STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G010	A. BUILDING _____ B. WING _____	11/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-BURKE ICF/MR GROUP HOME	101 STEPHENS DRIVE MORGANTON, NC 28655

(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 review of facility records and interviews, the facility failed to assure the Emergency Plan (EP) contained specific information relative to 5 of 5 clients residing in the home (#1, #2, #3, #4 and #5). The finding is: Review of the facility's emergency plan, conducted on 11/26/18, revealed no client specific information was included in the plan. Further review of the emergency plan on 11/27/18, verified by interview with the qualified intellectual disabilities professional and staff in the home, revealed the facility had not included specific information in the EP regarding client needs, preferences, means of communication, behavioral information or medical support needed which would enable persons unfamiliar with each individual client to provide care during an emergency.	E 007	The Patient Assessments will be added to the Emergency Plan for all 5 individuals living in the home. Patient Assessments include individual information pertaining to emergency contact information, presenting problems, behavioral history, nutrition, diet, medical history and current issues, medications, allergies, possible danger to self or others, daily routine and services, support devices, and any additional information needed to support the individual. The Facility Administrator and Qualified Professional will ensure that the Patient Assessments are placed with the Emergency Plan. RECEIVED DEC - 3 2018 DHSR NH L & C BLACK MOUNTAIN / WRO	01/26/2019
W 351	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE	W 351		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cindy Davis BS/QP | TITLE: Executive Director | (X6) DATE: 11/29/18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G010	A. BUILDING _____ B. WING _____	11/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 351	Continued From page 1 CFR(s): 483.460(f)(1) Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure a complete dental examination was completed within one month of admission for 1 of 3 sampled clients (#1). The finding is: Review of the record for client #1, conducted on 11/27/18, revealed client #1 was admitted to the facility on 12/21/17. Further review of the record for client #1 revealed a person centered plan (PCP) dated 1/4/18. No documentation of an oral/dental examination was included in the 1/4/18 PCP. Interview with the qualified intellectual disabilities professional on 11/27/18 revealed client #1 is edentulous and has not been seen by a dentist or been scheduled for a dental examination since admission to the facility over 11 months ago.	W 351	A complete dental examination has been scheduled for the individual on 12/11/18 at 1pm. The Facility Administrator will ensure that the individual attends the scheduled appointment and that the results are documented and placed in the record. The Qualified Professional will ensure that a dental examination is completed upon admission for all individuals within the timeframes specified.	01/26/2019
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the	W 436		

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W 436	Continued From page 2 interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a wheelchair in good repair for 1 of 3 sampled clients (#5). The finding is: Observations conducted in the group home on 11/26/18 revealed client #5 sat in a geri-chair during leisure activities and while eating his supper meal. Further observations conducted on the morning of 11/27/18 revealed client #5 sat in his wheelchair while eating his breakfast and during his morning routine. Further observations of client #5's wheelchair revealed the right armrest had a rough surface due to numerous cracks in the cover as well as a split along the edge of the pad exposing several inches of the foam padding which was protruding from underneath. Interview conducted with the qualified intellectual disabilities professional and staff in the home revealed the armrest on client #5's wheelchair had been cracked and split for an undetermined length of time and that the process to purchase a new wheelchair for client #5 had been initiated, however, no date for when a new wheelchair or repair to the current armrest would be accomplished was available currently.	W 436	The Facility Administrator and Qualified Professional will ensure that the arm rest is replaced. Sheepskin has been purchased to cover the rough surface of the armrest until the part is replaced. Staff will be in-serviced on reporting wear and tear of client equipment and devices in a timely manner.	01/26/2019