STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G080	A. BUILDING _____ B. WING _____	07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSS I GROUP HOME	1617 MOSS SPRINGS ROAD ALBEMARLE, NC 28001

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E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical	E 015	E 015- The Residential Manger and the QP noted that the EP plan states that we should have a gallon of water per person for a minimum of 3 day. It is also noted that there should be 21 gallons of water on site. The Residential manager has purchased additional water and we currently have 21 gallons of water on site. The manager will monitor weekly to ensure that there is sufficient amount of water present. The QP will monitor monthly. DHSR NHL & C Black Mountain MRO Received JUL 31 2018 by: SKH	7/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sheila Brown QP — TITLE — (X6) DATE: 7/24/2018

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 015	Continued From page 1 supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: The facility failed to ensure sufficient water supplies was available in accordance with the facility emergency plan (EP) as evidenced by observations, interviews and review of the facility EP. The finding is: Review of the facility's EP revealed a list of required foods and beverages and the amounts required. Continued review revealed the facility should have a gallon of water per person for a minimum of 3 days. Observations of the emergency food supplies revealed 6 gallons of water were available for use if needed Interview with the home manager, verified by review of records, revealed the facility houses 5 residents with 2 staff required for first and second shift. Continued interview with the home manager and further review of the facility EP revealed the facility should have 21 gallons of water on site for emergency purposes. Therefore, the facility has insufficient water supply to meet the facility EP requirements.	E 015	W 130-Staff will be inserviced on privacy for the individuals. Staff will make sure that all of the individuals close their door when using the bathroom. Staff will monitor Client#5 and all other individuals in the home to ensure that they have privacy while in the bathroom. The direct support staff will monitor daily, the Residential manager will monitor weekly, and the QP will monitor monthly. Completion date:	8/21/18
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7)	W 130		

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W 130	Continued From page 2 The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: The facility failed to promote privacy during the care of personal needs for 1 of 3 sampled clients (#5) as evidenced by observations and interviews. The finding is: Observations in the group home on 7/12/18 at 8:02 AM revealed client #5 went into the bathroom, pull his pants down and sat on the toilet. It was noted a staff person was present at the time and standing in the hallway beside the bathroom door. Continued observations revealed the home manager to come by and prompt the staff person on the need to close the door and the staff person stated I am standing here. Interview with the home manager substantiated the staff person should have closed the door to allow the client to have privacy while in the bathroom. Therefore, staff failed to promote privacy during the care of personal needs for client #5.	W 130	W 227- A. The team will meet and assess Client#5 toileting needs. Upon assessing his needs the team will develop a formal goal for closing the door for privacy while using the bathroom. The QP will monitor monthly. B. The team will meet and assess #4 behavior of removing toilet paper from the bathroom. Once the team has met a program will be develop to address Client#4 behavior of taking toilet paper from the bathroom. The Residential manager will monitor weekly, the QP will monitor monthly and the Psychologist will monitor quarterly.	9/10/18
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: The facility failed to ensure the person centered	W 227		

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W 227	Continued From page 3 plans (PCPs) included formal objectives to address identified needs for 2 of 3 sampled clients (#4 and #5) relative to privacy and behaviors, as evidenced by observations, interviews and review of records. The findings are: A. The facility failed to ensure the PCP dated 9/30/17 for client #5 included formal objective training to address needs in privacy. Observations in the group home on 7/11/18 at 4:16 PM to enter the bathroom and toilet without closing the door. Staff were not noted to be present at the time. Continued observations on 7/11/18 at 4:40 PM revealed client #4 to again go to the bathroom to toilet and staff were noted to prompt him to close the door for privacy. Interviews with the home manager revealed staff frequently have to prompt the client to close the door when toileting to promote privacy. Continued interviews with the home manager and the qualified intellectual disabilities professional (QIDP), verified by review of the 9/30/17 PCP, revealed no formal programming has been implemented to address the client's need to learn to close the bathroom door for privacy. B. The PCP dated 3/1/18 for client #4 failed to include formal objective training to address identified needs of behavior management. Observation of client bathrooms at 4:00 PM on 7/11/18 revealed toilet paper was not available in the client bathrooms (2). Interview with the home manager on 7/12/18 and continued interview with the QIDP substantiated client #4 often removes the toilet paper from the bathrooms.	W 227		

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W 227	Continued From page 4 Review of the PCP for client #4 revealed a behavior support plan (BSP) dated 6/12/18 stating the client has a behavior of toilet stuffing with toilet paper, clothing or other objects and staff should be attentive in monitoring client #4. The BSP did not address client #4's behavior on removing toilet paper from the bathroom. Further review of the PCP revealed a community/home life assessment dated 2/1/18 which notes the client requires partial physical assistance and verbal prompting from staff when toileting. Interview with the QIDP and the home manager on 7/12/18 substantiated there were no interventions in the PCP or BSP for the client's repeated behavior of taking the toilet paper from the client bathrooms.	W 227	W 371-All staff will be inserviced on client's participation with medications. When giving medications to the individuals, staff will state the name of the medication, what the medication is for, and the side effects of the medications. Staff will role play giving medications during staff meetings to ensure that everyone is aware of these procedures in giving medications. This will be done for Client #4 and Client #3 and all other individuals that reside in the group home. The Residential manager will monitor weekly, the QP will monitor monthly and the RN will monitor quarterly.	9/10/18
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure 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: The facility's system for drug administration failed to ensure clients were taught to administer their own medications to the extent possible for 2 of 2 clients observed to receive medications (#3 and #4) as evidenced by observations and interviews. The findings are: A. Observations in the group home on 7/12/18 at	W 371		

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W 371	Continued From page 5 7:18 AM revealed client #4 to be taken to the medication closet to receive medications. Continued observations revealed the medications to include a Multi-vitamin, Glipizide, Inositol, Boost and Vaseline applied to arms. Further observations revealed client participation was limited to assisting with punching pills out of the bubble pack, swallowing the pills and drinking the water. It was noted staff failed to tell the client what the medication was, what it was for or what possible side effects might be. B. Observations in the group home on 7/12/18 at 7:27 AM revealed client #3 to be taken to the medication closet to receive medications. Continued observations revealed the medications to include Polyethylene Glycol, Ativan, Seroquel, Senexon, Benztropine, Certavite, Simethicone and Vanicream applied to hands and arms. Further observations revealed client participation was limited to assisting with punching pills out of the bubble pack, swallowing the pills and drinking the water. It was noted staff failed to tell the client what the medication was, what it was for or what possible side effects might be. Interview with the qualified intellectual disabilities professional revealed staff administering medications should have at least identified the medications being administered to ensure the facility's system for self administration of medications is being taught.	W 371		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel.	W 440	W 440-Quarterly fire drill will be conducted with the scheduled number of personnel for all shifts. The number of staff participating in the fire drill will be noted on the fire drill report. A schedule has been completed to have drills done at varying times throughout the shift. The Residential manager will monitor weekly. The QP will monitor monthly.	9/10/18

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W 440	Continued From page 6 This STANDARD is not met as evidenced by: The facility failed to show evidence quarterly fire drills were conducted with each shift of personnel relative to third shift, as evidenced by interview and review of records. The finding is: Review of the facility fire drill reports from 7/17 until 6/18 revealed 3rd shift drills were conducted on 9/5/17 at 5:30 AM with 2 staff assisting, 12/4/17 at 5:30 AM with 2 staff assisting, 3/5/18 at 5:00 am with 1 staff assisting and on 6/4/18 at 5:30 AM with 1 staff assisting. Interview with the home manger revealed 3rd shift runs from 11:00 PM until 5:55 AM. Continued interview with the home manger revealed only 1 staff person is scheduled for 3rd shift. Additional interviews with the home manager and the qualified intellectual disabilities professional revealed the residents of the home begin getting up at approximately 5:30 AM. Therefore, the facility failed to show evidence quarterly fire drills were conducted for 3rd shift with the scheduled number of personnel for 2 of 4 quarters and failed to vary times fire drills were conducted during 3rd shift.	W 440		
W 484	DINING AREAS AND SERVICE CFR(s): 483.480(d)(3) The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by:	W 484	W484-Staff will be trained on ensuring that all appropriate eating utensils are provided for each meal. The Residential manager will monitor weekly, the QP will monitor monthly.	9/10/18

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W 484	Continued From page 7 The facility failed to ensure appropriate eating utensils were consistenly provided to residents during the evening meal and the morning meal as evidenced by observations and interview. The finding is: Observations of the evening meal on 7/11/18 from 5:25 PM to 5:40 PM revealed each client to carry their own place setting to the table. Continued observations revealed the only eating utensil provided was a fork. Additional observations revealed the meal consisted of hard and soft tacos, sweet potato fries and a beverage. Further observations during the meal revealed client #2 was served a soft taco with meat lettuce and tomato on a plate. The client was instructed to eat using her fork. However, at 5:33 PM the client was observed to be unable to use the fork to cut the taco and began using her fingers to eat the meat, lettuce and tomato. Staff again prompted her to use the fork. She picked up the fork and began eating the meat, lettuce and tomato but was still unable to cut the tortilla and again used her fingers. Additional observations revealed at no time did staff attempt to provide a knife or assist in cutting the taco for client #2. Observations of the morning meal on 7/12/18 from 6:40 AM until 7:05 AM revealed each client to carry their own place setting to the table. Continued observations revealed the only eating utensil provided was a spoon. Additional observations revealed the meal to consist of cereal, cheese toast and beverages. Further observations during the meal revealed at 6:45 AM client #2 was given a piece of cheese	W 484		

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W 484	Continued From page 8 toast. Staff was observed to to get a knife from the kitchen and cut the toast into bite size pieces for her with benefit of training. Staff was also observed to get a knife and assist client #1 with cutting her cheese toast. Interview with the home manager verified a knife, spoon and fork should have been provided for both meals, adding staff should be using hand over hand in assisting with cutting. Therefore, the facility failed to ensure appropriate eating utensils were provided for each meal.	W 484		