

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2018
NAME OF PROVIDER OR SUPPLIER TWINBROOKS			STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028	
(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	<p>PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure the right to privacy and obtain written informed consent for 1 of 3 sampled clients (#6) related to use of an audio monitor, and failed to assure the right to privacy for 1 non-sampled client (#2) related to the use of a live feed video monitor. The finding is:</p> <p>Observations in the home on 8/13/18 from 4:00 PM through 5:00 PM revealed an audio monitor receiver located on a side table next to a couch in the living room. The monitor was on and at 4:05 PM a staff member could be heard talking to client #6 while in his bedroom. Continued observations on 8/14/18 from 6:50 AM to 7:40 AM revealed the same audio monitor and a video monitor, both located on side tables in the living area. Both monitors were on and the video monitor camera was displaying a video of client #2's bed. At 7:10 AM, staff could be heard prompting client #6 to go to the bathroom. At 7:13 AM, a staff member could be seen on the video monitor in client #2's bedroom assisting him with putting on compression hose. From 6:50 AM through 7:30 AM, client's #2, #3 and #5 were all observed sitting in the living area at various times.</p> <p>Review of the record for client #6 on 8/14/18</p>	W 129	<p>The facility will ensure that all individual clients have the opportunity for personal privacy. The QP will ensure that informed consent for client #6 is obtained for use of audio monitor.</p> <p>For preventive measures the QP will ensure informed consent is obtained from guardians for the protection of client rights.</p> <p>The Habilitation Specialist will inservice train staff on the proper use of audio and video monitors.</p> <p>IDT will monitor by completing weekly observations until the issue is ressolved. For preventive measures the IDT will continue to monitor with monthly QA assessments.</p>	10/13/18



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

8/22/18

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2018
NAME OF PROVIDER OR SUPPLIER TWINBROOKS			STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028		
(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 1 revealed a person centered plan (PCP) dated 6/22/18. The PCP indicated client #6 had a noise monitor in his bedroom to monitor for seizure activity. Further review of the record did not reveal current written/informed consent for the use of the audio monitor. Review of the record for client #2 on 8/14/18 revealed a PCP dated 11/9/17. Further review of the record revealed a current consent for the use of a live video monitor due to a history of frequent falls when attempting to get out of his bed. Interview with the qualified intellectual disabilities professional (QIDP) on 8/14/18 confirmed the audio monitor for client #6 and the video monitor for client #2 should not be left on in the living area where other client's and possibly visitors could overhear and see interactions and treatment. The QIDP also confirmed there was no current written/informed consent for the use of client #6's audio monitor.	W 129			
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	W 249	The facility will ensure that each individual has a individual program plan that contains needed interventions and services, and for active treatment to be provided for the achievement of the objectives identified in the individual's plan.	10/13/18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2018
NAME OF PROVIDER OR SUPPLIER TWINBROOKS			STREET ADDRESS, CITY, STATE, ZIP CODE 189 FAIRMONT DRIVE MOCKSVILLE, NC 27028		
(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	<p>Continued From page 2</p> <p>interview, the team failed to assure an oral hygiene objective listed on the person centered plan (PCP) for 1 of 3 sampled clients (#6) was implemented. The finding is:</p> <p>Morning observations in the home on 8/14/18 at approximately 8:00 AM revealed client #6 brushing his teeth in the bathroom. Further observation revealed a visible white timer device located on the bathroom cabinetry shelving. Continued observations revealed the white timer device was not utilized while client #6 brushed his teeth.</p> <p>Interview with staff on 8/14/18 at 8:05 AM revealed client #6 uses the timer device and it should have been utilized while client #6 brushed his teeth.</p> <p>Review of the record for client #6 on 8/14/18 revealed a person centered plan (PCP) dated 6/22/18 with the current objective #H2G to "...use a timer to brush his teeth for a minimum of 2 minutes with 100% accuracy of a period of three consecutive months" by 4/1/19. Further review revealed the objective rationale: "Due to plaque build up."</p> <p>Interview with the Habilitation Specialist on 8/14/18 verified client #6 has a current objective to utilize the timer during toothbrushing and staff should have used the timer. Further interview revealed the task analysis for this objective changed to modified gums.</p>	W 249	<p>The IDT will meet and discuss client #6's oral hygiene needs, and the Habilitation Specialist will ensure that the appropriate dental hygiene program is implemented, including training of staff on program implementation.</p> <p>IDT will complete weekly observations/QA assessments to ensure that the issue is resolved.</p> <p>For preventative measures the IDT will continue to monitor with monthly Observations/QA assessments.</p>	10/13/18	