

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

PRINTED: 08/22/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2018
NAME OF PROVIDER OR SUPPLIER ELLENDALE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4165 NC HWY 127 TAYLORSVILLE, NC 28681		
(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 227	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: The individual program plan (IPP) for 1 of 3 sampled clients (#1) failed to included objective training to address identified needs relative to dining as evidenced by observations, interview and review of records. The finding is:</p> <p>Observations in the group home on 8/20/18 from 5:30 PM to 5:55 PM revealed client #1 to be assisted to the table for the evening meal. Continued observations revealed the client's place setting to include dycem mat, plate guard, nosey cup and a built up curved spoon knife and fork. Further observations revealed the client's meal to consist of a ground up hamburger, coleslaw, french fries and beverage. Additional observations revealed the client to use the spoon to feed himself.</p> <p>Subsequent observations of the evening meal revealed the client to load large bites of food onto his spoon and then place it in his mouth and to eat without stopping. It was further noted staff prompted the client to take smaller bites, to slow down and take a drink on several occasions during the meal. Interview with the home manager (HM) verified by review of the 7/31/18 adaptive behavior inventory assessment revealed the client does need prompting to eat at an appropriate speed and to eat without filling his</p>	W 227	<i>see attached</i>	<i>10/21/18</i>	



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

TITLE

(X6) DATE

Spide Perry

BSQP

9-7-18

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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W 227	Continued From page 1 mouth to full. Continued review of the records for client #1 revealed a 7/24/18 IPP for client #1. Review of this IPP verified by interview with the facility HM revealed no objective training to address the client's rate of eating or taking too large of a bite. Therefore, the team has failed to implement objective training to address the identified needs of client #1 relative to dining.	W 227			

W227

10-21-18

A formal program will be implemented and staff will be inserviced on an objective in order to address identified need relative to client #1's dining. Formal objectives will be implemented for all clients as needed and monitored by the QP and/or Program Specialist. Monitoring of identified objectives will occur through monthly progress reviews by the Program Specialist, through quarterly QP progress reviews, as well as through direct observations at least weekly by the QP and or designee.

Kristi Berry BSQP
9-7-18

