STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G018	A. BUILDING _____ B. WING _____	07/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGDALE LANE GROUP HOME	934 SPRINGDALE LANE GASTONIA, NC 28052

(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 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 record review and interview, the facility failed to ensure 1 of 3 sampled clients (#1) and 1 non-sampled client (#2) were provided the right to retain personal possessions relative to electronics. The finding is: A. The facility failed to assure client #1 was assured the right to a personal possession relative to electronics. For example: Review of records for client #1 on 7/17/18 revealed an individual support plan (ISP) dated 10/25/17. Review of the ISP revealed a communication objective that included the use of a "Kindle". Review of the communication objective dated 11/1/17 revealed client #1 will follow a picture symbol schedule when given 4 or less verbal prompts, 100% of the time for 6 consecutive months. Additional review of the communication objective methodology revealed throughout the day staff will set up the client's schedule with 3 picture cues. At each transition client #1 will take the picture off and put it in the box, then complete the task. The methodology further referenced the use of a kindle device to address leisure time in client #1's daily schedule. Interview with the qualified intellectual disabilities professional (QIDP) revealed client #1 has a personal Kindle device that is kept in the group	W 137		

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

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W 137	Continued From page 1	W 137		

home office. The QIDP further indicated the group home office is always kept open however client's do need to ask for assistance in going into the office to obtain any items. Further interview with the QIDP revealed client #1's electronic device is kept in the office to charge the device and to keep other client's from entering the client's room and taking it. Subsequent interview with the QIDP verified the client's electronic device could be charged from the client's room and there has been no history of the item being taken by another client.

B. The facility failed to assure client #2 was assured the right to a personal possession relative to electronics. For example:

Observation in the group home on 7/17/18 revealed the QIDP to pull out a electronic tablet device, belonging to client #2, from a desk in the group home office while attempting to locate an electronic device for another client.

Review of records for client #2 on 7/17/18 revealed an ISP dated 5/18/18. Review of the ISP revealed a living skills objective that client #2 will complete the steps necessary to use his IPAD to open and participate in reading programs or a hard copy book with moderate assistance or gather materials necessary to read a hard cover book, 75% of the time for 3 consecutive months.

Interview with the QIDP revealed client #2's personal IPAD is kept in the office of the group home to charge the device and to keep other client's from entering the client's room and taking it. The QIDP further indicated the group home office is always kept open however clients do need to ask for assistance in going into the office

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	34G018	A. BUILDING _____ B. WING _____	07/17/2018

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W 137	Continued From page 2 to obtain any items. Subsequent interview with the QIDP verified the client's electronic device could be charged from the client's room and there has been no history of the item being taken by another client.	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 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 observation, record review and staff interview, the team failed to assure sufficient interventions to address the communication needs for 2 of 3 sampled clients (#1 and #5). The finding is: A. The team failed to assure sufficient interventions to address the communication needs for client #1. For example: Observations in the group home on 7/17/18 of client #1 revealed the client to be mostly non-verbal and staff prompting him using physical prompting and verbalizations. Staff was observed supporting client #1 with transitions of his morning routine to include going to the bathroom, hand washing, brushing his teeth, breakfast prep, eating breakfast, medication	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 249	Continued From page 3	W 249		

administration and going for a walk with physical and verbal gestures only. It should be noted there were no observations of client #1 in the group home on 7/16/17 due to a community outing the client participated in with staff.

Review of records for client #1 on 7/17/18 revealed an individual support plan (ISP) dated 10/25/17. Review of the ISP revealed a communication objective implemented 11/1/17. Review of the communication objective revealed client #1 will follow a picture symbol schedule when given 4 or less verbal prompts, 100% of the time for 6 consecutive months. Additional review of the communication objective methodology revealed throughout the day staff will set up the client's schedule with 3 picture cues. At each transition client #1 will take the picture off and put it in the box, then complete the task. The methodology further referenced the use of a kindle device to address leisure time in client #1's daily schedule.

Interview with the qualified intellectual disabilities professional (QIDP) on 7/17/18 verified client #1's communication objective was a current objective and should have been implemented as written in the ISP. Further interview with the QIDP confirmed there was no communication board in the group home for the client although she did not know why.

B. The team failed to assure sufficient interventions to address the communication needs for client #5. For example:

Observations in the group home on 7/16-17/2018 of client #5 revealed the client to be mostly non-verbal. Staff was observed prompting

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W 249	Continued From page 4 the client using physical prompting and verbalizations. Staff was further observed supporting client #5 with various transitions throughout the survey to include going to the med room, participating in leisure activities, going to the bathroom, hand washing, setting the table, meal participation, showering and going for a walk with physical and verbal gestures with the exception of a picture cue used for medication administration on 7/17 only. Review of records for client #5 on 7/17/18 revealed an ISP dated 9/20/17. Review of the ISP revealed a communication evaluation dated 10/8/17 to identify client #5 to have poor socialization skills, and conversation skills to be almost non-existent. Further review of the communication evaluation revealed receptive visual support in the form of schedules, calendars, and task sequence should be used to increase the client's understanding and develop her independence. Interview with the group home manager (HM) on 7/17/18 revealed client #5 has picture cues that should be used for all transitions of the client to support communication deficits. Further interview with the facility HM revealed client #5 will gather the picture cues at times and lose them causing the need for new cards currently to be made. Interview with the QIDP verified client #5 should have been supported with transitions with picture cues as indicated in the current communication assessment.	W 249		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure	W 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G018	A. BUILDING _____ B. WING _____	07/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 371	Continued From page 5	W 371		

that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.

This STANDARD is not met as evidenced by:
Based on observations, record review and interviews, the system for drug administration failed to assure 2 of 2 clients (#1 and #5) observed during the medication pass were provided the opportunity to participate in medication self-administration or provided teaching related to name, purpose and side effects of medications administered. The findings are:

A. The system for drug administration failed to assure client #5 was provided teaching related to the name, purpose or possible side effects of medications received, or the opportunity to participate in the administration of medication received. For example:

Observations in the group home on 7/16/18 at 4:20 PM revealed client #5 to be verbally directed to the medication administration area for administration of afternoon medications. Client #5 was observed to walk to the medication administration closet and stand near staff while staff accessed all medications, punched all medications into a paper cup and handed the cup to the client with no education relative to name, purpose or side effects. The client was further observed to take all medications with a cup of water poured by staff and exit the medication area. Observation on 7/17/18 at 8:08 AM revealed staff to verbally and with the use of a

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W 371	Continued From page 6	W 371		

picture cue, direct client #5 to the medication closet for administration of morning medications. Continued observation revealed staff to access all medications and punch all medications into a paper cup while providing education to the client relative to name and purpose of medications.

Review of records for client #5 on 7/17/18 revealed a medication self administration assessment dated 6/6/18. Review of the medication self administration assessment revealed client #5 to be inconsistent with dexterity to punch out medication from the medication card. Additional review revealed client #5 to have the ability to get medication from the medication card to the medication cup.

Interview with medication administration staff on 7/16/18 revealed she only provides education to client #5 relative to medications if the client has had a change in medications such getting a new medication. Interview with the facility nurse on 7/17/18 revealed client #5 should be provided with education relative to name, purpose and side effects with the administration of all medications. Further interview with nursing revealed client #5 should have been provided the opportunity to hand over hand assist with participating in the administration of all medications.

B. The system for drug administration failed to assure client #1 was provided teaching related to the name, purpose or possible side effects of medications received or the opportunity to participate in the administration of medication received. For example:

Observation on 7/17/18 at 8:15 AM revealed staff to verbally direct client #1 to the medication closet

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W 371	Continued From page 7 for administration of morning medications. Continued observation revealed staff to access all medications and punch all medications into a paper cup while providing education to the client relative to name and purpose of medications. The client was observed to take all medications with water and exit the medication area. Review of records for client #1 on 7/17/18 revealed a medication self administration assessment dated 6/6/18. Review of the medication self administration assessment revealed client #1 to have the ability with assistance to punch out medication from the medication card. Interview with nursing on 7/17/18 revealed client #1 should have been provided the opportunity to hand over hand assist with participating in the administration of all medications.	W 371		