PRINTED: 06/25/2018
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
	34G061	A. BLDG. _____ B. WING _____	06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGIA COURT	107 MISS GEORGIA COURT CARY, NC 27511

(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 reviews and interviews, the facility failed to ensure 1 of 4 audit clients (#1) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of adaptive equipment use. The finding is: Client #1's adaptive clothing protector was not used as indicated. During lunch observations on 6/19/18 at the day program, client #1 consumed his meal without clothing protector. Spillage was noted on client clothing. During dinner observations on 6/19/18 at the home, client #1 consumed his meal without clothing protector. Spillage was noted on client clothing. Review on 6/20/18 of client #1's IPP dated 3/8/18 revealed, "Adaptive equipment:...clothing protector."	W 249	This deficiency will be corrected by the following actions: A. Clinical Supervisor will in-service and train staff at the group home and Wake Enterprises regarding proper program implementation. This training will include, but not be limited to adaptive equipment and its usage and overall active treatment when opportunities present themselves. This training will also address program documentation. B. Clinical Supervisor will monitor monthly. C. Home Supervisor will monitor bi-weekly RECEIVED JUN 29 2018 DHSR-MH Licensure Sect	8/20/18

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

Dave Mabe | Operations Manager | 6/28/18

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.

PRINTED: 06/25/2018
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
	34G061	A. BLDG. _____ B. WING _____	06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GEORGIA COURT	CODE 107 MISS GEORGIA COURT CARY, NC 27511

(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	Continued From page 1 Interview on 6/20/18 with the QIDP revealed client #1 should use a clothing protector as indicated in the IPP. PHYSICIAN SERVICES CFR(s): 483.460(a)(3)	W 249	See Page 1	8/20/18
W 322	The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 4 audit clients (#5) received a complete annual physical examination. The finding is: Client #5 did not have a complete physical. Review on 6/20/18 of client #5's physical assessment dated 2/19/19 revealed "genitals: will not allow." During an interview on 6/20/18, the qualified intellectual disabilities professional (QIDP) confirmed the genitals were not assessed as indicated by the physician. Further interview revealed he did not know exactly when client #5's genitals will be assessed.	W 322	This deficiency will be corrected by the following actions: A. RN will ensure that all consumers obtain preventive and general care as ordered by physician. B. Home Supervisor will set up appointment to maintain preventive general health care. C. RN/Clinical Supervisor will monitor monthly at core team.	8/20/18
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	W 324	See page 3	8/20/18

PRINTED: 06/25/2018
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
	34G061	A. BUILDING _____ B. WING _____	06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGIA COURT	107 MISS GEORGIA COURT CARY, NC 27511

(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 324	Continued From page 2 Diseases of the American Academy of Pediatrics. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure immunization records for 1 audit client (#5) had been obtained. The finding is: Clients #5's records did not include his past immunization history. Review on 6/20/18 of client #5's record revealed he had been admitted to the facility on 6/19/17. Additional review of the record indicated the client had received annual influenza on 10/23/17, tuberculin testing on 6/14/17 and Tetanus on 2/22/17; however, no history of other past immunizations was located. During an interview on 6/20/18, the qualified intellectual disabilities professional (QIDP) confirmed client #5's immunization history was not current.	W 324	This deficiency will be corrected by the following actions: A. In consultation with the Guardians CANC will ensure all immunizations required by ICF/Medicaid regulations are obtained. CANC will work with guardians to retrieve and/or obtain past immunization history. If unable to accomplish, CANC will consider discharging any individual unwilling to comply with ICF/Medicaid regulations. If needed, discharge will be done so according to CANC policy. B. In consultation with guardians, RN/Home Supervisor will set up appointments to begin obtaining missing historical Immunizations. C. RN/Residential Manager/Clinical Supervisor will monitor immunization records monthly	8/20/18
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to ensure all drugs and biologicals remained locked until the point of preparation and administration. This affected all the clients residing in the home. The findings are:	W 382	This deficiency will be corrected by the following actions: A. Clinical Supervisor and/or Home Supervisor will in-service direct care staff on the appropriate protocol concerning medication administration, drug storage and record keeping. B. Home Supervisor will monitor medication administration weekly. C. Clinical Supervisor will monitor medication administration, drug storage and record keeping bi-monthly.	8/20/18

PRINTED: 06/25/2018
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
	34G061	A. BLDG. _____ B. WING _____	06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGIA COURT	107 MISS GEORGIA COURT CARY, NC 27511

(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 382	Continued From page 3 The computer room was unlocked and left unsupervised while there was medication in bin on the table. During observations in the home on 6/20/18 at approximately 6:20 am to 6:32 am, the medication in a bin in the computer room was unsupervised on 3 separate occasions. This allowed anyone to gain access to the area. The staff had retrieved medication bins on the 3 separate occasions from medication room, then left the computer room unsupervised. During an interview on 6/20/18, the staff revealed the medication bin should have been returned to medication room. During an interview on 6/5/17, the qualified intellectual disabilities professional (QUID) revealed the medication should remain locked until the point of preparation and administration	W 382	See page 3	8/20/18
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure a sanitary environment was provided to avoid transmission of infections and prevent possible cross-contamination. This potentially affected all clients residing in the home. The finding is: Precautions were not taken to promote client/staff	W 454	This deficiency will be corrected by the following actions: D. Home Supervisor will review, train, and in-service staff on OSHA guidelines and safety precautions to avoid cross-contamination. E. Home Supervisor will monitor for OSHA and safety precautions weekly. F. Clinical Supervisor will monitor for OSHA and safety precautions bi-monthly.	8/20/18

PRINTED: 06/25/2018
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
	34G061	A. BLDG. _____ B. WING _____	06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEORGIA COURT	107 MISS GEORGIA COURT CARY, NC 27511

(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 454	Continued From page 4 health/safety and prevent possible cross-contamination. During observations in the home on 6/20/18 at approximately 7:30 am, client #1 was not wearing gloves when he obtained the trash in a bag from the staff at the back door. while outside, the staff opened the trash barrel as the client dumped the trash bag. Further observation revealed the staff went back to the house obtained a mop in a bucket, went to the tap opened the water. The staff used a cooking pot to fill the bucket on the floor with water. The staff then put the cooking pot in a pile of the clean dishes. At no time did client #1 or the staff wash their hands. During an interview on 6/20/18, the staff revealed client #1 and the staff should have washed their hands before proceeding to another activity. During an interview on 6/20/18, the qualified intellectual disabilities professional (QIDP) revealed client #1 and the staff should have washed hands after handling the trash.	W 454	See page 4	6/20/18