STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G251	A. BUILDING _____ B. WING _____	11/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAREN LANE HOME	**3224 KAREN LANE MONROE, NC 28112**

(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 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(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:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to develop specific facility based strategies as part of the emergency preparedness plan. The finding is: Review of the facility's Emergency Plan (EP) on 11/14/18 revealed the EP to contain a risk assessment and community strategies. However, further review of the EP substantiated by interview with the home manager and the qualified intellectual disabilities professional (QIDP) on 11/14/18, revealed the EP did not include individual client identification with specific information regarding each client's needs to enable care by volunteers or persons unfamiliar with the client which would not violate the Health Insurance Portability and Accountability Act (HIPAA). Interview with the home manager on 11/14/18 revealed identification with a photo and specific	E 007		

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

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E 007	Continued From page 1 information identifying each resident's needs could be located in their facility record that also includes confidential information. Interview with the QIDP on 11/14/18 confirmed the residents of the facility have communication deficits, mobility needs, adaptive equipment, special diets, and behavioral plans that must be addressed. Further interview with the home manager and QIDP on 11/14/18 confirmed specific strategies for each client must be planned for, individualized, and documented specifically to address each client's needs within the EP.	E 007		
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, record review and interviews, the facility failed to assure 1 of 3 sampled clients (#2) received needed interventions and services in sufficient number and frequency to support objectives stated in the individual program plan . The finding is: Observations conducted at the day program on 11/13/18 beginning at 11:45 AM revealed client #2 completed his lunch in the dining area and was assisted by staff to proceed to his classroom	W 249		

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W 249	Continued From page 2 where he was observed sitting in his wheelchair with a soft helmet hanging on the back of the chair. Client #2 was not observed to be wearing his helmet during day program observations from 11:45 AM to 12:35 PM. Further observations conducted in the group home during the afternoon of 11/13/18 and the morning of 11/14/18 revealed client #2 was wearing his helmet except when he was eating. Review of the record for client #2, conducted on 11/14/18, revealed a Person Centered Plan (PCP) dated 4/25/18 documented client #2 is to wear a soft helmet when transferring, ambulating and sitting. Interviews conducted with the residential manager, qualified intellectual disabilities professional (QIDP) and the nurse revealed client #2 wears the soft helmet due to frequent seizures and a history of falls. Further interview with the QIDP and the nurse verified client #2 should wear the soft helmet at all times except when he is eating or sleeping.	W 249		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the system for drug administration failed to assure that all drugs were administered without error for 1 of 2 clients (#3) observed during drug administration. The finding is:	W 369		

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W 369	Continued From page 3 Observation conducted on 11/14/18 at 8:10 AM revealed client #3 was prompted by staff to enter the drug administration area and was assisted by staff to receive the following medications: Refresh Tears eye drops-one drop in right eye, Ofloxacin 0.3% ophthalmic solution-one drop in the right eye, Peridex 0.12% solution 1/8 ounce-swab gums with toothette, Risperidone 0.5 mg., Zantac 150 mg., Allegra 180 mg., Cogentin 0.5 mg., Calcium 600 mg., Vitamin D-3 2000 units, Miralax powder 17g mixed in 8 ounces of orange juice, and Docusate sodium 100 mg.-one capsule. Review of the record for client #3 revealed the most recent physician's orders dated September 1, 2018 through November 30, 2018 documented client #3 was prescribed Docusate sodium 100 mg. -take two capsules by mouth (daily). Further review of the medication administration record for client #3 revealed client #3 was scheduled to receive Docusate sodium 100 mg.-two capsules at 8:00 AM daily. Interview conducted on 11/14/18 at 8:50 AM with the staff responsible for medication administration revealed client #3 should have received Docusate sodium 100 mg.-two capsules during the morning medication administration. It should be noted that following this interview staff prompted client #3 to return to the medication administration area at 9:20 AM and assisted him to receive Docusate sodium 100 mg.-one capsule to complete the prescribed dose of 200 mg. Interview with the nurse conducted on 11/14/18 verified client #3 should receive Docusate Sodium 100 mg.-two capsules during the 8:00 AM medication administration as prescribed by the physician.	W 369		

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