STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G303	A. BUILDING _____ B. WING _____	12/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE ROAD	7621 MONROE ROAD CHARLOTTE, NC 28212

(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 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure an injury was reported to the administrator immediately for 1 of 3 sampled clients (#3). The finding is: Observations conducted in the group home on 12/18/18 at 4:50 PM revealed client #3 had an open, excoriated area approximately 1/2 inch in diameter on her left hand near the base of her thumb. Interview conducted with direct care staff at that time revealed no knowledge of how or when the injury to client #3's left hand occurred. Review of incident/accident reports for client #3, conducted on 12/19/18, revealed the most recent incident involving injury to client #3 was dated 5/11/18 and documented client #3 was scratched on the arm by another client on that date. Interviews conducted with the qualified intellectual disabilities professional (QIDP) and the nurse revealed the injury to client #3's hand had not been reported to the QIDP or the nurse and no treatment treatment had been documented as having been completed. Further interview with the nurse verified the injury to client #3's hand should have been reported to the nurse and the QIDP immediately.	W 153		
W 331	NURSING SERVICES	W 331		

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 331	Continued From page 1 CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Nursing services failed to provide services in accordance with client needs relative to ensuring staff are properly trained in the administration of medications procedures for 4 of 4 clients observed during medication administration (#2, #3, #5 and #6) as evidenced by observations and interviews. The findings are: A. Nursing services failed to ensure staff was knowledgeable of the appropriate procedures for administering medications relative to sanitation, client participation, and client teaching for client #3. For example: Observations of the medication administration for client #3 on 12/19/18 at 7:11 AM revealed client #3 to receive Cymbalta 30 mg, Cymbalta 60 mg, Vitamin D, and Claritin. Further observation revealed staff to punch medications into her ungloved hand and subsequently into a med cup, after she had used her ungloved hand to cover her mouth from her cough. Continued observations revealed staff did not provide teaching to client #3 about the medications, their purpose, or possible side effects. Further observations revealed staff did not encourage client #3's participation in the med administration except for the pouring of client #3's water with which to swallow her medications. Further observations revealed staff to use a plastic spoon to scrape medications out of the med cup for client #3 after client #3 put the med cup to her	W 331		

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W 331	Continued From page 2	W 331		

mouth. Subsequent observation revealed the staff to return the contaminated spoon to the large container of clean spoons.

Interview with the facility nurse on 12/19/18 confirmed staff should have used gloved/clean hands and thrown away the contaminated spoon to prevent the spread of germs. Continued interview with the facility nurse conformed staff should have provided teaching to client #3 about her medications,their purpose and possible side effects, and encouraged participation at each step of the medication pass for client #3.

B. Nursing services failed to ensure staff was knowledgeable of the appropriate procedures for administering medications relative to privacy, sanitation, client participation, and client teaching for client #2. For example:

Observations of the medication administration for client #2 on 12/19/18 at 6:08 AM revealed staff to enter client #2's room without knocking and proceeded to administer medications, leaving the door open as other clients passed by. Further observation revealed client #2 sitting on her bed in her room where she remained during the medication pass. Continued observation revealed #2 to receive Inhospitable 500 mg, Abilify 2 mg, Zyrtec 10 mg, Zoloft 100 mg, Synthroid 137 mg and Vit D. Continued observations revealed staff to punch all medications into her ungloved hand, later transferring them into a medication cup. Further observations revealed staff broke a medication which fell onto a used bubble pack, which she proceeded to add to the medication cup and administer to client #2. Continued observations revealed staff did not provide teaching about the

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medications, their use or side effects to client #2. Subsequent observations revealed staff did not encourage client #2's participation in the med administration except for the pouring of client #2's water for administration of medications, which client #2 did independently.

Interview with the facility nurse confirmed staff should have provided privacy, used gloved hands, provided teaching to client #2 about her medications their purpose and possible side effects, and encouraged participation at each step of the medication pass for client #2.

C. Nursing services failed to ensure staff was knowledgeable of the appropriate procedures for administering medications relative to privacy, sanitation, client participation, and client teaching for client #5. For example:

Observations of the medication administration for client #5 on 12/19/18 at 6:18 AM revealed client #5 to be seated at the breakfast table preparing to eat breakfast. Continued observations revealed staff to enter client #5's room without knocking or permission, pulling the medication cart with her. Further observations revealed staff to request client #5 to come to her room to take her medication, which she did. Continued observations revealed client #5 to receive Oscal for her morning medication. Further observation revealed staff to punch the medication into her ungloved hand, later transferring the medication into a medication cup. Further observations revealed staff did not engage client #5 in sign language or participation in the med pass. Further observations revealed staff did not provide teaching about the medications, their use or side effects to client #5. Subsequent

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observations revealed staff did not encourage client #5's participation in the med administration except for the pouring of client #5's water for administration of medications, which client #5 accomlished with hand over hand assistance from staff.

Interview with the facility nurse on 12/19/18 confirmed staff should utilize sign lanuage with client #5 for her med pass. Continued interview with the facilty nurse confirmed staff should have provided teaching to client #5 about her medications, their purpose and possible side effects, along with encouraging participation at each step of the medication pass for client #5.

D. Nursing services failed to ensure staff was knowledgeable of the appropriate procedures for administering medications relative to sanitation, client participation, and client teaching for client #6. For example:

Observations of the medication administration for client #6 at 6:30 AM on 12/19/18 at revealed client #6 to be sitting on her bed in her bedroom. Continued observations revealed client #6 to receive Colase 50 mg, Keppra 500mg, and Lactalose 15 cc. Further observations revealed staff to punch all medications into her ungloved hand, later transferring them into a medication cup. Continued observations revealed staff did not provide teaching about the medications or their use or side effects to client #6. Subsequent observations revealed staff did not encourage client #6's participation in the med administration except for the pouring of client #6's water for administration of medications, which client #6 did with assistance from staff.

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W 331	Continued From page 5 Interview with the facility nurse confirmed staff should have used gloved hands, provided teaching to client #6 about her medications, their purpose and possible side effects, and encouraged participation at each step of the medication pass for client #6.	W 331		