STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G187	A. BUILDING _____ B. WING _____	06/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-NASH HOUSE II	3505 HAWTHORNE RD ROCKY MOUNT, NC 27803

(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 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, policy review and interviews, the facility failed to ensure staff were sufficiently trained regarding the use of latex gloves. The finding is: Staff were not sufficiently trained regarding the use of latex gloves. During morning observations in the home on 6/26/18 from 6:45am - 7:03am, a staff person was observed wearing latex gloves while exiting the bedroom of a client. The staff person then propelled the clients' wheelchair down the hallway, touched a pitcher, poured the client a drink, obtained a pen to write a note and walked through the house wearing the gloves. Further observations revealed the staff putting on another pair of gloves and wearing them from 7:03am until 7:17am, again while walking around the house. During an interview on 6/26/18, staff revealed gloves should be worn when bathing clients, assisting with toothbrushing, assisting with the clients' laundry or coming in contact with bodily fluids. The staff further revealed gloves do not need to be worn when pushing a wheelchair, pouring drinks or writing a note. Review on 6/26/18 of the facility's glove use	W 189		

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

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W 189	Continued From page 1 policy revised 2011 stated, "...2. Gloves are not used for routine work when contact with body fluids is not likely, such as...pushing someone in a wheelchair or a similar task...." During an interview on 6/26/18, the qualified intellectual disabilities professional (QIDP) indicated the facility's policy does not state if gloves should be used or not used for propelling a clients' wheelchair.	W 189		
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 a pattern of interactions between staff and clients supported the implementation of the Person Centered Plan (PCP) in the areas of self-help/domestic skills, choice making skills and adaptive equipment use. This affected 3 of 3 audit clients (#1, #2, #5). The findings are: 1. Client #5's wheelchair foot rests were not used as indicated. During morning observations in the home on	W 249		

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W 249	Continued From page 2	W 249		

6/26/18 from 6:50am - 9:00am, client #5 was positioned in her wheelchair. The wheelchair did not have foot rests attached to it. During this time, the client's foot rests were noted in her bedroom. At 8:57am, as client #5 was taken to her bedroom to prepare for toothbrushing, her left foot dragged along the floor while being pushed down the hallway.

Staff interview on 6/26/18 revealed client #5 should have her foot rests attached to her wheelchair while in the home; however, they are removed when she is positioned at the dining table for meals. The staff also indicated the client should have her foot rests attached to her chair during outings.

Review on 6/25/18 of client #5's PCP revealed she requires staff to move her wheelchair from place to place. Additional review of the client's Physical Therapy (PT) evaluation dated 5/18/18 revealed recommendations to "Continue to encourage [Client #5] to sit upright in wheelchair using pillows at her sides, with BLE's elevated on the leg rests..."

Interview on 6/26/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #5 does not utilize her foot rests when positioned at the table during meals but they should be attached to her wheelchair at other times in the home and on community outings.

2. Client #5 was not prompted or encouraged to clear her dirty dishes after dinner.

During observations in the home on 6/25/18 at 6:40pm, staff cleared client #5's dirty dishes for her without prompting or assisting her to

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W 249	Continued From page 3	W 249		

complete this task.

Staff interview on 6/26/18 revealed client #5 can assist with clearing her spoon but not other items after meals because it is difficult for her to reach the tall utility cart used for clearing items from the table. The staff noted, "We try to let her be as independent as she can."

Review of client #5's PCP dated 5/29/18 revealed, "Her strength at mealtimes includes her willingness to be as independent as possible during her meals." Additional review of a habilitation evaluation dated 5/17/18 noted she requires manipulation to put away utensils, dishes, and rubbish appropriately.

Interview on 6/26/18 with the QIDP indicated client #5 can "somewhat" clear her dishes after meals. The QIDP acknowledged client #5 may have certain physical limitations which could require a different way of clearing her place that did not involve the use of a utility cart.

3. Client #1 was not prompted to utilize her knife.

During dinner observations in the home on 6/25/18, client #1 was not prompted to utilize her knife during dinner. Client #3 was observed picking up a whole slice of pork loin and biting it on eight separate occasions. Further observations revealed there was a knife at client #3's place setting. Additional observations revealed a staff person was sitting next to client #3 during her entire meal. At no time was client #3 prompted to utilize her knife.

During an interview on 6/25/18, the staff reported client #3 can utilize her knife "a little" when it

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W 249	Continued From page 4 comes to cutting her food. Review on 6/26/18 of client #3's habilitation technician evaluation dated 10/3/17 revealed she can independently utilize a knife to cut her food. During an interview on 6/26/18, the QIDP confirmed client #3 should have been prompted to cut her food with a knife. 4. Client #2 was not afforded choice making at her meal. During dinner observations in the home on 6/25/18, client #2 made four attempts to begin eating. Further observations revealed while client #2 had her spoon in her hand and began eating, staff physically removed the spoon from her hand and placed it down on the table, each time. Staff was heard telling client #2, "Wait until you get all of your food." During an interview on 6/25/18, the staff revealed client #2's spoon should not have been physically removed from her hand. Further interview revealed client #2 should have been allowed to eat, even though she did not have all of the meal on her plate. Review on 6/26/18 of client #2's PCP dated 2/27/18 stated, "...she will push activities away, or throws items in front of her....", if she is not interested. During an interview on 6/26/18, the QIDP revealed picking up her spoon was an indication client #2 was ready to eat.	W 249		
W 376	DRUG ADMINISTRATION	W 376		

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W 376	Continued From page 5 CFR(s): 483.460(k)(8) The system for drug administration must assure that drug administration errors and adverse drug reactions are reported immediately to a physician. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure drug administration errors were reported immediately to a physician. This affected three clients (#2, #3, #5) residing in the home. The findings are: All drug errors were not reported to a physician. Review on 6/26/18 of facility's medication error reports from October '18 - April '18 revealed the following errors: 11/19/17 - Client #5's 8am dose of Aspirin was missed. 12/3/17 - Client #2's Docusate Calcium was not punched from the blister pack. 12/10/17 - Client #3's Synthroid was "one pill off". 1/20/18 - Client #5 had not been given her 4pm dose of Baclofen and Zanaflex. Additional review of the reports and nurses's notes did not indicate a physician had been notified regarding these errors. Interview on 6/26/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the nurse usually notifies the physician regarding medication errors and then documents this	W 376		

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W 376	Continued From page 6 notification on the medication error form or in a nurse's note.	W 376		