16 revealed he can assist with several areas of meal preparation independently. He can specifically bake bread, muffins with assistance. He can prepare combination dishes with assistance. He can wash

W 249		W 249		

Continued From page 12 dishes and store dishes with assistance.

Interview on 6/5/18 with direct care staff revealed client #2 can assist with loading and emptying dishwasher with only verbal cues. Further interview revealed he likes to assist in the kitchen with meal preparation and can assist with preparing meals, making combination dishes, sometimes with only verbal cues.

Interview on 6/5/18 with the QIDP revealed client #2 has many strengths in the area of meal preparation and should be encouraged to assist with preparing meals. Further interview revealed client #2 can assist in preparing combination dishes, put items into the oven and take items out using oven mitts and he can load and empty the dishwasher with verbal cues.

6. Client #5's fluid restriction was not implemented.

During observations throughout the survey on 6/4 - 6/5/18, client #5 drank several glasses of various liquids including water, tea, coffee, diet soda and juice. Throughout this time, staff did not track or document the client's fluid intake.

During an interview on 6/5/18, when asked if client #5 was on a fluid restriction, the staff stated, "Not really".

Review on 6/5/18 of client #5's IPP dated, "...I am on a water restriction and should be observed when I drink liquids. I am allowed to drink as much coffee and drinks as my rights limitation allow." Additional review of the client's physician's orders dated 3/27/18 noted, "2 liter fluid restriction per day."

W 249	Continued From page 13 Interview on 6/5/18 with the QIDP revealed client #5 does have a fluid restriction due to abnormal sodium levels and his fluids should be documented to ensure he does not exceed his fluid limit. Additional interview on 6/5/18 with the facility's nurse revealed she was not sure if a restriction was in place and she would have to research it and consult with the dietitian and physician.	W 249		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) 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. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 3 audit clients (#5) was taught to use his necessary adaptive equipment appropriately. The findings are: Client #5 was not taught to use his eyeglasses appropriately. During observations in the home throughout the survey on 6/4 -6/5/18, client #5 did not wear eyeglasses. The client was not prompted or encouraged to wear eyeglasses.	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G041	A. BUILDING _____ B. WING _____	06/05/2018

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W 436	Continued From page 14 Staff interview on 6/5/18 revealed client #5 had broken his eyeglasses about a month ago and they had been sent to be repaired. Review on 6/5/18 of client #5's individual program plan (IPP) dated 9/26/17 revealed under adaptive equipment noted, "Glasses." The plan indicated, "It is also important that my glasses remain in good shape because I tend to break them when I get upset...Wears glasses to correct vision." Review of the plan noted, "[Client #5] is encouraged to wear his glasses throughout the day...When [Client #5] gets agitated he will break his glasses and throw them in the trash." Further review of the record indicated the client had broken his eye glasses at least three times over the past 13 months. The record did not include training to address client #5's misuse of his eyeglasses. Interview on 6/5/18 with the Qualified Intellectual Disabilities Professional (QIDP) and Behavior Analyst revealed client #5's behavior plan should have strategies to protect the client's eyeglasses when he becomes aggressive or agitated; however, no formal training to teach him how to use his eyeglasses appropriately had been implemented.	W 436		
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure food substitutions and foods actually served were documented. The finding is:	W 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G041	A. BUILDING _____ B. WING _____	06/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR GROUP HOME	1070 PACKING PLANT ROAD SMITHFIELD, NC 27577

(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 481	Continued From page 15 Food substitutions were not documented. Review on 6/5/18 of the breakfast menu revealed the following: Seasonal fruit or juice, cereal of choice, yogurt, wheat toast, beverage of choice or milk. The lunch menu noted the following: Chicken and dumplings, green beans, mandarin oranges, whole wheat bread, beverage of choice. Observations of the breakfast meal on 6/5/18 revealed clients were not offered yogurt and no substitution was provided. Additional observation of the home's refrigerator did not include yogurt. Further observations of food items prepared for the lunch meal revealed baked chicken legs and mixed vegetables had been provided. Review on 6/5/18 on the menu substitution form revealed the last documentation occurred on 4/25/18. During an interview on 6/5/18, the Qualified Intellectual Disabilities Professional (QIDP) confirmed all menu substitutions should be documented on the menu substitution form.	W 481		

COUNTY MANOR GROUP HOME
PLAN OF CORRECTIONS
FOR
Recertification Survey Conducted on June 4-5, 2018

E 032 Primary/Alternate Means for Communication

QMRP will confer with the Unit Safety Committee to update the Emergency Preparedness Plan to include alternate means of communicating (during power failure) with facility staff, federal, state, regional, and local emergency management agencies.

QMRP will provide emergency preparedness training to all staff. A yearly Clinical Agreement will be used to document dates and times of training.

QMRP will monitor Clinical Agreements on a yearly basis. If any errors are found, make – up drills will be ran to ensure yearly requirement is met.

Completion Date: August 3, 2018

E 037 Training Program

QMRP and Unit Safety Committee to ensure program staff are trained on pertinent aspects of the Emergency Preparedness Plan to provide specific details regarding the plan and/ or be able to locate the information upon request.

QMRP will provide emergency preparedness training to all staff. A yearly Clinical Agreement will be used to document dates and times of training.

QMRP will monitor Clinical Agreements on a yearly basis. If any errors are found, make – up drills will be ran to ensure yearly requirement is met.

Completion Date: August 3, 2018

W137 PROTECTION OF CLIENT RIGHTS

QMRP will review all individuals IPP's and Behavior Support Plans to ensure it reflects how staff will assist individuals' in protecting their rights. Staff that work with individuals in the home will receive training on their BSP's and IPP's specifically in the area of the right to retain and use appropriate personal possessions.

Client #5 ABI, IPP, and BSP will be updated accordingly and inserviced to staff trained to assist him.

Monitoring will be through Monthly Interaction Assessments. Assessments are completed by QMRP, Hab. Spec., Home Supervisor, OT/PT Hab. Assistant and/or Behavior Specialist. Staff will receive immediate feedback/correction on assessment results.

Completion Date: August 3, 2018

W249 PROGRAM IMPLEMENTATION

All IPPs will be reviewed by the QMRP for the level of support needed in all domains. Staff will be in-serviced on the needs and strengths of all clients. IPPs will be implemented as written.

1. Client # 4 Sensory backpacked will be evaluated by the OT/Team to see if backpack use remains effective.
2. Client # 4 Communication guidelines will be re-inservice by Habilitations Specialist.
3. Client #2 formal toothbrushing goal will be re-inserviced by Habilitation Specialist to encourage brushing for 2 minutes.
4. Client # 2 formal communication program will be implemented by SLP and in-serviced by Habilitation Specialist.
5. Staff will be trained by Habilitation Specialist on Client #6 skills during meal preparation and encourage full participation.
6. Client # 6 will have his labs/diet reviewed by Dietician and recommendations reviewed and inserviced by OT/PT Habilitation Assistant.

Monitoring to be accomplished at least three times per month using formal program assessments and direct observations Mealtime/assessments by QMRP, Habilitation Specialist, Home Supervisor, and OT/PT Assistant. Assessments and results of observations will be reviewed during monthly Core Team and house meetings.

Completion Date: August 3, 2018

W436 SPACE AND EQUIPMENT

QMRP and/or Habilitation Specialist to review all individual's current Adaptive Equipment in the home.

Habilitation Specialist will implement a formal goal to assist Client # 5 to protect his glasses.

Monitoring to be accomplished using a formal program, direct observations /assessments by QMRP, Habilitation Specialist, Home Supervisor. Assessments and results of observations will be reviewed during monthly Core Team and house meetings.

Completion Date: August 3, 2018

W481 MENUS

QMRP/ Home Supervisor will in-service all staff on menu substitution for all diets, including the therapeutic diets. Meal preparation sheets will be completed on a daily basis.

Monitoring to be accomplished at least three times per month using formal program assessments and direct observations Mealtime/assessments by QMRP, Habilitation Specialist, Home Supervisor, and OT/PT Assistant. Assessments and results of observations will be reviewed during monthly Core Team and house meetings.
Completion Date: August 3, 2018

RHA
HEALTH SERVICES, INC.

DHSR - Mental Health

JUN 19 2018

Lic. & Cert. Section

June 15, 2018

Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Dear Mrs. Wilma Worsley-Diggs,

Enclosed is the plan of correction for the deficiencies cited during the June 4-5, 2018 Recertification survey for the Country Manor Group Home. Please contact Fred Nelson or myself at (919)894-5124 if you have questions or need additional information. We look forward to your return visits.

Respectfully,

Vincent Pressley MS/QP
Clinical Supervisor
RHA Health Services, Inc.