| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G203 | A. BUILDING _____ B. WING _____ | 10/10/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| VOCA-BLAIRFIELD | 111 BLAIRFIELD COURT N WILKESBORO, NC 28659 |

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| W 227 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(4)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interviews and review of records the individual support plans (ISPs) failed to have sufficient interventions to address identified needs in communication skills for 2 of 3 sampled clients (#1 and #5) and medical desensitization for 1 non-sampled client (#4). The findings are:<br><br>A. The ISP dated 10/12/17 for client #1 failed to include sufficient interventions to address communication deficits.<br><br>Observations during the 10/9-10/10/18 survey revealed client #1 to be non-verbal and to use gestures, sign language and facial expressions to communicate with staff. Continued observations revealed staff to use verbal and physical prompts to transition the client to various activities such as leisure activities, medication administration, washing hands and meal participation. Further observations revealed the client to be cooperative with transitioning to the different activities. At no time was it observed for staff to use manual signs to communicate with client #1.<br><br>Review of records for client #1 on 10/9/18 revealed the client's ISP dated 10/12/17 to include objective training relative to medication administration, money management, hygiene and | W 227 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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washing clothes. Further review of records on 10/10/18 for client #1 revealed communication assessments dated 9/7/17 and 9/24/18 with recommendations indicating manual sign training is essential for staff at the group home and training should be ongoing. Further review of recommendations included in the 9/7/17 and 9/24/18 communication assessments revealed the need for client #1 to be provided multiple household chores to keep her busy and engaged.

Interview with the qualified intellectual disabilities professional (QIDP) and home manager (HM) on 10/10/18 revealed staff had not been provided manual sign training relative to client #1's communication needs. Additional interview with the QIDP verified no communication tools had been developed to support client #1's need for using manual signs in communicating with staff. The QIDP further confirmed client #1 had no formal objective training relative to household chores with the exception of washing her clothes.

B. The ISP dated 10/9/18 for client #5 failed to include sufficient interventions to address communication deficits.

Observations during the 10/9-10/10/18 survey revealed client #5 to be mostly non-verbal and to use gestures, noises, minimal words and facial expressions to communicate with staff. Continued observations revealed staff to use verbal and physical prompts to transition the client to various activities such as leisure activities, time in room, meal participation and taking his dishes to the kitchen after meals. Further observations revealed the client to be cooperative with transitioning to different activities. At no time was it observed for staff to

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use manual signs to communicate with client #5. An observation of the wall outside the kitchen area of the home revealed a board identified as client #5's sign board with manual signs for work, eat and drink. Further observation of the communication board revealed the directive: Please use eat and drink signs whenever client #5 is eating or drinking.

Review of records for client #5 on 10/9/18 revealed the client's ISP dated 10/9/18 to include objective training relative to medication administration, money management, hygiene, laundry and loading the dishwasher. Further review of records on 10/10/18 for client #5 revealed communication assessments dated 9/7/17 and 9/24/18 with recommendations indicating manual sign training is essential for staff at the group home and training should be ongoing.

Interview with the QIDP and HM on 10/10/18 revealed staff had not been provided manual sign training relative to client #5's communication needs. Further interview with the QIDP verified client #5 had manual sign pictures for staff to use when communicating words such as: lunch box, refrigerator, go, brush teeth, room, toilet, shoes and phone. Subsequent interview with the QIDP and HM verified manual signs should have been used by staff at various times in communicating with client #5 although the client has no formal objectives to address the use of manual signs.

C. The ISP dated 9/7/18 for client #4 failed to include sufficient interventions to address medical desensitization needs.

Observations in the group home on 10/9/18 of

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client #4 at 5:15 PM revealed the client to be agitated and to refuse verbal and gestural prompts from staff to eat dinner. Client #4 was further observed to increase in agitation becoming combative with staff, ambulating through the group home independently making verbalizations that reflected confusion, staring out windows of the group home, grabbing and flipping small tables in the group home and requiring multiple staff to support interventions with protecting the client from self injurious behavior of hitting her head in door frames of the group home. Continued observation at 6:25 PM revealed 911 to be contacted by administrative staff to support medical evaluation of the client. The client was observed to leave the facility by ambulance at 7:10 PM. Observation on 10/10/18 at 7:00 AM revealed client #4 to have returned to the group home and to sit in the living room of the group home watching television holding a baby doll. Continued morning observation revealed client #4 to participate in the breakfast meal, walk with staff to the medication room for morning medications and to be cooperative throughout the morning observations with staff prompts, gestures and assistance with completing her morning routine.

Review of records for client #4 on 10/10/18 revealed the client to have a elevated ammonia level since 3/2018 with medical oversight since the identified elevation and ongoing lab work weekly since 7/30/2018 to monitor ammonia levels. Continued review of records for client #4 revealed a change in medication on 3/14/18 by the neurologist with reducing Depakote dosage to 250 mg QID and titrating dosage down until it was discontinued in 8/2018. Additional record review revealed client #4 to need valium to complete

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various appointments due to combative behavior: CT Scan on 7/18/18, OB exam 8/1/18, vision exams and abdomen scan 10/3/18. A review of notes from general medical treatment revealed on 8/3/18: client #4 was agitated and needed touch to calm. Ran into doorway. Noticeable bilateral cataracts. Referral to Greystone Eye Care. 9/5/18: Client agitated, verbally loud. Client does calm with a snack, does not allow much exam. Review of client #4's ISP dated 9/7/18 revealed a behavior support plan with medication to include Diazepam 10mg 30 minutes prior to ophthalmology appointments, 5mg prior to CT scan.

Interview with staff on 10/9/18 revealed client #4 had never demonstrated the severe behaviors and active ambulation with verbalizations that the client demonstrated during the current incident. Interview with the facility nurse on 10/10/18 verified client #4 has had elevated ammonia levels since 3/2018 and is continuing to have medical oversight due to condition. The facility nurse verified client #4 to have a medical appointment on the current day of 10/10/18 to further explore with the medical doctor regarding ammonia levels and incident on 10/9/18. The facility nurse further confirmed after getting the client to the emergency room on 10/9/18 that labwork revealed the clients ammonia levels to be low.

Subsequent interview with the facility nurse verified client #4 can be uncooperative at medical appointments and multiple appointments have had to be rescheduled due to the clients lack of cooperation also resulting in the use of sedation to support completion of medical evaluations. The facility nurse confirmed client #4 was

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| W 227 | Continued From page 5<br>scheduled for a abdomen CT scan on 10/3/18 and was too combative and procedure is rescheduled for 10/18/18. The facility nurse further revealed client #4 has been too combative for vision treatment and ophthalmology treatment can not be provided for cataracts until ammonia levels are stabilized due to type of sedation needed for treating cataracts.<br><br>Interview with the facility behaviorist on 10/10/18 revealed he had scheduled an appointment with the client's psychiatrist for 10/22/18 and would be trying to get an earlier appointment if possible to address the client's behavior on 10/9/18. Interview with the facility nurse, behaviorist and QIDP verified client #4 has a history of cooperation difficulty at medical appointments and is currently using sedation for various medical exams. Interview further verified, client #4 did not currently have a program to address cooperation difficulty with medical appointments. | W 227 | | |