		ID HUMAN SERVICES MEDICAID SERVICES				APPROVED . 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	(X3) DATE SURVEY COMPLETED		
		34G236	B. WING		11/2	28/2018		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
ROBERT E LEE GROUP HOME				1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
E 032	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		E 03	DEFICIENCY)				
	event of a power failu was available for use Interview on 11/27/18	ire; however, no cell phone in the home.						
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE	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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 11/30/2018

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			CONCEPTION		OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	· · ·	(X3) DATE SURVEY COMPLETED		
		34G236	B. WING		1	1/28/2018	
NAME OF PROVIDER OR SUPPLIER ROBERT E LEE GROUP HOME			ST	TREET ADDRESS, CITY, STATE, ZIP COD	E		
				519 ROBERT E LEE DRIVE /ILMINGTON, NC 28412			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE	
E 032	Continued From page 1 confirmed there is currently no alternative means		E 032				
W 240	of communication during a power failure. INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i)		W 240				
		m plan must describe to support the individual e.					
	Based on observatio review, the facility fail Program Plan (IPP) for included specific infor client's family style di	not met as evidenced by: ns, interviews and record led to ensure the Individual or 1 of 3 audit clients (#5) rmation to support the ning skills. The finding is:					
	Client #5's IPP did no regarding his family s	t include specific information tyle dining skills.					
	11/27/18 at 6:07pm, or chopper to grind up h dinner plate. The clie dinner table with his f prepared. Client #5 v	is meat and place it on his ent then returned to the full plate of food already					
	3/20/18 revealed the cholesterol, mechanic supplements. Addition not include any inform	of client #5's IPP dated client receives a low cal soft diet with Boost onal review of the plan did nation regarding the client's eeded during family style					

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-				FOR	D: 11/30/2018 M APPROVED
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
	34G236	B. WING		11	/28/2018
ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
E LEE GROUP HOME					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	ILD BE	(X5) COMPLETION DATE
confirmed client #3's information regarding client consumes a cho participate in all aspec FOOD AND NUTRITI	IPP does not include family style dining since the opped diet and does not cts of family style dining. ON SERVICES				
Each client must rece well-balanced diet inc	ive a nourishing, luding modified and				
Based on observation review, the facility fail modified diet was pro-	ns, interviews and record ed to ensure client #3's vided as indicated. This				
Client #3 was not provindicated.	vided a chopped diet as				
11/27/18 at 11:14am, peanut butter and jelly pieces and a bag of C dispensed from the ba	client #3 consumed a y sandwich cut into bite-size Cheetos. The Cheetos were ag 1 or 2 at a time by staff.				
11/28/18 at 7:25am, or toasted English muffir next to her, the client bite at a time with pro between bites. Client items without difficulty	Elient #3 consumed a whole in cut in half. As a staff sat consumed the muffin one mpts to take sips of liquid in #3 consumed the food /.				
	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER E LEE GROUP HOME SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L Continued From page confirmed client #3's information regarding client consumes a che participate in all aspe- FOOD AND NUTRITI CFR(s): 483.480(a)(1 Each client must rece well-balanced diet inc specially-prescribed c This STANDARD is r Based on observation review, the facility fail modified diet was pro- affected 1 of 3 audit c Client #3 was not pro- indicated. During lunch observa 11/27/18 at 11:14am, peanut butter and jelly pieces and a bag of C dispensed from the bac Client #3 consumed ti difficulty. During breakfast obse 11/28/18 at 7:25am, c toasted English muffir next to her, the client bite at a time with pro- between bites. Client items without difficulty	CORRECTION IDENTIFICATION NUMBER: JAG236 ROVIDER OR SUPPLIER E LEE GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 confirmed client #3's IPP does not include information regarding family style dining since the client consumes a chopped diet and does not participate in all aspects of family style dining. FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure client #3's modified diet was provided as indicated. This affected 1 of 3 audit clients. The finding is: Client #3 was not provided a chopped diet as indicated. During lunch observations at the day program on 11/27/18 at 11:14am, client #3 consumed a peanut butter and jelly sandwich cut into bite-size pieces and a bag of Cheetos. The Cheetos were dispensed from the bag 1 or 2 at a time by staff. Client #3 consumed the food items without	S FOR MEDICARE & MEDICAID SERVICES OP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLI A. BUILDING_ 346236 B. WING ROVIDER OR SUPPLIER ID E LEE GROUP HOME ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 2 ID Confirmed client #3's IPP does not include information regarding family style dining since the client consumes a chopped diet and does not participate in all aspects of family style dining. FOOD AND NUTRITION SERVICES W 460 CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. W 460 This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure client #3's modified diet was provided as indicated. This affected 1 of 3 audit clients. The finding is: Client #3 was not provided a chopped diet as indicated. During lunch observations at the day program on 11/27/18 at 11:14am, client #3 consumed a peanut butter and jelly sandwich cut into bite-size pieces and a bag of Cheetos. The Cheetos were dispensed from the bag 1 or 2 at a time by staff. Client #3 consumed the food items without difficulty. During breakfast observations in the home on 11/28/18 at 7:25am, client #3 consumed a whole toasted English muffin cut in half. As a staff sat next to her, the client consumed the muffin o	S FOR MEDICARE & MEDICAID SERVICES preperiorencies (x1) PROVIDERSUPPLIERCULA 346236 8. WING ROVIDER OR SUPPLIER 8. WING E LEE GROUP HOME STREETADDRESS, CITY, STATE, ZIP CODE 191 PROBERT E LEE DRIVE (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Continued From page 2 W 240 continued From page 2 W 240 continued From page 10 tanit) style dining, since the client consumes a chopped diet and does not participate in all aspects of family style dining, FOOD AND NUTRITION SERVICES W 460 CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. W 460 This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure client #3's modified diet was provided as indicated. This affected 1 of 3 audit clients. The finding is: Client #3 was not provided a chopped diet as indicated. Client #3 consumed a whole toasted English muffin cut in that. As a staff sat next to her, the client consumed the food items without difficulty. During lunch observations in the home on 11/2/2/18 at 7:25am, client #3 consumed a whole toasted English muffin cut in that. As a staff sat next to her, the client consumed the food items without difficulty.	MENT OF HEALTH AND HUMAN SERVICES OMB NU SFOR MEDICARE & MEDICALD SERVICES OMB NU prediction is a service of the service of

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/30/2018 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G236	B. WING			11/2	28/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S			
ROBERT	E LEE GROUP HOME			1519 ROBERT E LEE DRI WILMINGTON, NC 284			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 460	order: low cholesterol salt at table (Cardiac meals use of maroon between bites, chopp Additional review of c posted at the day pro "This diet is used for chewing or swallowin to the regular diet but ground to minimize cl should be the consist cooked ground beef." Staff interview (2) on client #3's food should is "OK" to have her but interview indicated clii mechanical soft" diet. Interview on 11/28/18 confirmed client #3 sh	revealed, "Clarification I, low saturated fat no added diet) Full supervision at spoon, sips of beverage ed diet with use of chopper." hopped diet guidelines gram (no date) revealed, clients who have difficulty gThe foods are the similar may be served chopped or newingChopped foods ency of a garden pea or 11/27 - 11/28/18 revealed d be dime size pieces and it reads bite-sized. Additional ent #3 receives a "chopped with the Home Manager nould consume a chopped foods placed in a chopper	W 4	60			

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