		ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u> 0938-0391 </u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>				E SURVEY PLETED
		34G164	B. WING			01/	/15/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1213 MOSS SPRINGS ROAD		
	VALL GROUP HOME				ALBEMARLE, NC 28001		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD		COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	AIE	DATE
W 129			W	129	Э		
	CFR(s): 483.420(a)(7	()					
	-	ure the rights of all clients.					
		must provide each client					
	with the opportunity for	or personal privacy.					
		not met as evidenced by:					
	Based on observatio						
	-	failed to assure the right to					
		itten informed consent for 1					
		#3) related to use of an					
	audio monitor. The fi	nding is:					
		ome on 1/15/19 at 8:20 AM					
		onitor receiver located on a					
		t to a couch in the living					
	room. Continued obs	servations revealed the					
		es were heard coming from					
	the monitor, and 2 oth	ner clients sitting in the living					
	room during this time	could overhear the voices					
	as well.						
	Interview on 1/15/19 a	at 8:21 AM with staff					
	revealed the audio me	onitor is for client #3 and is					
	used to monitor him to	o prevent falls. Further					
	interview revealed an	audio monitor is stationed					
	in client #3's room an	d both audio monitors are					
	left on. Continued inte	erview with staff, revealed he					
	had been in client #3'	s room along with client #3					
	minutes ago to assist	the client with care needs.					
	Subsequent interview	revealed the staff member					
		eryone else in the living					
	room area could also						
		with client #3 during this					
	time as well.	5					
	-						
	Review on 1/15/19 of	a facility record dated					
	I DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	۱ ۶		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.

PRINTED: 01/22/2019

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	: 01/22/2019 APPROVED . 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				(X3) DATE SURVEY COMPLETED		
		34G164	B. WING				01/1	5/2019	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
A JACK V	VALL GROUP HOME				1213 MOSS SPRINGS ROAD ALBEMARLE, NC 28001				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE	
W 129	in 2/18 to ensure the home. In addition, rev 12/19/18 documents of regarding client #3 to to a wall. Interview on 1/15/19 of disabilities profession the Director of Quality added the baby monit support plan (ISP) in prevent falls. Continu- client #3 had experier one during 10/18 and enhance safeguards to with other safety mea alarm, a safety floor m sensor for his bedroo Interview on 1/15/19 of baby audio monitor fo on in the living area w possibly visitors could QIDP and the Director confirmed there was n consent for the use of INDIVIDUAL PROGR CFR(s): 483.440(c)(4 The individual program objectives necessary as identified by the co	e addition of a baby monitor safety of client #3 in the view of a facility record dated other safety measures include securing a dresser with the qualified intellectual al (QIDP) and subsequently / Services verified the facility tor to client #3's individual 2/18 as a safeguard to ued interviews revealed need falls during 8/18 and the facility sought to further to protect client #3 from falls sures including a bed pad nat and a motion detector m door. with the QIDP confirmed the or client #3 should not be left /here other clients and d overhear interactions. The r of Quality Services also no current written/informed f client #3's baby monitor. AM PLAN		129	9				
	This STANDARD is r	not met as evidenced by:							

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		MEDICAID SERVICES				O. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		34G164	B. WING		0	1/15/2019		
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP COD	θE			
A JACK V	VALL GROUP HOME			213 MOSS SPRINGS ROAD LBEMARLE, NC 28001				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
W 227	Continued From page		W 227					
	sampled clients (#4) training to address id promoting self-indepe	ort plan (ISP) for 1 of 3 failed to include objective entified needs relative to endence as evidenced by ew and review of records.						
	Client #4 did not parti promote increased er self-independence.							
	1:30 PM revealed clied dining area floor. Fur home on 1/14/19 from revealed client #4 sat watching TV and part for 20 minutes. Contii PM - 5:10 PM reveale with the door closed a for medications only t room after receiving h observations at 5:20 come out of his room setting, and wait to ea ask client #4 to partic client #4 refused and Morning observations 1/15/19 from 6:45 AM noted to be in his room	oup home on 1/14/19 at ent #4 swept the home's rther observations at the in 3:30 PM - 4:30 PM t in the living room area ticipated in a sensory activity nued observations from 4:40 ed client #4 was in his room and out of his room briefly to return immediately to his his medications. Subsequent PM revealed client #4 to , sit at his dining table place at his meal. While staff did tipate in chore activities, remained in his room. s at the group home on 1 - 7:05 AM client #4 was m. Further observations exit his room at 7:10 AM to						
	eat breakfast, and fin Continued observatio returned to his room a	ish eating at 7:35 AM. ons revealed client #4						

Facility ID: 921401

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURV COMPLETED NAME OF PROVIDER OR SUPPLIER 34G164 B. WING 01/15/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1213 MOSS SPRINGS ROAD		RTMENT OF HEALTH AN ERS FOR MEDICARE &						FORM	D: 01/22/2019 APPROVED D: 0938-0391	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1213 MOSS SPRINGS ROAD	STATEMENT O	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /				(X3) DATE SURVEY COMPLETED		
1213 MOSS SPRINGS ROAD			34G164	B. WING			_	01/	15/2019	
A JACK WALL GROUP HOME 1213 MOSS SPRINGS ROAD	NAME OF PR	F PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
A JACK WALL GROUP HOME ALBEMARLE, NC 28001	A JACK WALL GROUP HOME									
	PREFIX	X (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRE) CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA		(X5) COMPLETION DATE	
W 227 Continued From page 3 W 227 Year Continued To Part Stated 0 Year Continued To Part Stated 0 Year Continue To Part Stated To Part Stated 0 Year Continue To Part Stated 0 Year Continue to receive regular form local part, playing bingo game, arts & crafts, skating, variety of music and dancing sometimes, reading comice, looking at coupons, community outings. Continue to receive regular formal training opportunities to assist in the kitchen, participating in various simple meal preparation activities to increase his skills in this area." Review on 1/15/19 of goals for client #4 revealed objectives for brush teeth, complete chores, participate in meal preparation participation, display 0 aggression against self/others/property, use/follow writhen transition schedule, focus on tasks and select a healthy snack. Review on 1/15/19 of client #4's behavior support plan (SEP) effective date 11/18 identified preventive measures for staft for use to interact with him as "for increasing participation staff should bring simple activities to [client #4] and use object, gesture and hand-over-hand, or verbal prompts to as		 #4 prefers to remain it vocational activities a 9:30 AM - 10:30 AM a daily schedule posted located on a table in the assessments: enjoys playing bingo game, a of music and dancing comics, looking at co Continued review revision continue to receive resopportunities to assiss in various simple meal increase his skills in the Review on 1/15/19 of objectives for brush the participate in meal practivity, medication are display 0 aggression use/follow written trant tasks and select a here. Review on 1/15/19 of plan (BSP) effective of preventive measures with him as "for inclus soon as he participate a verbal prompts to assission as he participate are a verbal prompts to assission as he participate are a tec.)." 	n his room and has t the home scheduled from as evidenced by client #4's d on a physical clipboard the living room. client #4's ISP dated following need/preference walking in local park, arts & crafts, skating, variety sometimes, reading upons, community outings. ealed "[Client #4] will egular formal training t in the kitchen, participating al preparation activities to his area." goals for client #4 revealed eeth, complete chores, eparation, money skill dministration participation, against self/others/property, nsition schedule, focus on althy snack. client #4's behavior support date 11/18 identified for staff to use to interact reasing participation staff ctivities to [client #4] and nd hand-over-hand, or sist him with participation. As es in an activity, give him ctivity (positive attention,	w	22					

Facility ID: 921401

If continuation sheet Page 4 of 9

				CONSTRUCTION		8-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVE COMPLETED	
		34G164	B. WING		01/15/20	19
NAME OF P	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
A JACK V	WALL GROUP HOME			13 MOSS SPRINGS ROAD .BEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COM	(X5) PLETIO DATE
W 227	Continued From page	e 4	W 227			
	more goals to promot self-independence ac 1/15/19 with the QIDI	ed client #4 is in need of te increased engagement in ctivities. Further interview on P revealed client #4 enjoys e iPad is currently being				
W 340	NURSING SERVICE CFR(s): 483.460(c)(5		W 340			
	other members of the appropriate protective measures that include	st include implementing with a interdisciplinary team, a and preventive health e, but are not limited to raff as needed in appropriate methods.				
	Based on observatio services failed to ass needed in appropriate	not met as evidenced by: n and interview, nursing ure staff were trained as e health methods during ation. The findings are:				
	staff assisting client # packs of medications Naltrexone, Risperido Hydrocortisone, Certa	5/19 at 7:05 AM revealed 41 with punching out his pill consisting of Vitamin D, one, Topiramate, avite, Tegretol XR, vetiracetam into a clear				
	observations revealed dispenser box unit wa apparatus where the supposed to fall into to underneath. Continue much of client #1's put	d within the clear medication as a conical shaped				

Facility ID: 921401

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/22/2019 / APPROVED). 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G164	B. WING			01/	15/2019
NAME OF PR	OVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE		
A JACK WALL GROUP HOME					1213 MOSS SPRINGS ROAD ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	the medication technic the bare palm of her h medication cup and a #1. B. Observation of more administration on 1/18 staff assisting client # pack of medications of Fish Oil, Folbic, Lamo Topiramate. Further of of his pills fell within the the medication disper the medication cup ar retrieved the pills into placed the pills into a administered them to Interview on 1/15/19 a medication technician within the inside comp dispenser box unit an interview revealed she staff of this problem. Interview on 1/15/19 a revealed there are tim shake the medication the pills to fall into the not a frequent probler Interview on 1/15/19 o revealed staff should before she retrieved t manger verified glove medication area for st revealed all staff are t	o the medication cup and cian retrieved the pills into and, placed the pills into a dministered them to client 7,19 at 7:35 AM revealed 5 with punching out his pill consisting of Divalproex DR, otrigine, Zonisamide, and observations revealed many ne inside compartments of isser box unit instead of into ad the medication technician the bare palm of her hand, medication cup and client #5. at 7:40 AM with the involved or revealed pills often fall partments of the medication d it is a problem. Further e has informed supervisory at 7:47 AM with another staff nes when you will need to dispenser box unit to get e medication cup and this is n. with the home manager have put gloves on first he pills and the home s were present in the raff use. Further interview	W	340			

Facility ID: 921401

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					OMB NO. 0938-03 (X3) DATE SURVEY		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED		
		34G164	B. WING		01/15/2019		
NAME OF P	ROVIDER OR SUPPLIER	·	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
A JACK	VALL GROUP HOME			1213 MOSS SPRINGS ROAD ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETI		
W 340	interview on 1/15/19 disabilities profession revealed staff should	with the qualified intellectual	W 340				
W 455	CFR(s): 483.470(l)(1) There must be an act	ive program for the nd investigation of infection	W 455				
	Based on observation failed to ensure a sar provided to avoid tran infection and prevent cross-contamination. affected 2 of 6 clients	•					
		taken to promote client ossible cross-contamination ministration.					
	staff assisting client # packs of medications Naltrexone, Risperido Hydrocortisone, Certa Omeprazole, and Lev medication dispenser	5/19 at 7:05 AM revealed 41 with punching out his pill consisting of Vitamin D, one, Topiramate, avite, Tegretol XR, vetiracetam into a clear box unit. Further d within the clear medication					

Event ID: SRGU11

Facility ID: 921401

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		D HUMAN SERVICES				FORM	: 01/22/2019 1APPROVED
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	-	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		34G164	B. WING		_	01/ [,]	15/2019
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
A JACK V	VALL GROUP HOME			1213 MOSS SPRINGS ROA ALBEMARLE, NC 2800			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 455	supposed to fall into t underneath. Continue much of client #1's pu- inside compartments box unit instead of into the medication techni- the bare palm of her h medication cup and a #1. B. Observation of more administration on 1/18 staff assisting client # pack of medications of Fish Oil, Folbic, Lamo Topiramate. Further of of his pills fell within th the medication cup and retrieved the pills into a administered them to Interview on 1/15/19 a medication technician within the inside comp dispenser box unit an interview revealed sho staff of this problem. Interview on 1/15/19 a revealed there are tim shake the medication the pills to fall into the not a frequent problem	he medication cup located ed observations revealed inched pills fell within the of the medication cup and cian retrieved the pills into hand, placed the pills into a dministered them to client rning medication 5/19 at 7:35 AM revealed 5 with punching out his pill consisting of Divalproex DR, otrigine, Zonisamide, and observations revealed many he inside compartments of hiser box unit instead of into hd the medication technician the bare palm of her hand, medication cup and client #5. At 7:40 AM with the involved or revealed pills often fall partments of the medication d it is a problem. Further e has informed supervisory at 7:47 AM with another staff hes when you will need to dispenser box unit to get e medication cup and this is m.	W 455				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/22/2019 / APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G164	B. WING				01/	15/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA	TE, ZIP CODE		
A JACK	VALL GROUP HOME				1213 MOSS SPRINGS ROAD ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 455	manger verified glove medication area for si revealed all staff are t administer medication interview on 1/15/19 v disabilities profession revealed staff should gloves and not her ba pills. In addition, the 0	es were present in the taff use. Further interview trained to properly ns to clients. Continued with the qualified intellectual	W	458				

Facility ID: 921401

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