STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G057	A. BUILDING _____ B. WING _____	11/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD COUNTY GROUP HOME #3	401 WOODLAWN CIRCLE CLYDE, NC 28721

(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 observations and interviews, the facility failed to assure adequate staff training specific to wheelchair safety during transport for 1 of 3 sampled clients (#3). The finding is: Observation at the group home on 11/27/18 at 9:55 AM revealed client #3 to be loaded onto the facility van in a wheelchair. Further observation revealed staff to secure the client's wheelchair in the van with straps that included locking clips. Continued observation revealed staff to clip the rear straps of the van to the back tires of the wheelchair. Upon this observation, this surveyor interviewed staff and the facility qualified intellectual disabilities professional (QIDP). The QIDP was then observed to redirect staff to ensure the client was secured in the facility van by the frame of the wheelchair, not the wheelchair tires. Interview with staff revealed she forgets sometimes to secure the client by the wheelchair frame and she was trained incorrectly by another staff. Interview with the QIDP verified client #3 should always be secured during transport by the frame of the wheelchair. Further interview with the QIDP verified staff could benefit from additional training to address the safety of client #3 during transport.	W 189		
W 249	PROGRAM IMPLEMENTATION	W 249		

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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W 249	Continued From page 1 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 observations, record review and interview, the facility failed to ensure sufficient interventions were implemented to assure continuous active treatment and that objectives listed on the individual service plan (ISP) were implemented as prescribed for 3 of 3 sampled clients (#1, #3 and #5). The findings are: A. The interdisciplinary team failed to implement sufficient interventions to address client needs relative to adaptive behaviors for client #1. For example: Observation in the group home on 11/27/18 at 7:43 AM revealed client #1 to walk to the living room area of the home, sit on the couch and listen to music from the television and browse cartoons from an electronic device. Continued observation at 8:00 AM revealed client #1 to put the electronic device on the side table next to the couch and to go to sleep. Client #1 was observed to sleep from 8:10 AM until 9:10 AM with one verbal prompt from staff requesting if the client wanted to engage in arm weight exercises to which the client refused and went back to	W 249		

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W 249	Continued From page 2	W 249		

sleep. At 9:10 AM client #1 was observed to wake up, go to the restroom and return to the living room couch until staff offered the opportunity for a phone call. Client #1 was observed to sleep for over 60 minutes of survey observations with no prompts offered by staff for structure with active treatment or liesure options, except to engage in arm weight exercises.

Review of records for client #1 revealed a behavior support plan (BSP) dated 8/27/18 for target behaviors of aggression and scratching skin. Further review of the BSP identified client #1's need for structure to address target behaviors. Additional record review revealed a psychological evaluation for client #1 recommending the need for structure to address maladaptive behaviors and preferred activities of the client to include music and looking through magazines/papers. Subsequent record review revealed client #1's need for structure while providing no direction with additional active treatment interventions in the group home except preferred activities of music and magazines.

Interview with the facility qualified intellectual disabilities professional (QIDP) revealed client #1 needs structure to address target behaviors of the BSP. Additional interview with the QIDP verified staff should have provided additional prompts to client #1 relative to active treatment or preferred activities to support structure during her morning routine.

B. The interdisciplinary team failed to implement sufficient interventions to address client needs relative to adaptive behaviors for client #5. For Example:

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W 249	Continued From page 3 Observations throughout the 11/26-27/18 survey client #5 was observed to be verbally prompted by staff to participate in various activities that included: a number identification activity, setting the table, meal participation, multiple leisure options, brushing teeth and nail care. Observations of client #5 revealed a refusal gesture to multiple verbal prompts from staff upon the initial request then client #5 at times would return to the requested activity for participation such as meals. Staff were observed to walk away from the client when client #5 would indicate a refusal gesture without any further encouragement. Review of records for client #5 revealed a BSP dated 11/5/18. Review of the BSP revealed a target behavior of refusal behavior (resists care). Further review of the BSP revealed strategies to address refusal behavior with utilizing treats like yogurt/cookie and using favorite objects of the client (clock/flashlight) when helping with his care. Interview with the QIDP verified client #5 likes to do things in his own time and will often refuse verbal prompts from staff regarding activities and treatment. Additional interview with the QIDP verified staff should have used appropriate strategies of the client's BSP to address refusal behavior. The QIDP further verified staff should have used client #5's favorite objects to encourage the client with participation in care/treatment. C. The interdisciplinary team failed to implement sufficient interventions to address client needs relative to communication for client #3. For example:	W 249		

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W 249	Continued From page 4 Observations in the group home during the 11/26-27/18 survey revealed client #3 to be mostly non-verbal. Additional observation revealed client #3 to be prompted by staff with transitions and activity engagement with verbal and physical gestures. Observation of staff during the dinner meal on 11/26/18 revealed staff to sign "thank you" to client #3 in response to the client's meal participation. Client #3 was not observed to communicate with hand signs or be prompted to use hand signs as a form of communication during any observation. Review of current training objectives for client #3 on 11/26/18 revealed a communication objective to use hand signs with a revised date of 3/8/17. Further review of the communication objective revealed client #3 will use new and known hand signs spontaneously to communicate socially and to communicate wants/needs with 50% accuracy. Further review of Client #3's hand sign program revealed staff may provide cueing to the client in the following manner: "Do you need help with that? Show me the sign for help.", "Are you done with dinner? Show me the sign for finished." Signing should be elicited and encouraged throughout all of client #3's daily activities and routines. A review of client #3's communication evaluation dated 3/1/18 revealed recommendations to maintain/increase client #3's use of signing vocabulary to enhance overall communication by continuing hand signs program as written and to continue to elicit and monitor use of previously learned signs, gestures and verbalizations. Interview with the QIDP on 11/27/18 verified client #3's communication program relative to hand signs remains current and the client does know	W 249		

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W 249	Continued From page 5 various hand signs. Additional interview with the QIDP verified staff should have prompted or encouraged client #3 to utilize hand signs at various times to include conversations with staff and with activity engagement.	W 249		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was served at an appropriate temperature for 1 of 5 client's residing in the home for one of two meals observed. Observation in the group home on 11/27/18 at 7:50 AM revealed client #3 to sit at the kitchen table for breakfast. Staff was observed to remove client #3's oatmeal from the microwave and bring it to the client while stating "It's hot." Client #3 was observed to take a bite of oatmeal and immediately remove her spoon and the oatmeal from her mouth. Client #3 was then observed to sit and look at her oatmeal while staff prompted the client to let it cool. Interview with staff revealed she did not have a food thermometer to test food temperature. Further interview with staff indicated she used her finger to test the temperature of the oatmeal. Interview with the facility QIDP verified staff should not be using their finger to test food temperature and food should be served at an appropriate temperature that is safe for all clients.	W 473		