STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G137	A. BUILDING _____ B. WING _____	07/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERLYN	6113 BLUE LANTERN ROAD GIBSONVILLE, NC 27249

(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 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop specific facility-based strategies as part of their emergency plan (EP) relative to specific client information. The finding is: Review of the facility's EP on 7/30/18 revealed a risk assessment, identified risks/hazards, and	E 006		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G137	A. BUILDING _____ B. WING _____	07/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERLYN	6113 BLUE LANTERN ROAD GIBSONVILLE, NC 27249

(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 006	Continued From page 1 community-based strategies. However, further review of the EP, substantiated by interview with the facility administrator, revealed the EP did not contain client specific information, which would be important to assist anyone unfamiliar with the clients. Review of the records on 7/30/18 and 7/31/18 revealed 3 of 6 clients to be mostly non-verbal with resulting communication needs. All clients had behavior support plans or guidelines. One client had a specific diet consistency and diet allergies. All residents were observed to receive medications. Therefore, the EP did not contain specific client information, necessary for the care of clients by personnel not familiar with the clients.	E 006		
W 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations and interview, the specially constituted committee, designated as the Human Rights Committee (HRC), failed to ensure privacy by failing to assure written, informed consents were obtained for the use of video monitoring cameras located in common areas of the group home for 6 of 6 clients residing in the home. The finding is: Observations in the group home on 7/30/18 and 7/31/18 revealed five video cameras located on the ceiling of the kitchen, living room, dining room and at the end of the hallway connected to the	W 129		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G137	A. BUILDING _____ B. WING _____	07/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERLYN	6113 BLUE LANTERN ROAD GIBSONVILLE, NC 27249

(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 129	Continued From page 2 kitchen. These cameras allowed for the viewing of all common areas in the home. Review of client records on 7/31/18 did not reveal any evidence of informed consent by guardians or review for the use of the cameras by the HRC. Interview with the qualified intellectual disabilities professional (QIDP) on 7/31/18 revealed the cameras were used to monitor staff. The QIDP confirmed the HRC had not reviewed the use of the cameras, and guardian consent for the use of the cameras had not been obtained for all six clients residing in the home, therefore failing to ensure personal privacy for all clients in the home.	W 129		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: The facility's system for ensuring drugs were administered in compliance with physician's orders failed for 1 of 4 sampled clients (#4) observed as evidenced by observations, interview and review of records. The finding is: Observations in the group home of the medication administration on 7/30/18 at 4:25 PM revealed client #4 received a Latuda 20 mg tablet without food and an Amantadine HCL 100 mg tablet. Interview with staff administering the medications revealed client #4 was about ready to eat his dinner and this is why he did not administer food along with the Latuda tablet to	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G137	A. BUILDING _____ B. WING _____	07/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERLYN	6113 BLUE LANTERN ROAD GIBSONVILLE, NC 27249

(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 368	Continued From page 3 client #4. Continued observations revealed client #5 ate his dinner meal at 5:10 PM. Review of the physician's orders dated 7/1/18 to 7/31/18 revealed client #4 is to receive a Latuda 200 mg tablet by mouth with food twice daily. Continued review of the 7/1/18 to 7/31/18 physician's orders and verified by the qualified intellectual disabilities professional (QIDP) revealed Latuda 20 mg is to be administered with food as ordered.	W 368		
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure each place setting, during the dinner meal included appropriate eating utensils for 1 of 6 clients in the home (#5). The finding is: Observations on 7/30/18 at 5:05 PM, revealed all six clients in the home seated at the dining table preparing to eat the dinner meal consisting of beef mac, turnip greens, cornbread and fruit. All clients were observed to have a fork, spoon and knife as a part of the place setting, except for client #5 who had only a knife. At 5:11 PM staff were observed providing client #5 with a spoon, at which time the client asked for a fork. Continued observations throughout the dinner meal revealed client #5 eating all food items with a spoon. Interview with the qualified intellectual disabilities	W 475		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G137	A. BUILDING _____ B. WING _____	07/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERLYN	6113 BLUE LANTERN ROAD GIBSONVILLE, NC 27249

(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 475	Continued From page 4 professional on 7/30/18, confirmed a fork was not available for client #5. Interview with the home manager on 7/31/18 revealed that a fork, or forks were likely thrown away by clients following previous meals while emptying plates into the trash can.	W 475		