STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G247	A. BUILDING ______ B. WING ______	11/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINOAK GROUP HOME	**3175 BANK ROAD LINCOLNTON, NC 28092**

(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	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 observation and interview, the facility failed to assure each employee was provided with training that enables the employee to perform his duties effectively, efficiently and competently relative to maintaining a safe environment. The finding is: Observations conducted in the home on 11/20/18 at 7:10 AM revealed staff spilled coffee onto the floor in the dining area from a cup he was carrying to the table. Staff was then observed to mop the area, leaving the floor wet. Continued observations at 7:15 AM revealed client #5 entered the dining area walking rapidly and fell onto the floor. Client #5 was then observed to get up from the floor, state "I slipped and fell. I'll get the wet floor sign." Client #5 was then observed to retrieve the wet floor sign from another area of the home and place it in the dining area where the floor was wet. Interview conducted on 11/20/18 with the qualified intellectual disabilities professional verified staff should dry the floors in the group home if mopping any area where clients are active and/or place the provided wet floor sign in front of the area to prevent slips and falls.	W 189		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi)	W 247		

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

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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The individual program plan must include opportunities for client choice and self-management.
This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the person centered plans (PCPs) failed to include opportunities for choice and self-management for 5 of 6 clients (#1, #2, #3, #4 and #6) observed during the breakfast meal, and for 2 of 6 clients (#2 and #5) relative to leisure choice. The findings are:

A. Staff failed to ensure opportunities for choice and self-management were provided relative to meal preparation for client's #1, #2, #3, #4 and #6. For example:

Observation conducted in the group home on 11/19/18 at 5:40 PM revealed all six clients residing in the home loaded onto the van for a dinner outing in the community. Further observations conducted in the home on 11/20/18 beginning at 6:45 AM revealed six plates were located on the kitchen counter with breakfast items including scrambled eggs and biscuits already plated with an eating utensil on each plate. Continued observation revealed staff prepared six bowls of oatmeal in the microwave oven and placed them on the kitchen counter along with the pre-plated scrambled eggs and biscuits, placing a spoon in each bowl. Continued observation at 6:50 AM revealed staff poured orange juice into six glasses also located on the kitchen counter. Client #5 was present in the kitchen at 6:45 AM and was observed to ask staff if he could get his milk from the refrigerator, at which time staff prompted client #5 to leave the kitchen and sit at the dining table. Client #5 returned to the kitchen at 7:00 AM, retrieved his

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W 247	Continued From page 2 pre-plated meal from the counter, got spray margarine and chocolate milk from the refrigerator and began eating his breakfast meal. Further observation on the morning of 11/20/18 beginning at 6:45 AM revealed client #5 was the only client up and dressed for the day at that time. All other clients remained in their bedrooms dressing and preparing for the day's activities. On-going observations during the breakfast meal on 11/20/18 revealed clients #1, #2, #3, #4 and #6 were each served their pre-plated meal and pre-poured beverages by staff with minimal or no participation in choosing, preparing or serving their meal. Review of the record for client #1 on 11/20/18 revealed a PCP dated 9/17/18 which included an ABI dated 9/13/18 documenting client #1 had the skills to serve himself from a bowl or platter, pour from a small pitcher, prepare a dish in the microwave and set the table independently. Review of the record for client #2 on 11/20/18 revealed a PCP dated 7/31/18 which included an ABI dated 7/26/18 documenting client #2 had the skills to serve himself from a bowl or platter, pour from a small pitcher, prepare a dish in the microwave and set the table independently. Review of the record for client #3 on 11/20/18 revealed a PCP dated 6/1/18 which included an ABI documenting client #3 had the skills to serve himself from a bowl or platter, pour from a small pitcher, set the table and use a microwave independently. Review of the record for client #4 on 11/20/18 revealed a PCP dated 3/23/18 which included an ABI dated 3/16/18 documenting client #4 had the	W 247		

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skills to serve himself from a bowl or platter, pour from a small pitcher, and prepare a breakfast meal with partial independence.

Review of the record for client #6 on 11/20/18 revealed a PCP dated 8/24/18 which included an ABI dated 8/20/18 documenting client #6 had the skills to serve himself from a bowl or platter, pour from a small pitcher, and prepare a breakfast meal independently.

Interview conducted with the qualified intellectual disabilities professional on 11/20/18 verified all six clients residing in the group home should be provided with a choice related to all food items served and should be allowed to participate in meal preparation as indicated in their individual PCPs. This interview further verified all clients residing in the home are capable at some level of choosing, preparing, pouring and serving themselves their meals.

B. Staff failed to ensure opportunities for choice and self-management were provided relative to leisure choice for clients #2 and #5. For example:

Observation in the group home on 11/20/18 at 7:52 AM revealed client #5 to sit in the living room area with a book. Client #5 was observed to ask staff to watch television and the staff responded "we're not". Continued observation at 7:55 AM revealed client #2 to stand in the living room with no activity engagement and ask staff for a book and staff responded "no, you do that on second shift, not first shift." Client #2 then requested to watch "TV" and staff responded "No." Additional observation revealed staff to offer no other activity choice to client #2.

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W 247	Continued From page 4 Interview with group home staff revealed clients in the home get very engaged into the television if it is on and therefore, television was limited to try to get the clients to engage in other activities. Additional interview with staff revealed the "book" that client #2 was requesting is related to a second shift program and the books are kept in a locked closet in the home. It should be noted after the staff interview, staff turned the living room television on for the client's. Interview with the qualified intellectual disabilities professional (QIDP) on 11/20/18 revealed all clients should be allowed to engage in their preferred leisure choice during their leisure time. Further interview with the QIDP revealed there should be no restricted access to television if clients are in the living room and requesting to watch it. Subsequent interview confirmed client #2 should have been allowed access to his book/magazine and access is not limited to any certain shift nor should they be in a locked closet.	W 247		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the team failed to assure techniques to manage inappropriate behavior were not used as a substitute for active treatment for 1 of 3 sampled clients (#4) and 1 non-sampled client	W 288		

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(#5) relative to the storage of hygiene items. The findings are:

A. Observations in the group home on 11/20/18 at 7:45 AM revealed client #5 to exit the living room area of the home, walk to the laundry room and exit the laundry room with his toothbrush and toothpaste. Client #5 was then observed to enter the bathroom to brush his teeth. Further observation of the laundry room revealed the hygiene basket for client #5 sitting on a shelf.

Review of record for client #5 on 11/20/18 revealed a person centered plan (PCP) dated 1/31/18 with a behavior support plan (BSP) dated 11/6/18. Review of client #5's PCP revealed no objective training relative to the need for storage of hygiene items outside of the client's room. Review of the BSP revealed client #5 to have target behaviors of activity refusal, verbal disruption, bizarre/untrue statements, inappropriate toileting, property destruction, physical aggression, AWOL, tantrum behavior, self-injurious behavior and tearing clothing. No prevention strategies of the BSP were identified relative to storing the client's hygiene items in the laundry room.

Interview with group home staff on 11/20/18 revealed client #5's hygiene items are stored in the laundry room due to behaviors of the client relative to inappropriate use with smearing toothpaste on walls and pouring out liquid products while the client often also loses items. Staff further described client #5's room as a black hole and whatever the client takes into his room seems to disappear. Interview with the qualified intellectual disabilities professional (QIDP) on 11/20/18 verified storing hygiene items of client

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W 288	Continued From page 6 #5 in the laundry room was not a strategy tied to any programming for the client. Further interview with the QIDP revealed she was unaware the clients hygiene basket was being stored in the laundry room. Additional interview verified the QIDP was unaware of any behaviors of the client relative to inappropriate hygiene item use. B. Observation of the group home laundry room on 11/20/18 revealed the hygiene basket of client #4 to be stored on a shelf. Review of record for client #4 on 11/20/18 revealed a PCP dated 3/23/18 with a BSP dated 5/4/18. Review of client #4's PCP revealed no objective training relative to the need for storage of hygiene items outside of the client's room. Review of the BSP revealed client #4 to have target behaviors of stealing, self-injurious behavior, verbal aggression, physical aggression, property destruction, inappropriate urination, inappropriate sexual behavior, and AWOL. No prevention strategies of the BSP were identified relative to storing the client's hygiene items in the laundry room. Interview with group home staff on 11/20/18 revealed client #4's hygiene items are stored in the laundry room due to behaviors of the client relative to inappropriate use. Interview with the QIDP on 11/20/18 verified storing hygiene items of client #4 in the laundry room was not a strategy tied to any programming for the client. Further interview with the QIDP revealed she was unaware the client's hygiene basket was kept in the laundry room. Additional interview verified the QIDP was unaware of any behaviors of the client relative to inappropriate hygiene item use.	W 288		

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W 368	Continued From page 7	W 368		
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, record review and interview, the system for drug administration failed to assure all drugs were administered according to physician's order for 1 of 1 clients (#4) observed during drug administration. The finding is: Observation conducted in the group home on 11/20/18 at 7:00 AM revealed client #4 entered the dining area of the home and ate his breakfast meal, finishing his meal at 7:23 AM. Continued observation on 11/20/18 at 7:28 AM revealed client #4 was prompted by staff to come to the medication area where he was assisted to take medications including Amitza 24 mcg., Aspirin 81 mg., Buspar 15 mg., Zyrtec 10 mg., Clonidine 0.1 mg., Depakote 250 mg.-three tablets, Macrodantin 50 mg., Oyscal-Vitamin D 550/200, Paxil 20 mg., Vitamin D-3 2000 iu, Miralax powder 34g., Patanol ophthalmic sol. 0.1% -one drop in each eye, Nasonex nasal spray-one spray in each nostril and Reglan 10 mg.. Review of the record for client #4, conducted on 11/20/18 revealed current physician's orders documenting client #4 should take Reglan 10 mg.-one tablet by mouth before meals and at bedtime. Interview with the nurse, conducted on 11/20/18, verified client #4 should have received the Reglan 10 mg. before eating his breakfast	W 368		

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W 368	Continued From page 8 rather than after the meal as was observed.	W 368		