

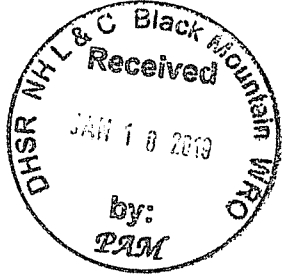
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

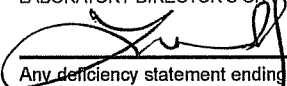
PRINTED: 12/27/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  34G209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2018
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NAME OF PROVIDER OR SUPPLIER  PISGAH GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 28 PISGAHVIEW AVENUE ASHEVILLE, NC 28803
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(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
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W 247	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi)</p> <p>The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6) were provided opportunities for choice and self management relative to meal preparation and other household skills. The findings are:</p> <p>Observations in the group home on 12/18/18 from 7:09 AM through 7:22 AM revealed a staff member pouring water into a pot and putting it on the stove, getting items from the refrigerator and pantry, and preparing oatmeal and toast. A staff member was also observed getting cups, bowls, plates and utensils from drawers and cabinets and then setting the dining table for all clients. Client #2 was observed to provide minimal assistance preparing his own oatmeal and toast. Otherwise, no clients were observed assisting with meal preparation or setting the table. It should be noted that all clients except client #2, chose to have cereal instead of oatmeal. Continued observations from 8:20 AM through 8:32 AM revealed staff to prepare lunch items for client's #1 and #4, as well as sweep the dining room floor, clean the kitchen area and wash the dishes.</p> <p>Review of the record for client #1 on 12/18/18 revealed an individual service plan (ISP) dated 12/27/17. The ISP included a current Comprehensive Functional Assessment (CFA) which indicated the client enjoys helping in the kitchen and likes cooking, as well as helping</p>	W 247	<p style="text-align: center;">    <i>See attached</i> </p>	2/14/19
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Program Administrator	(X6) DATE 1/7/19
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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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W 247	<p>Continued From page 1 others.</p> <p>Review of the record for client #2 on 12/18/18 revealed an ISP dated 7/16/18. The ISP indicated the client is cooperative and helpful. The ISP also included documentation that client #2 participates in household chores, including setting the table and dusting.</p> <p>Review of the record for client #3 revealed an ISP dated 11/20/18. The ISP indicated the client is "extremely helpful around the home" and enjoys helping to cook, clean and run errands. The ISP included a current CFA which indicated the client "loves to help in the kitchen and is good at it". The CFA also indicated the client helps with all chores around the house.</p> <p>Review of the record for client #4 revealed an ISP dated 8/20/18. The ISP included a current CFA which indicated the client likes cooking and likes helping others.</p> <p>Review of the record for client #5 revealed an ISP dated 5/21/18. The ISP indicated the client is capable of completing many household chores with minimal assistance from staff. The ISP also indicated client #5 "sets the table quite nicely with verbal and physical prompting".</p> <p>Review of the record for client #6 revealed an ISP dated 3/19/18. The ISP included a current CFA which indicated the client is helpful, likes to help in the kitchen, and likes to clean.</p> <p>Interview with the residential services director (RSD) on 12/18/18 confirmed all clients in the home are capable of assisting with all household chores and activities. The RSD indicated that</p>	W 247	See attached.	2/14/19	

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W 247	Continued From page 2 staff members in the home should have prompted all clients to assist with meal activities and other household chores during the morning on 12/18/18.	W 247			
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 interview, the facility failed to assure 3 of 4 sampled clients (#4, #5 and #6) received a continuous active treatment, and sufficient interventions and services to address topical medication administration needs. The findings are:  A. The team failed to assure client's #5 and #6 received continuous active treatment on 12/17/18 during the 12/17-18/18 survey. For example:  1. Observations in the group home on 12/17/18 at 4:05 PM revealed a staff member prompting client #5 to check a chore/activity schedule located in the living area, and the client then began getting ready to take a shower. At 4:35 PM client #5 checked the chore/activity schedule, and then went to his room. Client #5 was not	W 249	<i>See attached</i>	<i>2/14/19</i>	

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W 249	<p>Continued From page 3</p> <p>observed coming out of his room until 5:25 PM, at which time staff prompted him to check the schedule again and the client returned to his room. At 5:55 PM, client #5 was observed to come out of his room and go to the living area, and a staff member was observed to prompt the client to put shoes on, and again the client returned to his room. At 6:10 PM, client #5 was observed sitting down at the dining table to begin eating dinner. In total, client #5 was noted to spend 95 of 125 observed minutes on 12/17/18, in his room.</p> <p>Review of the record for client #5 on 12/18/18 revealed an individual service plan (ISP) dated 5/21/18. Review of the current program objectives revealed 7 programs including math, toe nail care, exercising for 30 minutes and cleaning eye glasses. Continued review of the ISP revealed documentation that client #5 should not spend longer than 25 minutes in his room and that spending longer than that could make it difficult to engage him in activities. The ISP also indicated client #5 was capable of completing most household chores, and well as well as playing board games and doing crossword puzzles.</p> <p>Interview with the facility residential services director on 12/18/18 confirmed client #5 should not spend excessive amounts of time in his bedroom, and confirmed the client should have received more options for training and leisure on 12/17/18 to assure continuous active treatment.</p> <p>2. Observations in the group home on 12/17/18 at 4:05 PM revealed client #6 going outside with a timer to spend time on the back porch area. The client was observed to be outside until 4:40 PM,</p>	W 249	See attached	2/14/19	

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W 249	<p>Continued From page 4</p> <p>at which time he chose to have time in his room and was observed to take a timer into his room. At 5:20 PM, client #6 briefly came out of his room and then returned to the bedroom. At 5:45 PM, the client went to the kitchen area and washed his hands and briefly assisted with the dinner meal preparation, and at 5:55 PM returned to his room. At 6:10, client #6 was observed to be at the dining table preparing to eat dinner. In total, client #6 was noted to spend 75 of 125 observed minutes on 12/17/18, in his room.</p> <p>Review of the record for client #6 on 12/18/18 revealed an ISP dated 3/19/18. Review of the current program objectives revealed a program using letters of the alphabet and guidelines for exercise. The ISP, also included a behavior intervention program which indicated the client should be checked on every 5 minutes to assure no skin picking self injurious behavior was occurring. Continued review of the ISP revealed a current comprehensive functional assessment which indicated the client enjoys crafts and table games and is able to be involved in structured activities.</p> <p>Interview with the residential services director on 12/18/18 confirmed client #6 should not spend excessive amounts of time in his bedroom and confirmed the client should have received more options for training and leisure on 12/17/18 to assure continuous active treatment.</p> <p>B. The team failed to assure topical program and guidelines were implemented for clients #4 and #6 during the 12/17-18/18 survey. For example:</p> <p>1. For client #4, morning observations in the group home on 12/18/18 at 7:02 AM revealed</p>	W 249	See Attached	2/14/19	

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W 249	<p>Continued From page 5</p> <p>staff handing client #4 his treatment basket from a locked cabinet in the laundry room . The client was observed to independently take the basket to his room and to the bathroom for his bath. Staff was observed to bring the client a medication cup of mineral oil to add to his bath but did not stay with the client. The client was observed to independently return the treatment basket to staff at 7:45 AM before eating breakfast.</p> <p>Review of client #4's ISP dated 8/20/18 revealed a topical program for client #4 to independently gather and apply appropriate amounts of topicals 90% of trials attempted for 6 consecutive months. Further review of the program, substantiated by interview with staff, revealed staff are to be present with client #4 to teach him to apply appropriate amounts of prescribed topicals to his body. The facility failed to assure client #4's topical program was implemented as prescribed.</p> <p>2. For client #6, morning observations in the group home on 12/18/18 at 7:47 AM revealed staff handing client #6 his treatment basket from a locked cabinet in the laundry room. The client was observed to independently take the basket to his bedroom before returning the basket at 7:55 AM before breakfast.</p> <p>Review of client #6's ISP dated 3/19/18 revealed topical guidelines for client #6, with the help of staff supervision and assistance, maintain proper hygiene and topical treatment care. Further review of the the topical guidelines note that staff will supervise client #6 and will not leave client #6 unattended during topical administration. Interviews with the residential services director and facility nurses verified client #6 should not be left alone with topicals. The facility failed to</p>	W 249	See attached	2/14/19	

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W 249	Continued From page 6 assure client #6's topical guidelines were implemented as prescribed.	W 249		
W 367	<p><b>DRUG ADMINISTRATION</b> CFR(s): 483.460(k)</p> <p>The facility must have an organized system for drug administration that identifies each drug up to the point of administration.</p> <p>This STANDARD is not met as evidenced by: The facility failed to assure an organized system was maintained to identify each drug up to the point of administration for 2 of 4 sampled clients (#4 and #6) as evidenced by observation, interview and record verification. The findings are:</p> <p>A. Morning observations in the group home on 12/18/18 at 7:02 AM revealed staff handing client #4 his treatment basket from a locked cabinet in the laundry room. The client was observed to independently take the basket to his room and to the bathroom for his bath. Staff was observed to bring the client a medication cup of mineral oil to add to his bath but did not stay with the client. The client was observed to independently return the treatment basket to staff at 7:45 AM before eating breakfast.</p> <p>Observations of client #4's treatment basket with staff, substantiated by interview with staff, revealed client #4's basket to contain shaving cream and razors, Minerin Cream, Ear Wax Remover, Metronidazole .75% Cream. Further observations, confirmed by interview with staff revealed none of the treatments in client #4's basket were noted to have prescription labels.</p>	W 367	See Attached	2/14/19

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W 367	Continued From page 7  Review of client #4's physician's orders dated 9/24/18 revealed client #4 is prescribed several of the items in his treatment basket. These include Metronidazole .75% Cream, apply to face and forehead twice daily after shower; Ear Wax Remover, place two drops in each ear every evening; and Minerin Cream, apply to entire body, including face, twice daily. If shower is in the evening apply after shower.  Interview with the facility nurse and LPN verified staff should be assisting client #4 when he has his treatment basket and the prescribed medications should have labels on them. By failing to monitor client #4 properly with his treatment basket and failing to maintain proper medication labeling on prescribed medications, staff failed to assure their system for identifying each drug up to the point of administration was functioning as required.  B. Morning observations in the group home on 12/18/18 at 7:47 AM revealed staff handing client #6 his treatment basket from a locked cabinet in the laundry room. The client was observed to independently take the basket to his bedroom before returning the basket at 7:55 AM before breakfast.  Observations of client #6's treatment basket with staff, substantiated by interview with staff, revealed client #4's basket to contain Bag Balm, razors, Minerin Cream, Vaseline, Ketoconazole 2% Cream, Newskin liquid bandage, finger nail clippers and deodorant. Further observations, confirmed by interview with staff revealed none of the treatments in client #6's basket were noted to have prescription labels.	W 367	See Attached	2/14/19	



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W 367	Continued From page 8  Review of client #6's physician's orders dated 9/24/18 revealed client #6 is prescribed several of the items in his treatment basket. These include Ketoconazole 2% Cream, apply to hands, feet, and between toes every morning as antifungal; Minerin Cream, apply to entire body, hands and cuticles twice daily; Petroleum Ointment Base (Vaseline), apply liberally to each foot at bedtime, then wear socks; and Newskin Liquid, apply to any open skin area as needed. In addition, although the client's treatment basket was noted to contain Bag Balm, no prescription for client #6 was noted in the physician's orders.  Interview with the facility nurse and LPN verified staff should be assisting client #6 when he has his treatment basket and the prescribed medications should have labels on them. By failing to monitor client #6 properly with his treatment basket and failing to maintain proper medication labeling on prescribed medications, staff failed to assure their system for identifying each drug up to the point of administration was functioning as required.	W 367			
W 382	<b>DRUG STORAGE AND RECORDKEEPING</b> CFR(s): 483.460(l)(2)  The facility must keep all drugs and biologicals locked except when being prepared for administration.  This STANDARD is not met as evidenced by: The facility failed to assure all drugs and biologicals were kept locked except when being prepared for administration for 2 of 4 sampled clients (#4 and #6) as evidenced by observation,	W 382	See Attached	2/14/19	

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W 382	<p>Continued From page 9 interview and record verification. The findings are:</p> <p>A. Morning observations in the group home on 12/18/18 at 7:02 AM revealed staff handing client #4 his treatment basket from a locked cabinet in the laundry room. The client was observed to independently take the basket to his room and to the bathroom for his bath. Staff was observed to bring the client a medication cup of mineral oil to add to his bath but did not stay with the client. The client was observed to independently return the treatment basket to staff at 7:45 AM before eating breakfast.</p> <p>Observations of client #4's treatment basket with staff, substantiated by interview with staff, revealed client #4's basket to contain shaving cream and razors, Minerin Cream, Ear Wax Remover, Metronidazole .75% Cream. Further observations, confirmed by interview with staff revealed none of the treatments in client #4's basket were noted to have prescription labels.</p> <p>Review of client #4's physician's orders dated 9/24/18 revealed client #4 is prescribed several of the items in his treatment basket. These include Metronidazole .75% Cream, apply to face and forehead twice daily after shower; Ear Wax Remover, place two drops in each ear every evening; and Minerin Cream, apply to entire body, including face, twice daily. If shower is in the evening apply after shower.</p> <p>Interview with the facility nurse and LPN verified staff should be assisting client #4 when he has his treatment basket to assure the prescribed medications are administered properly. By failing to monitor client #4 properly with his treatment</p>	W 382	See Attached	2/14/19	

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W 382	<p>Continued From page 10</p> <p>basket, staff failed to assure the client's medications were locked except when being prepared as required.</p> <p>B. Morning observations in the group home on 12/18/18 at 7:47 AM revealed staff handing client #6 his treatment basket from a locked cabinet in the laundry room. The client was observed to independently take the basket to his bedroom before returning the basket at 7:55 AM before breakfast.</p> <p>Observations of client #6's treatment basket with staff, substantiated by interview with staff, revealed client #4's basket to contain Bag Balm, razors, Minerin Cream, Vaseline, Ketoconazole 2% Cream, Newskin liquid bandage, finger nail clippers and deodorant. Further observations, confirmed by interview with staff revealed none of the treatments in client #6's basket were noted to have prescription labels.</p> <p>Review of client #6's physician's orders dated 9/24/18 revealed client #6 is prescribed several of the items in his treatment basket. These include Ketoconazole 2% Cream, apply to hands, feet, and between toes every morning as antifungal; Minerin Cream, apply to entire body, hands and cuticles twice daily; Petroleum Ointment Base (Vaseline), apply liberally to each foot at bedtime, then wear socks; and Newskin Liquid, apply to any open skin area as needed. In addition, although the client's treatment basket was noted to contain Bag Balm, no prescription for client #6 was noted in the physician's orders.</p> <p>Interview with the facility nurse and LPN verified staff should be assisting client #6 when he has his treatment basket to assure the prescribed</p>	W 382	<p style="text-align: center;">See Attached</p>	2/14/19
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G209</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/18/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>PISGAH GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>28 PISGAHVIEW AVENUE ASHEVILLE, NC 28803</b>		
(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 382	Continued From page 11 medications are administered properly. By failing to monitor client #6 properly with his treatment basket, staff failed to assure the client's medications were locked except when being prepared as required.	W 382	See Attached	2/14/19	

**Plan of Correction  
Pisgah Group Home  
Annual Recertification Survey  
Dec 17 and 18, 2018**



**W247-Individual Program Plan.** The individual program plan must include opportunities for client choice and self-management.

Staff will be re-trained on resident participation in meal preparation and chore duties.

Observation/coaching sessions will be done by the Program Administrator, Residential Services Director, QP, and/or the House Manager to ensure that the residents are participating to the best of their abilities in all household chores and meal preparation.

All re-training and observation/coaching sessions will be completed by February 14, 2019

**W249—Program Implementation.** 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 individual program plan.

- A. Staff will be trained Active Support via a 2 hour training, to be given by the COO. This training will include the use of schedules and timers to keep residents active and engaged.
- B. Staff will be re-trained on the proper way to administrate topical medications.

Success of this re-training will be measured during weekly observation and coaching sessions done by the Program Administrator, Residential Services Director, QP, and/or the House Manager

All retraining and observation/coaching sessions will be completed by February 14, 2019

**W367-Drug Administration.** The facility must have an organized system for drug administration that identifies each drug up to the point of administration.

All topical medications and treatments will be stored in their original boxes/packaging. All staff will be re-trained on keeping the topical medications and treatments in the boxes/packaging at all times.

All retraining will be completed by February 14, 2019

**W382-Drug Storage and Recordkeeping.** The facility must keep all drugs and biologicals locked except when being prepared for administration.

Staff will be re-trained on proper storage and handling of topical medications and treatments. Observations will be done by the Program Administrator, Residential Services Director, QP, and/or the House Manager to ensure that all topical medications and treatments are being administered and stored properly.

All retraining and observation/coaching sessions will be completed by February 14, 2019