STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G107	A. BUILDING _____ B. WING _____	07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEK ROAD GROUP HOME	138 MEEK ROAD GASTONIA, NC 28056

(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 revealed the EP to contain a thorough risk assessment and	E 006	The QIDP and HM for the Meek Rd Home will review the Meek Rd All Hazards Risk plan to assure Facility based and community based risk assessments utilizing an all hazard approach, including missing residents. Also each person will have an emergency face sheet that includes behavior needs for each person living at Meek Rd. The All Hazard plan will be reviewed for each person specific needs by the QIDP at least annually.	9/3/2018

DHSR NH L & C Black Mountain WRO Received JUL 30 2018 by: SKH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jonda J. Stillwell — TITLE: Assistant Director — (X6) DATE: 7/20/18

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 006	Continued From page 1 community-based strategies. However, further review of the EP, substantiated by interview with the qualified intellectual disabilities professional QIDP), revealed the individual client information was limited to general information contained on a face sheet. Continued review of the client information sheet, verified by interviews with the QIDP, revealed the information sheet did not include client specific behavioral needs for the clients residing in the group home to assist anyone unfamiliar with the residents working with them in an emergency situation.	E 006		
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 interview, the facility failed to assure 2 of 3 sampled clients (#4 and #5) received interventions in sufficient number and frequency to support the achievement of objectives prescribed in their Individual Program Plans (IPPs) to use a knife for cutting food. The findings are: A. The facility failed to assure sufficient interventions were provided to support a dining	W 249	The IDT for the Meek Road Group Home will assure that as soon as an IPP for a person has been formulated, each person will 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 IPP. Specifically, all persons' dining goals will be reviewed by the QIDP to assure full and adequate implementation. Person's #4 &#5's programs will be re-taught to all staff to assure competency of each staff ability to implement their dining goals. The HM and QIDP will observe at least bi-monthly, meal-time routines to assure compliance.	9/3/2018

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W 249	Continued From page 2 program for client #5 related to cutting his food. Observations conducted on 7/2/18 during the evening meal revealed client #5 was assisted by staff to serve himself candied yams, California blend vegetables, a slice of whole wheat bread, a ham steak, sliced peaches and beverages. Continued observations during the evening meal revealed client #5 used a fork to spear the ham steak, which he was then observed to eat by taking large bites around the edges while continuing to hold it on his fork. Staff was not observed to intervene or prompt client #5 to use his knife to cut the ham steak. Review of the record for client #5, conducted on 7/3/18, revealed an IPP dated 6/9/18 which contained a program objective implemented on 3/1/16 for client #5 to use a regular knife to cut his food using partial physical assistance. Interview conducted on 7/3/18 with the qualified intellectual disabilities professional (QIDP) verified client #5 has a program objective to use a knife to cut his food. This interview further verified staff should have prompted and assisted client #5 to use a knife to cut his ham steak during the evening meal on 7/2/18. B. The facility failed to assure sufficient interventions were provided to support a dining program for client #4 related to cutting food. Observations conducted on 7/2/18 during the evening meal revealed client #5 was assisted by staff to serve self candied yams, California blend vegetables, a slice of whole wheat bread, a ham steak, sliced peaches and beverages. Continued observations during the evening meal revealed	W 249		

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W 249	Continued From page 3 client #4 to attempt to cut the ham but was unable to do so. The client was then observed to pull the ham apart with her fingers and the eat the ham. Staff was not observed to assist or prompt client #4 to use her knife to cut the ham steak or to not eat with her fingers.. Review of the record for client #4, conducted on 7/3/18, revealed an IPP dated 10/27/17 which contained a program objective implemented on 10/27/17 for client #4 to use a regular knife to cut food using 3 partial physical assistance prompts. Interview conducted on 7/3/18 with the QIDP verified client #4 has a program objective to use a knife to cut food. This interview further verified staff should have prompted and assisted the client to use a knife to cut her ham steak during the evening meal on 7/2/18 and prompted not to use her fingers.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: The specially constituted committee, designated as the (HRC), failed to ensure a medication to control inappropriate behaviors was used only with written informed consent by the guardian for 1 of 3 sampled clients (#4) as evidenced by interview and review of records. The finding is: Review of client #4's records revealed physician's	W 263	The Interdisciplinary Team for the Meek Road Group Home will assure for program monitoring and change that the specially constituted committee (Human Rights Cmt) will insure that the positive behavior support programs, including, medications for assisting in behavior support, are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Specifically, the QIDP will obtain the written consent that followed the verbal consent given for person #4's Ativan. Also, all person's residing at Meek will have their records reviewed to assure there is written consent for all medications as approved by the HRC. The QIDP is responsible for obtaining consent for all medications as they are ordered. The QIDP will assure a monthly check of all consents per record and document the review to avoid any future occurrence.	9/3/2018

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W 263	Continued From page 4 orders dated 6/13/18. Review of these physician's orders, verified by interviews with the qualified intellectual disability professional (QIDP) and the nurse, revealed the client was prescribed Ativan 0.5 mg. one tablet po q 6 hrs. for extreme agitation. Continued interviews with the QIDP and the nurse revealed the Ativan was to be given be given only as a PRN medication. Continued review of the records revealed a medication administration record (MAR) for 6/18. Review of this MAR, verified by interviews with the QIDP and the nurse, revealed Ativan had been administered to client #4 on 6/18/18 at 4:52 PM. Additional review of the records revealed no written informed consent for the use of Ativan to assist in the control of agitation for client #4. Interviews with the QIDP and nurse substantiated no written informed consent by the guardian for the use of Ativan was available in the record for review.	W 263		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to assure a technique used to manage inappropriate behavior was not used as a substitute for an active treatment program for 1 of 3 sampled clients (#5). The	W 288	PERSON #5'S HAIRBRUSH HAS BEEN RETURNED TO HIS PERSONAL BASKET IN HIS ROOM. This item should have not been taken away or locked away from him. The IDT for the Meek Rd Group Home, specifically the QIDP and Lead QIDP, are completing an investigation regarding when and who made the wrong decision to place his hair-brush in the closet. HOWEVER, if by some chance their is a need to restrict anyone from their personal belongings, a through analysis will occur, along with Human Rights consent and guardian consent. The QIDP and HM are responsible for checking the locked medication closet and the locked other biologicals closet (cleaning supplies) weekly to assure there are no personal items for any person living at Meek Road being kept away from them. This will be documented at least monthly by the QIDP.	9/3/2018

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W 288	Continued From page 5 finding is: Observations conducted on 7/3/18 at 7:10 AM revealed client #5 was prompted by staff to enter the medication administration area where he was assisted to take the following medications: Ativan 1 mg., Acidophilus 1 cap, Albuterol sulfate 2 mg., enteric coated Aspirin 81 mg., Celexa 20 mg., Allegra 180 mg., KDur 20 meq., Seroquel 300 mg., Snoot S-two tablets, Calcium 500+D, Miralax powder 17 grams, Metamucil 1 tsp., Flunisolide nasal spray-two sprays each nostril and Theraderm lotion to hands and face. Continued observations on 7/3/18 at 7:20 AM revealed staff retrieved a hairbrush from a plastic bin located in the medication administration closet and used it to brush client #5's hair. Staff was further observed to place the hairbrush back in the plastic bin and lock the door to the medication closet. Review of the record for client #5, conducted on 7/3/18, revealed an Individual Program Plan (IPP) dated 6/9/18 which included a behavior support plan (BSP) dated 6/23/17. Continued review of the 6/23/17 BSP revealed identified target behaviors included screaming, obsessing, hitting others and confusion. Further review of the BSP revealed no documentation related to the restriction of client #5's access to his hairbrush by locking it in the medication closet. Interview conducted on 7/3/18 with the staff administering medications verified client #5's hairbrush was currently being kept locked in the medication closet to prevent client #5 from hitting himself on the head with it. Interview conducted on 7/3/18 with the qualified intellectual disabilities	W 288		

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W 288	Continued From page 6 professional revealed client #5's behavior of hitting himself on the head with his hair brush was not known to her, nor was the restriction of locking his hairbrush in the medication administration closet. This interview further verified the restriction of client #5's access to his hairbrush was not included in his current IPP.	W 288		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: The team failed to ensure medications used to control inappropriate behaviors was used only as an integral part of the individual program plan (IPP) for directed specifically towards the reduction of and eventual elimination of the behavior for which it is employed for 1 of 3 sampled clients (#4) as evidenced by interview and review of records. The finding is: Review of client #4's records revealed physician's orders dated 6/13/18. Review of these physician's orders, verified by interviews with the qualified intellectual disability professional (QIDP) and the nurse, revealed the client was prescribed Ativan 0.5 mg. one tablet po q 6 hrs. for extreme agitation. Continued interviews with the QIDP and the nurse revealed the Ativan was to be given be given only as a PRN medications.	W 312	The IDT for the Meek Road Group Home will assure all drugs used for control of inappropriate behavior must be used only as an integral part of the person's IPP that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Specifically, all persons BSP and medication usage will be reviewed by the QIDP and Lead QIDP to assure that only person #4's Ativan was overlooked by the latest version of the positive behavior support plan. The criteria by which nursing will use the Ativan for person #4 will be included in her BSP as well. This will be written by the Psychological Associate, checked by the QIDP and Lead QIDP, and consented by the guardian and the Human Rights Cmt. The QIDP will check all BSPs at least quarterly to assure any medications received by person's for inappropriate behavior are thoroughly documented in the BSP.	9/3/2018

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W 312	Continued From page 7 Continued review of the records revealed a medication administration record (MAR) for 6/18. Review of this MAR, verified by interviews with the QIDP and the nurse, revealed Ativan had been administered to client #4 on 6/18/18 at 4:52 PM. Further review of the records for client #4 revealed a IPP dated 10/27/17 which included a behavior support plan (BSP) to display no more than 5 episodes of inappropriate behaviors per month for 4 consecutive months. Continued review of this BSP revealed target behaviors were defined as inappropriate toileting, self-injurious behavior, inappropriate verbal behavior, aggression and pulling pants down. Additional interview with the QIDP verified the use of Ativan to control severe agitation was not addressed in the BSP and further agitation was not defined as a target behavior. Therefore, the facility failed to ensure the use of Ativan was an integral part of the IPP by having a method of measuring the effectiveness of the medication in the reduction of and eventual elimination of the behavior for which it is employed.	W 312		
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) 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 assure 1 of 3 sampled clients (#5) received annual physical examination,	W 322	The IDT for the Meek Road Group Home will assure the facility provides and obtains preventive and general medical care for all persons. The nurse and QIDP will review each persons' record to assure nothing in addition to Person #5's dental and eye has not been obtained in a timely manner. Person #5 will have his dental and eye exams completed and documented as soon as possible and a monthly preventative medical log form will be used by the nurse and QIDP for each person to avoid this in the future.	9/3/2018

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W 322	Continued From page 8 ophthalmology and dental examinations in a timely manner. The findings are: A. Review of the record for client #5, conducted on 7/3/18, revealed the most recent annual physical examination was documented as having been completed on 1/31/17. Interview with the nurse, conducted on 7/3/18, revealed no further documentation of a complete physical examination for client #5 was available for review at this time. Therefore, the facility failed to show evidence an annual physical examination was completed for client #5 for a period of over 17 months. B. Review of the record for client #5, conducted on 7/3/18, revealed an ophthalmology consultation dated 8/21/15 which included a recommendation to return in 1 year. Continued review of the record for client #5 revealed no further documentation of ophthalmology consultation. Interview conducted on 7/3/18 with the nurse and qualified intellectual disabilities professional revealed no further documentation of an ophthalmology examination was available for review at this time. Therefore, a period of over 2 years and 10 months has passed since the facility received a recommendation for an ophthalmology examination to be completed in 1 year. C. Review of the record for client #5, conducted on 7/3/18, revealed a dental consultation dated 1/31/17 which documented a recommendation for client #5 to have a dental examination under general anesthesia. Further review of the record for client #5 revealed this examination with surgical intervention was completed on 4/6/17 with a follow up visit on 4/19/17. Continued review of the record for client #5 revealed no further	W 322		

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W 322	Continued From page 9 documentation of dental examination for client #5. Interview with the nurse, conducted on 7/3/18, verified no further documentation of dental examination was available for review at this time. Therefore, the facility failed to evidence a dental examination was completed for client #5 for a period of over 14 months.	W 322		
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: Based on observation, record review and interview, the system for drug administration failed to assure all drugs were administered in compliance with physician's orders for 1 of 3 sampled clients (#5). The finding is: Observations conducted on 7/3/18 at 7:10 AM revealed client #5 was prompted by staff to enter the medication administration area, where he was assisted by staff to take the following medications: Ativan 1 mg., Acidophilus 1 cap, Albuterol sulfate 2 mg., enteric coated Aspirin 81 mg., Celexa 20 mg., Allegra 180 mg., KDur 20 meq., Seroquel 300 mg., Senokot S-two tablets, Calcium 500+D, Miralax powder 17 grams, Metamucil 1 tsp. Flunisolide nasal spray-two sprays each nostril and Theraderm lotion to hands and face. Continued observations on 7/3/18 at 7:25 AM revealed client #5 was assisted by staff to prepare his breakfast which he ate from 7:30-7:45 AM.	W 368	The IDT for the Meek Road ICF will assure the system for drug administration are administered in compliance with the physician's orders. Specifically, person #5 will have his label on his medication card updated to match the written doctor's order. The nurse will review all persons' medication cards with their written orders to assure there are no other discrepancies noted. The nurse will check each emar and medication card for person #5 monthly to assure the orders are a match,	9/3/2018

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W 368	Continued From page 10 Review of the record for client #5, conducted on 7/3/18, revealed physician's orders dated 6/8/18-9/8/18. Review of these physician's orders revealed a physician's order for Mobic 7.5 mg-take one tablet daily with breakfast. Interview with the nurse revealed the Mobic 7.5 mg. was signed in the electronic medication delivery system as given by staff at 9:04 AM. This interview further verified client #5 should receive his Mobic 7.5 mg with his breakfast as ordered by the physician.	W 368		