

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

PRINTED: 10/17/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 340161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306	
(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 000	<p>Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2)</p> <p>[(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:]</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>*[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.</p> <p>*[For CF/RIDs 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.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment</p> <p>* [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.</p> <p>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:</p> <p>The facility did not have an emergency plan</p>	E 000	<p>The administrative staff will develop and maintain an emergency preparedness plan that will be documented, facility based and community based risk assessment utilizing and all hazards approach, including missing and all hazards approach, including strategies for addressing emergency events identified by the risk assessment. The QIDP will remain all staff by 12-16-18. The plan will be retained twice annually and as needed. The director will monitor.</p>	12-16-18

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Sen M. Salmer

TITLE

Director

(X6) DATE

10/17/18

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G151	(X2) MULTIPLE CONSTRUCTION A. BUILDING NO.: D. WING:	(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306	
(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 000	Continued From page 1 based upon risk assessments.	E 000		
W 130	<p>Review on 10/16/18 of the facility's current EP plan (undated) 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.</p> <p>Interview on 10/16/18 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she was not sure if a risk assessment had been completed and no risk assessment for the facility's EP plan was available for review.</p> <p>PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to assure privacy for 1 of 3 audit clients (#5) during personal care. The finding is:</p> <p>Staff failed to assist client #5 in maintaining her privacy during bathing and dressing.</p> <p>During observations in the facility on 10/16/18 at 7:25am client #5 walked from the bathroom to the bedroom in a towel with part of her hip and leg visible. Staff verbally cued client #5 to walk back to the bathroom and get into the shower. Client</p>	W 130		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306	
(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 130	Continued From page 2 #5 walked into the shower and staff turned on the water. Direct care staff left the bathroom door and shower curtain open leaving client #5 visible to anyone who walked by the bathroom. Client #1's bedroom is directly across from this bathroom. Client #1 opened his bedroom door and client #5 was fully visible to him. Direct care staff asked him to stay in his bedroom until client #5 finished showering. After showering, direct care staff left the bathroom door open while assisting client #5 with dressing. Interview on 10/16/18 with direct care staff revealed client #5 gets upset when the bathroom door is closed. She stated no other staff was in the home and she was responsible for monitoring the other clients so she left the bathroom door open. Review on 10/16/18 of client #5's Individual program plan (IPP) dated 1/10/18 revealed, " (client #5) needs verbal prompting and assistance for brushing teeth, combing her hair, to close the door when bathing..."	W 130	The QIDP and group home manager will review each individual program plan and observe consumers as they go about their personal tasks of bathing, dressing, etc. We will then make an addendum to their program plan that fit their needs as it pertains to privacy. The staff will be retained to ensure that consumers are afforded their privacy when bathing, dressing, etc. The consumers will also have goals to assist them with their ability to exhibit their rights to privacy. QIDP will monitor.	12-16-18
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	W 189		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306		
(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 100	<p>Continued From page 3</p> <p>employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by. Based on observations and interviews, the facility failed to ensure all staff were sufficiently trained to perform their duties efficiently. This affected 3 of 3 audit clients (#2, #4, #5). The findings are:</p> <p>1. Direct care staff did not assist client #5 with privacy as indicated in her individual program plan (IPP).</p> <p>During observations in the facility on 10/16/18 at 7:25am client #5 walked from the bathroom to the bedroom in a towel with part of her hip and leg visible. Staff verbally cued client #5 to walk back to the bathroom and get into the shower. Client #5 walked into the shower and staff turned on the water. Direct care staff left the bathroom door and shower curtain open leaving client #5 visible to anyone who walked by the bathroom. Client #1's bedroom is directly across from this bathroom. Client #1 opened his bedroom door and client #5 was fully visible to him. Direct care staff asked him to stay in his bedroom until client #5 finished showering. After showering, direct care staff left the bathroom door open while assisting client #5 with dressing.</p> <p>Interview on 10/16/18 with direct care staff revealed client #5 gets upset when the bathroom door is closed. She stated no other staff was in the home and she was responsible for monitoring the other clients so she left the bathroom door open.</p> <p>Review on 10/16/18 of client #5's individual</p>	W 100	<p>The QIDP and the home manager will retrain staff on privacy practices in order to help train consumers to execute these practices. The QIDP will review all individual program plans to ensure that privacy goals are included on an addendum where needed for all clients in the area of closing bathroom doors when late showering and wearing bath robes as needed.</p> <p>QIDP manager will also review each individual program plan and make an addendum as needed. The QIDP will update each plan to include the usage and assistance of each eating utensil. This will also include tooth brushing. The home manager will ensure that staff is retained and that all equipment and supplies needed to implement the goals will be readily available to all consumers when needed. QIDP will monitor and make changes when needed.</p>	12-16-18	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306		
(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 189	<p>Continued From page 4</p> <p>program plan (IPP) dated 1/10/18 revealed, "[client #5] needs verbal prompting and assistance for brushing teeth, combing her hair, to close the door when bathing..."</p> <p>Interview on 10/16/18 with the qualified intellectual disabilities professional (QIDP) revealed client #5 has a bathrobe and should be prompted to wear this when she is walking between rooms in the facility during bathing and dressing. Further interview confirmed direct care staff have been trained to assist client #5 with privacy. Additional interview revealed she requires verbal prompting to close the bedroom and bathroom doors during bathing and dressing.</p> <p>2. Direct care staff did not assist clients #2, #4 and #5 with cutting up their food at supper observations on 10/15/18.</p> <p>a. During observations of supper at the facility on 10/15/18 at 5:25pm, client #5 served salisbury steak, rice and broccoli onto her plate. There were 2 direct care staff and 6 clients at the dining room table. Client #5 had a spoon and a fork for eating utensils. Her meat was not cut. She picked up the piece of meat and ate large pieces off of her fork. Her cheeks were full and she experienced much difficulty manipulating the food in her mouth, chewing and swallowing her food. Several times during the meal staff told client #5 to slow her pace of eating however she continued to pack her mouth full and have difficulty chewing and swallowing. At no time during this observation did direct care staff offer to provide a knife or offer to cut up her meat.</p> <p>b. During observations of supper at the facility clients #2 and #4 were served salisbury steak,</p>	W 189			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 340151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306	
(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 189	<p>Continued From page 5</p> <p>rice and broccoli onto their plates. There were 2 direct care staff and 5 clients at the table. Staff provided forks and spoons at each place setting. Both clients #2 and #4 used their spoons and forks to cut their meat</p> <p>Interview with direct care staff on 10/15/18 revealed they did not provide knives at meals at the facility. When asked if any of the clients mis-used knives or attempted to injure themselves with these utensils, staff stated, "No</p> <p>Interview on 10/16/18 with the QIDP revealed direct care staff should provide appropriate utensils and assist clients with cutting up their food at mealtimes. Additional interview confirmed direct care staff have been trained in each clients strengths and needs in the areas of dining.</p> <p>3. Direct care staff did not implement client #5's formal written training program in toothbrushing as written.</p> <p>During observation on 10/15/18 at the facility at 3:40pm, direct care staff assisted client #5 in retrieving her toothbrushing supplies from her bedroom. Once in the bathroom, staff assisted her in putting the toothpaste on her toothbrush and turning on the water in the sink. She was given verbal cues to brush her upper outside and lower inside teeth surfaces. The toothbrushing took about 45 seconds. <u>Direct care staff told client to cup her hands, put water in her hands and rinse her mouth. There was no cup in the bathroom.</u></p> <p>Review on 10/10/18 of client #5's IPP dated 1/10/18 revealed a formal training program for toothbrushing that was implemented on 1/10/18</p>	W 189		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31G151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306		
(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 189	Continued From page 6 with 9 steps using a backwards chaining methodology. Review of the method for the objective revealed: 9. Prepare toothbrush 8. brush outer surfaces upper teeth 7. Brush outer surfaces lower teeth 6. brush chewing surface lower teeth 5. brush chewing surface upper teeth 4. brush inside surface lower teeth 3. brush inside upper teeth 2. Brush tongue 1. rinse mouth Materials: cup, glass, toothbrush, toothpaste and towel Interview on 10/16/18 with the QIDP revealed this program for client #5 is current and should be implemented as written. Additional interview confirmed direct care staff have been trained how to implement this program.	W 189			
W 218	INDIVIDUAL PROGRAM PLAN CFR(a): 483.440(c)(3)(v) The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the comprehensive functional assessment for 1 of 3 sampled clients (client #5) failed to include assessment of sensorimotor development. The finding is: During observations of supper at the facility on 10/15/18 at 5:25pm, client #5 served Salisbury steak, rice and broccoli onto her plate. There	W 218	The administrative staff and QIDP will make an appointment with an occupational therapist for client #5 to determine if there is a problem with swallowing or chewing. Once completed staff will be retrained on the recommendation made by the OT. QIDP will review the individual program and make changes where needed and retrain staff. QIDP will monitor quarterly.	12-16-18	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G161	(X2) MULTIPLE CONSTRUCTION A. BLDG NO. _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28308	
(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
W218	<p>Continued From page 7</p> <p>were 2 direct care staff and 5 clients at the dining room table. Client #5 had a spoon and a fork for eating utensils, her meal was not cut. She picked up the piece of meal and ate large pieces off of her fork. Her cheeks were full and she experienced much difficulty manipulating the food in her mouth, chewing and swallowing her food. Several times during the meal staff told her to slow her pace of eating however she continued to pack her mouth full and have difficulty chewing and swallowing.</p> <p>Immediate interview with direct care staff on 10/16/18 revealed client #5 frequently attempts to pack her mouth full of food and that she has difficulty manipulating the food into chewing and swallowing. Further interview revealed there have been no choking episodes. Additional interview revealed this has not been reported to the qualified intellectual disabilities professional (QIDP).</p> <p>During observations in the facility on 10/16/18 at 7:10am client #5 was served cream of wheat and a half of a bagel onto her plate and bowl. At 7:12am client #5 and one other client were eating at the table with 1 direct care staff present. Client #5 packed a large amount of food into her cheeks and had great difficulty chewing and swallowing this food. Staff asked her to slow her pace of eating. She began to cough and spit the food into a napkin at her placesetting.</p> <p>Immediate interview with direct care staff on 10/16/18 revealed client #5 has recently began to accelerate her pace of eating and often packs large amounts of food into her mouth. She stated there has not been any choking episodes. Further interview revealed she has not reported this to the</p>	W218		

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

PRINTED: 10/17/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34Q161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4308 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306		
(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 218	Continued From page 8 QIDP.	W 218			
W 227	<p>Review on 10/16/18 of client #5's individual program plan (IPP) dated 1/10/18 revealed she requires more prompting with eating, pouring, passing, drinking, sipping, and use of utensils while dining.</p> <p>Interview on 10/16/18 with the QIDP revealed client #5 has recently begun to have difficulty with putting food put into her mouth, chewing and swallowing. Additional interview the team has not considered having client #5 re-evaluated by an Occupational Therapist to determine any physical difficulties she may be experiencing.</p> <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: Based on observation, record review and interview, the team failed to consider the development of training to address the sensorimotor needs for 1 of 3 sampled clients (client #5). The finding is:</p> <p>During observations of supper at the facility on 10/15/18 at 6:25pm, client #5 served salisbury steak, rice and broccoli onto her plate. There were 2 direct care staff and 5 clients at the dining room table. Client #5 had a spoon and a fork for eating utensils, her meat was not cut. She picked</p>	W 227	<p>The administrative staff and QIDP will make appointment with an occupational therapist for client #5 to determine if there is a problem with swallowing or chewing. Once completed staff will be retrained on the recommendation made by OT. QIDP will review the individual program and make changes where needed and retrain staff. QIDP will monitor quarterly.</p>	12-16-18	

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

PRINTED: 10/17/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306		
(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	
W227	<p>Continued From page 9</p> <p>up the piece of meal and ate large pieces off of her fork. Her cheeks were full and she experienced much difficulty manipulating the food in her mouth, chewing and swallowing her food. Several times during the meal staff told her to slow her pace of eating however she continued to pack her mouth full and have difficulty chewing and swallowing.</p> <p>Immediate interview with direct care staff on 10/15/18 revealed client #5 frequently attempts to pack her mouth full of food and that she has difficulty manipulating the food into chewing and swallowing. Further interview revealed there have been no choking episodes. Additional interview revealed this has not been reported to the qualified intellectual disabilities professional (QIDP). When asked if the team had considered any training for client #5 in this area, staff stated, "No."</p> <p>During observations in the facility on 10/16/18 at 7:10am client #5 was served cream of wheat and a half of a bagel onto her plate and bowl. At 7:12am client #5 and one other client were eating at the table with 1 direct care staff present. Client #5 packed a large amount of food into her cheeks and had great difficulty chewing and swallowing this food. Staff asked her to slow her pace of eating. She began to cough and spit the food into a napkin at her placessetting.</p> <p>Immediate interview with direct care staff on 10/16/18 revealed client #5 has recently began to accelerate her pace of eating and often packs large amounts of food into her mouth. She stated there has not been any choking episodes. Further interview revealed she has not reported this to the QIDP. When asked if the team had considered</p>	W227			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 340161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306	
(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	Continued From page 10 any training for client #5 in this area, staff stated, "Not that I know of."	W 227		
W 240	Review on 10/16/18 of client #5's Individual program plan (IPP) dated 1/10/18 revealed she requires more prompting with eating, pouring, passing, drinking, sipping, and use of utensils while dining Interview on 10/16/18 with the QIDP revealed client #5 has recently begun to have difficulty with putting food put into her mouth, chewing and swallowing. Additional interview revealed the team has not considered developing training to address client #5's dining needs. INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the individual program plans (IPP) for 1 audit client #5) included relevant information needed for staff regarding their use of eyeglasses. The findings are: Client #5's IPP's did not include information regarding eyeglasses use. 1. During observations in the facility and at the vocational program on 10/15/18 and on 10/16/18 client #5 wore glasses throughout observations. She commented several times that she needed	W 240	The QIDP will coordinate with the eye doctor for client #5 to determine when she needs to wear her eye glasses. Once the eye doctor makes the determination the QIDP will implement a goal for this consumer to assist her and train staff on this goal in order to meet her needs. QIDP will also add this to her Individual program plan. QIDP will monitor.	12-16-18

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G151	(X2) MULTIPLE CONSTRUCTION A. BULIDING _____ D. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306	
(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 240	Continued From page 11 her glasses to see items more clearly. Review on 10/16/18 of client #5's IPP dated 1/10/18 revealed no information regarding her use of eyeglasses. Review on 10/16/18 of a recent visit to the ophthalmologist dated 10/2/18 revealed she was seen for treatment of a corneal abrasion and treated with antibiotics three times daily for one week. There was no mention of use of glasses. Interview with direct care staff (2) on 10/15/18 revealed they were not certain whether client #6 needed her glasses for full time use or only when she needed to view items in closer proximity.	W 240		
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 observation, interviews and record reviews, the facility failed to ensure each client	W 249	The QIDP will review consumers individual program plans and make addendums as needed. Each plan will be updated to include the usage and assistance of each eating utensil for dining. The QIDP will also include tooth brushing and will assist in insuring that all equipment and supplies are needed to implement client goals Staff will be retained. The QIDP will review plans quarterly and make changes as needed.	12-16-18

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

PRINTED 10/17/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G151	(X2) MULTIPLE CONSTRUCTION A. DUPLICATE _____ B. Y/N _____		(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306		
(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	
W249	<p>Continued From page 12</p> <p>received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of dining, personal care skills. This affected 3 of 6 audit clients (#2, #4, #5). The findings are:</p> <p>1. Clients #1, #4 and #5 were not provided utensils in conjunction with their dining skills.</p> <p>a. During observations of supper at the facility on 10/15/18 at 5:25pm, client #5 served salisbury steak, rice and broccoli onto her plate. There were 2 direct care staff and 5 clients at the dining room table. Client #5 had a spoon and a fork for eating utensils. Her meat was not cut. She picked up the piece of meat and ate large pieces off of her fork. Her cheeks were full and she experienced much difficulty manipulating the food in her mouth, chewing and swallowing her food. Several times during the meal staff told client #5 to slow her pace of eating however she continued to pack her mouth full and have difficulty chewing and swallowing. At no time during this observation did direct care staff offer to provide a knife or offer to cut up her meat.</p> <p>b. During observations of supper at the facility clients #2 and #4 were served salisbury steak, rice and broccoli onto their plates. There were 2 direct care staff and 5 clients at the table. Staff provided forks and spoons at each place setting. Both clients #2 and #4 used their spoons and forks to cut their meat.</p> <p>Interview with direct care staff on 10/15/18 revealed they did not provide knives at meals at the facility. When asked if any of the clients mis-used knives or attempted to injure</p>	W249			

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

PRINTED: 10/17/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ D. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306	
(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	<p>Continued from page 13</p> <p>themselves with those utensils, staff stated, "No."</p> <p>Review on 10/16/18 of client #2's IPP dated 2/3/18 revealed he can independently feed himself. There was not additional information regarding his ability to use a knife.</p> <p>Review on 10/16/18 of client #4's IPP dated 12/9/17 revealed he maintains the skills for eating, pouring, drinking and sipping. There was not additional information regarding his ability to use a knife.</p> <p>Interview on 10/16/18 with the qualified intellectual disabilities professional (QIDP) revealed clients #1, #4 and #5 can use a butter knife to cut up their food and should be provided appropriate utensils to cut up their food</p> <p>2. Direct care staff did not implement client #5's toothbrushing program as it was written.</p> <p>During observation on 10/15/18 at the facility at 3:40pm, direct care staff assisted client #5 in retrieving her toothbrushing supplies from her bedroom. Once in the bathroom, staff assisted her in putting the toothpaste on her toothbrush and turning on the water in the sink. She was given verbal cues to brush her upper outside and lower inside teeth surfaces. The toothbrushing took about 45 seconds. Direct care staff told client to cup her hands, put water in her hands and rinse her mouth. There was no cup in the bathroom.</p> <p>Review on 10/16/18 of client #5's IPP dated 1/10/18 revealed a formal training program for toothbrushing that was implemented on 1/10/18 with 9 steps using a backwards chaining</p>	W 249		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER-SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306	
(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	Continued From page 14 methodology. Review of the method for the objective revealed: 0. Prepare toothbrush 8. brush outer surfaces upper teeth 7. Brush outer surfaces lower teeth 6. brush chewing surface lower teeth 5. brush chewing surface upper teeth 4. brush inside surface lower teeth 3. brush inside upper teeth 2. Brush tongue 1. rinse mouth Materials: cup, glass, toothbrush, toothpaste and towel	W 249		
W 262	Interview on 10/16/18 with the QIDP revealed this program for client #5 is current and should be implemented as written. PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on review of records and interview, the specially constituted committee, known as the Human Rights Committee (HRC), failed to review, approve and monitor behavior support plans (BSP) for 2 of 3 sampled clients (#4, #5). The findings are: The HRC did not review, approve and monitor the restrictive behavior plans for 2 of 3 audit clients.	W 262	The Director as well QIDP will ensure that all human rights committee meetings include documentation of the discussion and consumers behavior, behavior plans, and medications to aide in the control of these behaviors in addition informed consent forms will be signed by the human rights committee. Director and QIDP will monitor quarterly.	12-16-18

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER-SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306		
(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) CORRECTION DATE	
W262	Continued From page 15 1. Review on 10/16/18 of client #4's behavior support program (BSP) dated 3/1/18 revealed this program targeted the following behaviors: verbal aggression, physical aggression and non-compliance which incorporated the use of Zyraxa. During observations of a medication pass on 10/16/18 client #4 received Seroquel 20mg. (1) at 9:10am Review on 10/16/18 of his physician orders dated 6/23/18 revealed a physician order for Seroquel 20mg. (1) Review on 10/15/18 of the HRC minutes dated 6/29/18 and 9/27/18 revealed no discussion of client #4's BSP. Review on 10/16/18 of the informed consent for client #4's BSP revealed no signature from the HRC. Interview on 10/16/18 with the qualified intellectual disabilities professional (QIDP) revealed there was no documentation of the discussion of client #4's BSP in the HRC minutes on 6/29/18 and 9/27/18. 2. Review on 10/16/18 of client #5's BSP dated 10/31/16 revealed a program that targeted verbal aggression, property destruction and physical aggression. During observations of the medication administration pass on 10/16/18 client #5 received Haldol 10mg. (1.5 tablets) and Seroquel 25mg. (1).	W262			

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

PRINTED: 10/17/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 340161	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28308		
(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) COMPLETE DATE	
W 262	Continued From page 16 Interview on 10/16/18 with the QIDP confirmed client #5 receives Haldol and Seroquel in conjunction with the implementation of her BSP. Review on 10/16/18 of the HRC minutes dated 6/29/18 and 9/27/18 revealed no discussion of client #5's BSP. Review on 10/16/18 of the informed consent for client #5's BSP revealed no signature from the HRC. Interview on 10/16/18 with the QIDP revealed there was no documentation of the discussion of client #4's BSP in the HRC minutes on 6/29/18 and 9/27/18.	W 262			
W 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure drugs used for the control of inappropriate behaviors were used only as an integral part of the Behavior Support Plan (BSP) directed towards the reduction or elimination of behaviors for which the drugs were employed. This affected 1 of 3 audit clients (#5). The finding is:	W 312	The administrative staff and QIDP will ensure that drugs used to control inappropriate behaviors are included in all clients individual program plans. The QIDP will review and make addendums to their plans to include these medications. QIDP will monitor.	12-16-18	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G161	(X2) MULTIPLE CONSTRUCTION A. BOLLING _____ B. WARD _____	(X3) DATE SURVEY COMPLETED 10/16/2018	
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306		
(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 312	<p>Continued From page 17</p> <p>Client #5's psychotropic medication was not included in her individual program plan (IPP) or BSP.</p> <p>Review on 10/15/18 of client #5's BSP dated 10/31/16 revealed this program targeted verbal aggression, property destruction and physical aggression. Further review revealed there were no psychotropic medications listed in this program</p> <p>Review on 10/15/18 of client #5's IPP dated 1/10/18 revealed the use of Seroquel and Haldol were not included in her IPP.</p> <p>During observations of the medication administration pass on 10/16/18 at 9:40am, client #5 received Haldol 10mg. (1.5 tablets) and Seroquel 25mg. (1).</p> <p>Interview on 10/16/18 with the QIDP confirmed client #5 receives Haldol and Seroquel in conjunction with the implementation of her BSP. Further interview confirmed the use of these medications are not included in client #5's IPP and BSP.</p>			
W 369	<p>DRUG ADMINISTRATION CFR(s): 483.460(k)(2)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered without error.</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306		
(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 369	<p>Continued From page 18</p> <p>This affected 3 of 6 clients (#1, #4 and #5) observed receiving medications. The findings are:</p> <p>Staff failed to administer medications as ordered within the time prescribed by the physician.</p> <p>a. During observations in the facility on 10/16/18 the qualified intellectual disabilities professional (QIDP) administered the following medications to client #4 at 9:10am: Omeprazole 20 mg. (1), Loratadine 1 mg. (1), Senna Plus 8.6 mg. (1).</p> <p>Review on 10/16/18 of the physician orders dated 6/26/18 for client #4 revealed the following medications are ordered at 8am: Omeprazole 20 mg. (1), Loratadine 1 mg. (1), Senna Plus 8.6 mg. (1).</p> <p>b. During observations in the facility on 10/16/18 the QIDP administered the following medications to client #1 at 9:20am: Seroquel 200mg. (1), Aspirin 81 mg. (1), Lanoxin 0/125mg. (1), Toprol 10mg. (1), Colace 100mg (1), Cogentin 1mg. (1), Lisinopril 20mg. (1), Hydroxyzine 25 mg (1) Systane eyedrops (1) drop to each eye were administered later at 9:50am.</p> <p>Review on 10/16/18 of the physician orders for client #1 dated 6/26/18 revealed the following medications are ordered at 8am: Seroquel 200mg. (1), Aspirin 81 mg. (1), Lanoxin 0/125mg. (1), Toprol 10mg. (1), Colace 100mg (1), Cogentin 1mg. (1), Lisinopril 20mg. (1), Hydroxyzine 25 mg. (1) and Systane eyedrops (1) drop to each eye.</p> <p>c. During observations in the facility on 10/16/18 the QIDP administered the following medications</p>	W 369	The nurse will retrain staff in the area of medication administration so that all medications are given prescribed by the physician. If there is a change, the physician will be contacted. The nurse and QIDP will monitor.	12-16-18

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

PRINTED: 10/17/2018
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/16/2018
NAME OF PROVIDER OR SUPPLIER NO PLACE LIKE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28308		
(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	
W369	<p>Continued From page 19</p> <p>to client #5 at 9:40am: One a day vitamins (1), Rantidine 150mg. (1), Levocarnitino 330mg. (1), Ferrous Sulfate 325mg. (1), Newdexta 20/10 (1), Benzotropino 20mg. (1), Haldol 10mg (1) and Seroquel 25mg. (1).</p> <p>Review on 10/16/18 of the physician orders for client #1 dated 6/26/18 revealed the following medications are ordered at 8am: One a day vitamins (1), Rantidine 150mg. (1), Levocarnitino 330mg. (1), Ferrous Sulfate 325mg. (1), Newdexta 20/10 (1), Benzotropino 20mg. (1), Haldol 10mg. (1) and Seroquel 25mg. (1).</p> <p>Interview on 10/16/18 with the QIDP revealed the facility policy regarding medication administration requires that medications are administered an hour before or no later than one hour after a physician orders these medications. Further interview confirmed the physician was not contacted to get another order for these delayed medications</p>	W369			