STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G083	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLANCHE DRIVE	6208 BLANCHE DRIVE RALEIGH, NC 27607

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E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop an emergency preparedness (EP) plan including and based upon a community and facility-based risk assessment, utilizing an all-hazards approach. The finding is: The facility did not have an emergency plan	E 006	The following deficency will be corrected according to the following: A. Clinical Supervisorwill be trained on all requirements regarding Emergency and Disater Preparedness. B. Clinical Supervisor will complete a Risk Assessment specific to that site. The Risk Assessment will take into account any specific hazards and threats to be considered for that specific geographic location. C. The findings of this Risk Assessment will be integrated into the specific Emergency and Disaster Plan for the Hickory Avenue Group Home. D. The Emergency and Disaster Plan will also be revised to include the names, addresses, and contact information of relocation facilities. E. Clinical Surpervisor will revise any additional components of the Emergency Disaster Plan as required. F. If possible, the Clinical Supervisor will contact the local and/or state Emergency Planning Department to ensure site plans are integrate with city, county, and/or state plans. Any attempts to contact these emergency departments will be documented. G. Once revised, the Emergency and Disaster Plan will be reviewed and approved by Safety Committee. H. Once approved, all staff will be provided training of the Emergency and Disater Plan. This training will include, but not be limited to a written test and on-going mock disater drills. I. Plan will be reviewed and updated annually thereafter. J. Clinical Supervisor will monitor and document progress weekly.	11/18/18

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

Executive Director | 10/12/18

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 006	Continued From page 1 based upon risk assessments. Review on 9/19/18 of the facility's current EP plan dated 8/14/17 revealed the plan did not provide specific information in regards to a facility-based and community-based risk assessment using an all-hazards approach including flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing clients or other emergency types. Interview on 9/20/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he was not sure if a risk assessment had been completed and no risk assessment for the facility's EP plan was available for review.	E 006		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained to secure wheelchairs on the van appropriately. The finding is: Wheelchairs were not secured appropriately on the facility van. During observations at the home on 9/19/18 from 9:29am - 9:39am, staff secured two wheelchairs on the facility van. One wheelchair was secured using two tie downs placed on the right side of the	W 189	The following deficency will be corrected according to the following: A. Support Staff will complete Driver's Safety Training. B. Residential Manager (RM) will re-train and in-service all support staff on how to complete wheelchair tie-downs. C. RM will check weekly to ensure that all equipment is available to ensure that wheelchairs can be properly secured during transport. D. RM will monitor 3x/ weekly to ensure wheelchairs are properly secured prior to transport. E. Clinical Supervisor will monitor weekly to ensure wheelchairs are properly secured prior to transport.	11/18/18

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W 189	Continued From page 2 chair with one positioned in the front and one in the back. One tie down was attached to the wheel of the chair and the other to a bar on the front frame of the chair. Interview on 9/18/18 with the staff involved revealed this is how they normally secure wheelchairs on the van. Interview on 9/20/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff are trained by watching a video on how to secure wheelchairs on the van; however, the video was not available for review. The QIDP acknowledged having a tie down secured to the wheel of the chair and both tie downs secured on one side of the chair would likely not be correct.	W 189	Please refer to page 2, W 189.	
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 observations, interviews and record review, the facility failed to ensure 3 of 3 audit clients (#1, #2, #4) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of meal	W 249	Please refer to page 4, W 249.	

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W 249	Continued From page 3 preparation, family style dining, self-help skills and adaptive equipment use. The findings are: 1. Clients were not involved in cooking tasks in the home. During observations throughout the survey in the home on 9/19 - 9/20/18, clients were not prompted or assisted to participate in any cooking tasks. For example, on 9/19/18 at 3:30pm, prepared food items (chicken with noodles and mixed vegetables) were noted in containers on the counter in the kitchen. During this time, clients were at the day program. On 9/20/18 at 7:31am, staff prepared toast and poured dry cereal into a large bowl without any client participation. During this time, client #2 stood nearby. Interview on 9/19/18 with the home manager revealed the dinner meal was prepared by staff that afternoon because clients were getting home late. Additional interview indicated the mixed vegetables were canned and could have been heated quickly in the microwave. Review on 9/20/18 of client #2's IPP dated 1/11/18 revealed she needs "assistance with completing ADL's." Additional review of the client's Community/Home Living Assessment dated 1/11/18 indicated she can make food with no cooking and food with no mixing given physical assistance. The assessment noted client #2 can use a toaster, microwave and coffee maker with physical assistance. Review of client #4's IPP dated 3/1/18 revealed she can complete basic self-help skills with assistance. Additional review of the client's	W 249	The following deficency will be corrected according to the following: A. All consumer assessments will be reviewed to ensure that recommendations involving self-help skills, meal preparation, family style, and use of adaptive equipment is accurate and appropriate. B. Staff will be trained on client integration as it relates to meal prep activities, family style dining, self help skills, and the proper use of adaptive equipment. C. All staff will be trained on Active Treatment expectations. This training will inlcude company issue curriculum and testing. D. An adaptive equipment inventory will be completed for each consumer to ensure that all adaptive equipment is available at all times, and across all settings. E. Staff will be trained in Food Preparation. Training will include specifics on diet consistency, proper food storage, and maintaining proper food temperature prior to being served. F. RM will monitor all above areas 3x/ weekly. G. CS will monitor weekly.	11/18/18

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W 249	Continued From page 4 Community/Home Living Assessment dated 5/1//18 indicated she can make food with no cooking and food with no mixing given physical assistance. The assessment noted client #2 can use a toaster, microwave and coffee maker with physical assistance. Interview on 9/20/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients should have been involved with simple cooking tasks in the home. 2. Clients were not involved in all aspects of family style dining. During dinner and breakfast observations in the home throughout the survey on 9/19 - 9/20/18, staff poured drinks for each client and walked pitchers and serving bowls around the table without prompting clients to participate with these tasks. Staff interview on 9/20/18 revealed clients participate in family style dining "at all meals". The staff stated client #2 and client #4 have more skills in this area. Additional interview indicated the clients do not pour their drinks because "they will spill it". Review on 9/20/18 of client #2's IPP dated 1/11/18 revealed she needs "assistance with completing ADL's." Additional review of the client's Community/Home Living Assessment dated 1/11/18 indicated she eats family style independently and passes food to others given a verbal cue. Review of client #4's IPP dated 3/1/18 revealed she can complete basic self-help skills with	W 249	Please see page 3, W 249.	

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W 249	Continued From page 5 assistance. Additional review of the client's Community/Home Living Assessment dated 5/1//18 indicated she eats family style independently and passes food to others given a verbal cue. Interview on 9/20/18 with the QIDP confirmed clients should be participating in aspects of family style dining to the best of their abilities. 3. Client #1 was not assisted to feed herself using her adaptive spoon at meals. During observations throughout the survey at the day program and in the home on 9/19 - 9/20/18, staff fed client #1. For example, at the day program on 9/19/18 at 11:41am, staff fed client #1 using a plastic spoon. During additional observations in the home at dinner (5:30pm)and breakfast (8:00am), staff fed client #1 using an curved spoon with a built-up handle. Client #1 was not assisted to feed herself. Staff interview on 9/19/18 revealed client #1 can feed herself; however, her adaptive spoon was not available at the day program. Additional interview on 9/20/18 revealed client #1 can only feed herself finger foods and other foods are fed to her. Review on 9/20/18 of client #1's IPP dated 6/12/18 revealed she can feed herself independently using adaptive equipment. Additional review of an Occupational Therapy (OT) update dated 5/10/18 indicated the client uses a right angled spoon with a foam handle. Further review of the update noted client #1 can finger feed dry food and "she usually needs hand over hand assistance for loading spoon and	W 249	Please see page 3, W 249.	

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W 249	Continued From page 6 bringing to mouth. She uses her R hand for spoon use and L hand for finger feeding." Interview on 9/20/18 with the QIDP confirmed client #1 can feed herself given her adaptive spoon. Additional interview indicated the client should also have her adaptive spoon available for use at the day program. 4. Client #1 was not prompted or assisted to clear her place after meals. During observations in the home on 9/19 - 9/20/18, staff cleared client #1's place after meals without prompting or assisting her to participate with this task. Review on 9/20/18 of client #1's Community/Home Life Assessment dated 6/8/17 revealed she can take dirty dishes to the kitchen given physical assistance. Interview on 9/20/18 with the QIDP confirmed client #1 can assist with clearing her place by pushing the dirty items into a dish pan.	W 249	Please see page 3, W 249.	
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure data was collected as specified in	W 252	Please see page 8, W 252.	

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W 252	Continued From page 7 the Individual Program Plan (IPP). This affected 2 of 3 audit clients (#1, #2). The finding is: Clients' (#1, #2) physical therapy (PT) exercises were not documented as indicated. a. Review on 9/20/18 of client #1's record revealed PT range of motion exercises to bilateral lower extremities needed to be completed "5x per week" to maintain current joint mobility, increase circulation and engage muscles. The plan noted "Document participation in Monthly Exercise Program Log." Additional review of client #1's PT monthly exercise log sheets revealed no documentation for August '18 and September '18. b. Review on 9/20/18 of client #2's record revealed a PT Exercise Program dated 1/16/17. The program indicated client #2 should participate in activities such as walking, exercise or dance videos and group home activities that promote physical activity. The plan noted, "Encourage daily participation in staff supervised exercise program for optimum health...Document participation on Monthly Exercise Program Log." Additional review of client #2's PT monthly exercise log sheets revealed 4 days of documentation for June '18 and no documentation for July '18, August '18 and September '18. Interview on 9/20/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the PT exercises were current for client #1 and client #2 and should continue to be implemented and documented as indicated.	W 252	The following deficency will be corrected according to the following: A. All staff with be re-trained on how to properly run and document all program goals. Programming goals will include, but be limited to physical therapy, occupational therapy, and self help skills (ADL's). B. RM will monitor 3x/ weekly to ensure that programming is properly ran and documented. C. CS will monitor weekly to ensure that programming is properly ran and documented.	11/18/18

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W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #4's Individual Program Plan (IPP) was revised after she had successfully completed an objective. The finding is: Client #4 had successfully completed an objective; however, training continued. Review on 9/20/18 of client #4's IPP dated 3/1/18 revealed an objective to complete steps of self-medication tasks with verbal prompts for 75% of the time for 8 consecutive months (implemented 10/4/17). Additional review of progress notes for the objective revealed the following: 11/17 - 100% 12/17 - 100% 01/18 - 100% 02/18 - 100% 03/18 - 100% 04/18 - 100% 05/18 - 100% 06/18 - 100% 07/18 - 100% 08/18 - 100% Interview on 9/20/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the objective had been completed.	W 255	The following deficency will be corrected according to the following: A. All prgrams will be reviewed to ensure that they appropriately address the needs and functioning capacities of each individually consumer. B. If needed, program goals will be revised to accurately reflect the current programming needs of each consumer. C. Clinical personnel will be trained and in-serviced on how to properly monitor and revise program goals when needed. D. Data associated with the progression in any particular goal area will be tracked using the data tracking form. E. CS will monitor and evaluate progression monthly. Any needed changes and /or revisions will occur quarterly unless otherwise noted.	11/18/18

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W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure physician's orders were followed as written for 2 of 3 audit clients (#2, #4). The findings are: Physician's orders were not followed as indicated for client #2 and client #4. a. During observations of medication administration in the home on 9/20/18 at 6:48am, staff applied Hydrophor ointment to client #2's face, ears, neck, hands, and arms. Review on 9/20/18 of client #2's physician's orders dated July '18 revealed an order for Hydrophor ointment to be applied to the client's lips. Interview on 9/20/18 with the medication technician revealed she routinely applies the ointment to the areas observed due to the client's dry skin. Interview on 9/20/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the ointment should be applied as indicated by the physician. b. During observations of medication administration in the home on 9/20/18 at 7:00am, staff applied Debrox ear drops in both of client	W 368	The following deficency will be corrected according to the following: A. Registered Nurse (RN) will review all Physician Orders to ensure accuracy and appropriateness. If, any changes are warranted, RN will submit corrections to MD for their signature. B. RN will in-service all staff on the Physcian Orders for each consumer. C. RN will re-train staff on all medications administration procedures including, but not limited to medication administration, medication education, proper storage, reporting procedures, medication administration times, medication security, and what constitutes a medication error. D. RN will ensure all medications are properly labeled. Any medications not properly labled, RN will request a new label and/or new medication. E. RM will monitor the above, 3x/weekly. F. RN and CA will monitor weekly.	11/18/18

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W 368	Continued From page 10 #4's ears. Review on 9/20/18 of client #4's physician's orders dated July '18 revealed an order for Debrox ear drops 6.5%, 5 drops in both ears once a week. Review of the client's medication administration record (MAR) noted 9:00pm as the administration time. Interview on 9/20/18 with the medication technician revealed the ear drops are given PRN and in the morning. Interview on 9/20/18 with the QIDP revealed some discrepancies need to be worked out with the ear drops and the way the order is written.	W 368	Please see page 11, W 368.	
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure keys to the drug storage area were not accessible to unauthorized persons. The finding is: Keys to the medication closet were accessible to anyone in the home. During observations of medication administration in the home on 9/20/18 at 6:47am, the medication technician (MT) left the medication area and went into a bathroom to retrieve a pair of gloves. During this time, the keys to the drug storage area were left in the key hole of the door knob to	W 383	Please see page 11, W 368.	

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W 383	Continued From page 11 the medication closet and a client was also left in the room. During additional observations in the home at 7:24am, the MT left the medication area and went into the living room to retrieve a client. During this time, the keys to the drug storage area were left in the key hole of the door knob to the medication closet. Interview on 9/20/18 with the MT revealed she usually puts the keys in her pocket while giving medications; however, the dress she wore today does not have pockets. The MT also stated if clients in the home are "high functioning", the keys to the medication closet cannot be left in the door lock. Interview on 9/20/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the keys to the drug storage area should not be left in the door lock and should not be accessible to others.	W 383	Please see page 11, W 368.	
W 391	DRUG LABELING CFR(s): 483.460(m)(2)(ii) The facility must remove from use drug containers with worn, illegible, or missing labels. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure client #2's ointment was clearly and legibly labeled. This affected 1 of 3 audit clients. The finding is: Client #2's ointment container did not have a legible label. During observations of medication administration	W 391	Please see page 11, W 368.	

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W 391	Continued From page 12 in the home on 9/20/18 at 6:48am, staff removed client #2's Hydrophor ointment from the medication closet. The label on the ointment was not legible and all wording was missing. Immediate interview with the medication technician (MT) revealed the label had been illegible for a while which was likely caused by the oily ointment. Review on 9/20/18 of client #2's physician's orders dated July 2018 revealed an order for Hydrophor ointment to be applied to her lips daily at 7:00am. During an interview on 9/20/18, the home manager confirmed the ointment's label was illegible and needed to be replaced.	W 391	Please see page 11, W 368.	
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure all foods were served at an appropriate temperature. This potentially affected all clients residing in the home. The finding is: Hot foods were not served hot. During evening observations in the home on 9/19/18 from 3:30pm - 5:30pm, a container of recently cooked chicken and noodles and mixed vegetables were on the kitchen counter. Both containers were covered with lids. At approximately 5:30pm, clients began serving	W 473	Please see page 4, W 249.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G083	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLANCHE DRIVE	6208 BLANCHE DRIVE RALEIGH, NC 27607

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W 473	Continued From page 13 themselves the chicken and vegetables. The food was not reheated. Immediate interview with the home manager revealed the food was warm but she did not know the temperature of the food. The home manager later indicated food should be served within 15 minutes after cooking and acknowledged the chicken and vegetables should have been reheated. Review on 9/20/18 of the home's menu book revealed, "All food and beverages must be held at 140 or higher. All cold food and liquids must be held at 40 or lower. Once items are take from heat keeping and/or cold devices they must be served to clients within 15 minutes or reheated to 165 then served." Interview on 9/20/18 with the Qualified Intellectual Disabilities Professional (QIDP) indicated he did not know at what temperature food should be served; however, he acknowledged the dinner should have been reheated after being left out for 2 hours.	W 473	Please see page 4, W 249.	
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 3 audit clients (#1) ate in the least stigmatizing manner. The findings include:	W 488	Please see page 15, W 488.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G083	A. BUILDING _____ B. WING _____	09/20/2018

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W 488	Continued From page 14 Client #1 was not assisted to eat in the least stigmatizing manner possible. During breakfast observations in the home on 9/20/18, staff applied a large cloth clothing protector around client #1. The staff secured the upper portion of the clothing protector around the client's neck and extended the lower portion across the table in front of the client. The staff then placed client #1's plate on top of the lower portion of the clothing protector. Client #1 finger fed some portions of her meal with minimal spillage noted. Staff later fed the client the remaining portion of her meal, again,with minimal spillage noted. Staff interview on 9/20/18 revealed client #1's clothing protector was applied in this manner to "keep her clean". Review on 9/20/18 of client #1's Individual Program Plan (IPP) dated 6/12/18 revealed she uses a clothing protector to aid with controlling spillage during meals. The client's record did not indicate her clothing protector should be applied in the manner described. Interview on 9/20/18 with the Qualified Intellectual Disabilities Professional (QIDP) indicated he had seen client #1's clothing protector applied in the manner described and acknowledged it was not appropriate.	W 488	The following deficency will be corrected according to the following: A. RM will explore alternative options that will protect consumers clothing while they are dining. B. Whaever clothing protectors used, will be implemented and used in an aprpropriate and dignified way. C. All staff will be trained on how to properly implement clothing protectors while dining. D. Staff will also be trained on active treatment regarding dining so as to minimize food spillage. E. RM will monitor 3x/ weekly. F. CS will monitor weekly.	11/18/18