


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2018
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NAME OF PROVIDER OR SUPPLIER KAREN LANE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3224 KAREN LANE MONROE, NC 28112
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E 007	<p>EP Program Patient Population CFR(s): 483.475(a)(3)</p> <p>[(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:]</p> <p>(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.**</p> <p>*Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.]</p> <p>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:</p> <p>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).</p> <p>Interview with the home manager on 11/14/18 revealed identification with a photo and specific</p>	E 007	 <p>E007:BY JANUARY 12, 2019 THE TL/RM WILL UPDATE THE EMERGENCY PREPAREDNESS BOOK TO INCLUDE CURRENT PCP, BSP, CRISIS PLANS AND ADAPTIVE EQUIPMENT CHECKLIST FOR EACH INDIVIDUAL SUPPORTED TO IDENTIFY SPECIFIC NEEDS OF EACH INDIVIDUAL SUPPORTED IN THE EVENT OF AN EMERGENCY. ONCE PER MONTH THE EMERGENCY PREPAREDESS BOOK WILL BE REVIEWED AND UPDATED IF NECESSARY BY THE TL/RM.</p>	11/14/18
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nicholas Kumpas</i>	TITLE <i>QR Nov 30 2018</i>	(X6) DATE
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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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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	W249: BY JANUARY 12, 2019 THE DSP STAFF WILL RECEIVE PERSON SPECIFIC TRAINING TO ADDRESS MC'S HELMET PROTOCOL AS WELL AS ALL THE ADAPTIVE EQUIPMENT PROTOCOL'S FOR ALL THE INDIVIDUALS SUPPORTED AT THE KAREN LANE GROUP HOME. THE TL WILL MONITOR ALL ADAPTIVE EQUIPMENT PROTOCOLS AND TRAIN STAFF ON CHANGES AS NEEDED. THE RM WILL MONITOR ADAPTIVE EQUIPMENT VIA MONTHLY OBSERVATIONS.	11/12/19

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W 249	<p>Continued From page 2</p> <p>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.</p> <p>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.</p> <p>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.</p>	W 249		
W 369	<p>DRUG ADMINISTRATION CFR(s): 483.460(k)(2)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>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:</p>	W 369		1/2/19

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W 369	<p>Continued From page 3</p> <p>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.</p> <p>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.</p> <p>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.</p>	W 369	<p>W369: BY JANUARY 12, 2019 THE STAFF WHO FAILED TO ADMINISTER MEDICATION DURING STATE SURVEY OBSERVATION ACCORDING TO MONARCH'S MEDICATION ADMINISTRATION POLICY WILL RECEIVE AN ORAL WARNING, REVIEW OF MED ADMIN POLICY, MUST COMPLETE MED RE-CERT TRAINING AND 3 OBSERVATIONS BY RM, QP OR NURSE. MEDICATION ADMINISTRATION OBSERVATIONS WILL BE CONDUCTED BI-WEEKLY BY RM/TL OR RN UNTIL JANUARY 12TH AND MONTHLY THEREAFTER.</p>	

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