STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G210	A. BUILDING _____ B. WING _____	C 09/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUCKASEEGEE GROUP HOME	5400 TUCKASGEE ROAD CHARLOTTE, NC 28208

(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	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: The team failed to ensure the individual support plan (ISP) for client #1 included sufficient interventions to address needs in bathing as evidenced by interview and review of records. The finding is: Review of the facility's accident/incident reports revealed a report dated 9/11/18 regarding an incident which occurred on that date at 8:10 PM. Continued review of this report revealed client #1 was briefly left alone while bathing as staff went to get his pajamas. When staff returned it was noticed the client had turned the knobs on the water faucet, resulting in increased hot water temperature. Further review of the report revealed it was discovered the client had developed blisters/abrasions on his feet. The nurse was contacted and the client was taken to urgent care where he was treated with Sivadene 1% topical cream. Interview with the home manager revealed the client's guardians had stated the client will play with the knobs of the faucet and has done so all of his life. Continued interview with the home	W 249	The ISP for client #1 will be updated to include interventions to ensure adequate monitoring of client #1 while bathing. Staff will be trained on the updated ISP to ensure that they understand the importance of monitoring client #1 while he is bathing. This training and practice will be implemented by November 20, 2018. DHSR NHL & C Black Mountain WRO Received OCT 03 2018 by: SKM	11/20/18

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

Jennifer B | Compliance Specialist | 9/28/18

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 249	Continued From page 1 manager revealed it is understood staff would stay with client #1 while bathing. However, further interviews with the home manager, verified by review of the client's ISP dated 6/10/18, revealed no guidelines or objective training to address how staff are to assist/monitor/train the client during bathing. Therefore, the ISP failed to included sufficient interventions to address training/monitoring client #1 during bathing.	W 249		
W 426	CLIENT BATHROOMS CFR(s): 483.470(d)(3) The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by: The facility failed to ensure water temperature, in the group home where clients are not able to self-regulate the water temperature, did not exceed 110 degrees Fahrenheit as evidenced by interview and review of records. The finding is: Review of the accident/incident reports and the IRIS report revealed an incident occurred on 9/11/18 at 8:10 PM where client #1 was left alone for a brief time while bathing and "messed' with the knobs on the faucet and increased the hot water temperature. Continued review of these reports revealed the client was noticed to be red on lower part of body and to have blisters/abrasions on his feet and was taken to urgent care where he was treated with Sivadene	W 426	Group Home staff will continue to monitor and document water temperatures twice daily utilizing the Water Temperature log. Staff will be required to immediately notify the Group Home Manager immediately any time the temperature reading exceeds 110 degrees Farenheit. Group Home Manager will then contact the LIFESPAN maintenance department to check and adjust the hot water heater. Staff will receive training on appropriately checking and monitoring the water temperature as well as the process regarding contacting the Group Home Manager any time the water measures over 110 degrees farenheit. This training and practice will be implemented by November 20, 2018.	11/20/18

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W 426	Continued From page 2 1% topical cream. Review of the water temperature logs for the month of September 2018, verified by interview with the home manager, revealed the water temperature is to be checked 2 times daily at 5:00 AM and again at 5:00 PM. Continued review of the water temperature log revealed water temperature to be 101 degrees at 5:00 PM on 9/9/18, 100 degrees on 9/10/18 and at 5:00 PM on 9/11/18 the hot water temperature was noted to be 114 degrees. Interview with the group home manager, verified by further review of the water temperature logs, revealed staff are to notify the group home manager and maintenance department if the water temperature is above 110 degrees Fahrenheit. Additional interview with the group home manager revealed she was not contacted regarding the temperature until after the incident that occurred on 9/11/18 at 8:10 PM. Continued review of the water temperature log for the month of September revealed the water temperature had not exceeded 110 degrees prior to 9/11/18. Therefore, the facility failed to ensure water temperature did not exceed 110 degrees Fahrenheit and failed to follow their policy of contacting the group home manager if the temperature did exceed 110 degrees.	W 426		