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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G316	A. BUILDING ______ B. WING ______	09/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAVES	7106 LEAVES LANE CHARLOTTE, NC 28213

(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 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	Please see attached Plan of correction.	11/5/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Program Manager (X6) DATE: 09.25.18

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 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: Based on observations, verified by interviews and review of facility policy the team failed to ensure sufficient water was on site for emergency situations as required in the facility emergency plan (EP). The finding is: Review of the facility's EP, verified by interview with the qualified intellectual disabilities professional (QIDP), revealed the facility should have 1 gallon of water for each person per day for 3 days. Interviews with the home manager revealed 6 residents reside in the group home with 2 staff scheduled for first and second shifts for a total of 8 people. Therefore, per facility's EP the facility should have 24 gallons of water on hand. Observations in the group home on 9/4/18, substantiated by the QIDP, revealed the facility had 10 gallons of water on hand in case of an emergency. Continued interview with the group home manager substantiated only 6 gallons of water were present in the home on 9/4/18. Further interviews with the QIDP and the operations manager verified the facility should have 24 gallons of water per facility EP.	E 015		
W 249	PROGRAM IMPLEMENTATION	W 249		

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W 249	Continued From page 2 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: The team failed to ensure objectives listed on the individual support plans (ISP) for 3 of 3 sampled clients (#1, #2 and #6) relative to communication and behavior support plans were implemented with sufficient frequency and as prescribed to support the achievement of the objectives as evidenced by observations, interview and review of records. The findings are: A. The team failed to ensure communication objectives for 2 of 3 sampled clients (#1 and #2) were implemented with sufficient frequency to support the achievement of the objectives. 1. Review of the records for client #1, substantiated by interviews with the qualified intellectual disabilities professional (QIDP), revealed an ISP dated 3/8/18 which included an objective to follow a picture schedule. Review of this objective revealed the picture schedule included pictures for medication and clean room in the AM, and shower and medication in the PM. Observations in the group home on 9/5/18 at 7:32 AM revealed staff to verbally and gesturally	W 249	See attached	11/4/18

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W 249	Continued From page 3 prompt client #1 to the medication closet to take his morning medications. Continued observations revealed at no time was staff observed to prompt the client to the picture schedule. Interview with the QIDP revealed the pictures for the picture schedule are kept in the client's program book. Continued interview with the QIDP verified staff should have prompted the client for medications using the pictures for the picture schedule. 2.. Review of the records for client #2, substantiated by interviews with the QIDP, revealed an ISP dated 3/1/18 which included an objective to follow a picture schedule. Review of this objective revealed the picture schedule included pictures for medication, clean room and shower in the AM, and medication and dinner in the PM. Observations in the group home on 9/4/18 revealed staff to use verbal and gestural prompts to transition the client to eat the evening meal at 6:05 PM. Continued observations on 9/5/18 revealed staff to again use verbal and gestural prompts to transition the client to to eat the morning meal at 6:41 AM and at 7:35 AM to take medications. Additional observations revealed at no time was staff observed to prompt the client to the picture schedule. Interview with the QIDP revealed the pictures for the picture schedule are kept in the client's program book. Continued interview with the QIDP verified staff should have prompted to eat the evening meal, the morning meal and for medications using the pictures for the picture	W 249		

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W 249	Continued From page 4 schedule. B. The team failed to ensure the behavior support plan (BSP) for 1 of 3 sampled clients (#6) was implemented as prescribed. Review of the records for client #6 revealed a ISP dated 7/15/18 which included a behavior support plan (BSP) to reduce rates of physical aggression and non-compliance. Continued review of the BSP revealed physical aggression is defined as hitting, biting, kicking, head butting, pulling hair, scratching or other acts including attempts to do any of these behaviors. Additional review of the records revealed when any of these behaviors occur staff are to give a strong clear verbal prompt to stop the behavior and to redirect the client to another area and to have limited verbal contact with the client. Observations in the group home on 9/5/18 revealed at 7:55 AM client #6 was observed to hit or jump at client #3 staff were noted to prompt client #3 away from client #6. Continued observations revealed at 7:56 AM client #6 was again noted to attempt to hit client #3 and staff again prompted client #3 away from client #6. Additional observations at 7:59 AM as client #6 was getting on the van to go to the day program he hit at someone already in the van in the back seat and staff was noted to prompt client #6 into the front seat of the van. Interview with the QIDP, revealed client #6 does not actually hit client #3 but verified he does make the attempts. Continued interview with the QIDP substantiated staff should have given the strong verbal prompt to stop and to transition the client #6 to another area away from anyone else.	W 249		

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W 249	Continued From page 5 Therefore, staff failed to implement the interventions prescribed in the BSP.	W 249		
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: The team failed to ensure techniques to manage inappropriate behaviors is never used as a substitute for active treatment for 2 of 3 sampled clients (#1 and #2) as evidenced by observations, interviews and review of records. The findings are: A. Observations in the group home on 9/4/18 at 4:50 PM revealed client #1 to go to the garage and obtain clothing and take to this clothing to his personal bedroom. Interview with staff the QIDP, verified client #1's clothing is kept in the garage due to inappropriate behaviors. Review of the records for client #1 revealed an individual support plan (ISP) dated 3/8/18. Review of the 3/8/18 ISP revealed a behavior support plan (BSP) to display zero episodes of physical aggression. Continued review of the BSP revealed a target behavior of property destruction was also addressed. Additional review of the BSP, verified by the QIDP, revealed the BSP did not address keeping the client's clothing outside of his personal bedroom or include a method of introducing the clothing back	W 288	See attached	11/6/18

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W 288	Continued From page 6 into the client's personal bedroom. B. Observations in the group home on 9/4/18 at 5:10 PM revealed client #2 to go to the garage and obtain clothing and take to his personal bedroom. Interview with staff the QIDP, verified client #2's clothing is kept in the garage due to inappropriate behaviors. Review of the records for client #2 revealed an ISP dated 3/1/18. Review of the 3/1/18 ISP revealed a BSP to decrease episodes of property destruction and self-injurious behaviors to zero episodes for 12 consecutive months. Continued review of the BSP revealed the client's clothing is stored in the garage and through a written training program written by the QIDP, clothes will be re-introduced by into the client's bedroom. Additional review of the ISP dated 3/1/18, verified by interview with the QIDP, revealed no written training program has been developed or implemented to re-introduce the clothing back into client #2's personal bedroom. Therefore, the technique of storing client #1 and client #2's clothing in the garage is not tied to an active treatment program to substitute appropriate behaviors for inappropriate behaviors and to re-introduce the clothing back into personal bedrooms.	W 288		

Leaves Group Home
7106 Leaves Lane
Charlotte, NC 28213
Plan of Correction
Date of Recertification Survey: September 06th 2018
Provider # - 34G316

E 015: (B) 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

Community Alternatives of NC, specifically the Leaves group home, will ensure that the emergency preparedness policies and procedures will be implemented and followed. The appropriate amount of water according to the policies and procedures has been placed in the Leaves group home. The QIDP and the Residential Manager will complete monthly checks to ensure that all emergency preparedness protocol has been followed. The Program Manager will check the emergency water supply during monthly site reviews to ensure that all emergency preparedness protocol has been followed.

To be completed by: 11.05.18
Person(s) Responsible: QIDP, Residential Manager, Program Manager

W 249 PROGRAM IMPLEMENTATION: 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.

Community Alternatives of NC, specifically the Leaves group home, will ensure as soon as the interdisciplinary team has formulated a client's individual program plan, each client 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 individual program plan.

A & B. The QIDP will ensure all staff is retrained on all Behavior Support Plans as well as communication objectives, including client #1 and #2. Training will

include but not be limited to, frequency of implementation, methodology, data collection and utilizing the pictures consistently during daily routines. The Residential Manager will conduct observations 3 times weekly to ensure all communication objectives are implemented as prescribed during routine daily activities. The QIDP will conduct observations 2 times weekly and review the data collection to ensure all communication objectives are implemented as prescribed during routine daily activities. The Program Manager will conduct observations and chart reviews during monthly site reviews to ensure all communication objectives are implemented as prescribed during routine daily activities.

To be completed by: 11.06.18
Person(s) Responsible: Residential Manager, QIDP, Program Manager

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.

A & B. The QIDP and Behaviorist will retrain all staff to ensure that any techniques used to manage behaviors will be done following policies and procedures with the Behavior Support Plan and Individual Support Plan. Additionally, the QIDP will write a written training program that allows the individuals the opportunities to gain access to their clothes by in their rooms. The behaviorist will conduct weekly observations to ensure all individuals have access to their clothing per the ISP and BSP. The Residential Manager will conduct observations 3 times weekly to ensure all individuals have access to their clothing per the ISP and BSP. The QIDP will conduct observations 2 times weekly to ensure all individuals have access to their clothing per the ISP and BSP. The Program Manager will conduct observations during monthly site reviews to ensure all individuals have access to their clothing per the ISP and BSP.

To be completed by: 11.06.18
Person(s) Responsible: Behaviorist, Residential Manager, QIDP, Program Manager