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	34G164	A. BUILDING _____ B. WING _____	01/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A JACK WALL GROUP HOME	1213 MOSS SPRINGS ROAD ALBEMARLE, NC 28001

(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 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure the right to privacy and obtain written informed consent for 1 of 3 sampled clients (#3) related to use of an audio monitor. The finding is: Observations in the home on 1/15/19 at 8:20 AM revealed an audio monitor receiver located on a corner bookshelf next to a couch in the living room. Continued observations revealed the monitor was on, voices were heard coming from the monitor, and 2 other clients sitting in the living room during this time could overhear the voices as well. Interview on 1/15/19 at 8:21 AM with staff revealed the audio monitor is for client #3 and is used to monitor him to prevent falls. Further interview revealed an audio monitor is stationed in client #3's room and both audio monitors are left on. Continued interview 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 was unaware that everyone else in the living room area could also hear the client care conversation he had with client #3 during this time as well. Review on 1/15/19 of a facility record dated	W 129		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 129	Continued From page 1 9/6/18 documents the addition of a baby monitor in 2/18 to ensure the safety of client #3 in the home. In addition, review of a facility record dated 12/19/18 documents other safety measures regarding client #3 to include securing a dresser to a wall. Interview on 1/15/19 with the qualified intellectual disabilities professional (QIDP) and subsequently the Director of Quality Services verified the facility added the baby monitor to client #3's individual support plan (ISP) in 2/18 as a safeguard to prevent falls. Continued interviews revealed client #3 had experienced falls during 8/18 and one during 10/18 and the facility sought to further enhance safeguards to protect client #3 from falls with other safety measures including a bed pad alarm, a safety floor mat and a motion detector sensor for his bedroom door. Interview on 1/15/19 with the QIDP confirmed the baby audio monitor for client #3 should not be left on in the living area where other clients and possibly visitors could overhear interactions. The QIDP and the Director of Quality Services also confirmed there was no current written/informed consent for the use of client #3's baby monitor.	W 129		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by:	W 227		

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W 227	Continued From page 2 The individual support plan (ISP) for 1 of 3 sampled clients (#4) failed to include objective training to address identified needs relative to promoting self-independence as evidenced by observations, interview and review of records. The finding is: Client #4 did not participate in activities to promote increased engagement, self-independence. Observation at the group home on 1/14/19 at 1:30 PM revealed client #4 swept the home's dining area floor. Further observations at the home on 1/14/19 from 3:30 PM - 4:30 PM revealed client #4 sat in the living room area watching TV and participated in a sensory activity for 20 minutes. Continued observations from 4:40 PM - 5:10 PM revealed client #4 was in his room with the door closed and out of his room briefly for medications only to return immediately to his room after receiving his medications. Subsequent observations at 5:20 PM revealed client #4 to come out of his room, sit at his dining table place setting, and wait to eat his meal. While staff did ask client #4 to participate in chore activities, client #4 refused and remained in his room. Morning observations at the group home on 1/15/19 from 6:45 AM - 7:05 AM client #4 was noted to be in his room. Further observations revealed client #4 to exit his room at 7:10 AM to eat breakfast, and finish eating at 7:35 AM. Continued observations revealed client #4 returned to his room at 8:00 AM. Interviews on 1/14/19 with staff (2) revealed client #4 frequently remains in his room. Further interviews on 1/15/19 with staff (2) revealed client	W 227		

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#4 prefers to remain in his room and has vocational activities at the home scheduled from 9:30 AM - 10:30 AM as evidenced by client #4's daily schedule posted on a physical clipboard located on a table in the living room.

Review on 1/15/19 of client #4's ISP dated 9/27/18 revealed the following need/preference assessments: enjoys walking in local park, playing bingo game, arts & crafts, skating, variety of music and dancing sometimes, reading comics, looking at coupons, community outings. Continued review revealed "[Client #4] will 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, money skill activity, medication administration participation, display 0 aggression against self/others/property, use/follow written transition schedule, focus on tasks and select a healthy snack.

Review on 1/15/19 of client #4's behavior support plan (BSP) effective date 11/18 identified preventive measures for staff to 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 assist him with participation. As soon as he participates in an activity, give him reward of a favored activity (positive attention, etc.)."

Interview on 1/15/19 with the qualified intellectual disabilities professional (QIDP) and the group

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W 227	Continued From page 4 home manager verified client #4 is in need of more goals to promote increased engagement in self-independence activities. Further interview on 1/15/19 with the QIDP revealed client #4 enjoys his iPad; however, the iPad is currently being repaired.	W 227		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation and interview, nursing services failed to assure staff were trained as needed in appropriate health methods during medication administration. The findings are: A. Observation of morning medication administration on 1/15/19 at 7:05 AM revealed staff assisting client #1 with punching out his pill packs of medications consisting of Vitamin D, Naltrexone, Risperidone, Topiramate, Hydrocortisone, Certavite, Tegretol XR, Omeprazole, and Levetiracetam into a clear medication dispenser box unit. Further observations revealed within the clear medication dispenser box unit was a conical shaped apparatus where the punched pills were supposed to fall into the medication cup located underneath. Continued observations revealed much of client #1's punched pills fell within the inside compartments of the medication dispenser	W 340		

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box unit instead of into the medication cup and the medication technician retrieved the pills into the bare palm of her hand, placed the pills into a medication cup and administered them to client #1.

B. Observation of morning medication administration on 1/15/19 at 7:35 AM revealed staff assisting client #5 with punching out his pill pack of medications consisting of Divalproex DR, Fish Oil, Folbic, Lamotrigine, Zonisamide, and Topiramate. Further observations revealed many of his pills fell within the inside compartments of the medication dispenser box unit instead of into the medication cup and the medication technician retrieved the pills into the bare palm of her hand, placed the pills into a medication cup and administered them to client #5.

Interview on 1/15/19 at 7:40 AM with the involved medication technician revealed pills often fall within the inside compartments of the medication dispenser box unit and it is a problem. Further interview revealed she has informed supervisory staff of this problem.

Interview on 1/15/19 at 7:47 AM with another staff revealed there are times when you will need to shake the medication dispenser box unit to get the pills to fall into the medication cup and this is not a frequent problem.

Interview on 1/15/19 with the home manager revealed staff should have put gloves on first before she retrieved the pills and the home manger verified gloves were present in the medication area for staff use. Further interview revealed all staff are trained to properly administer medications to clients. Continued

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W 340	Continued From page 6 interview on 1/15/19 with the qualified intellectual disabilities professional (QIDP) on 1/15/19 revealed staff should have obtained and used gloves and not her bare hands to retrieve the pills.	W 340		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of possible infection and prevent possible cross-contamination. While this immediately affected 2 of 6 clients (#1 and #5), it potentially affects all 6 clients residing in the home. The findings are: Precautions were not taken to promote client health and prevent possible cross-contamination during medication administration. A. Observation of morning medication administration on 1/15/19 at 7:05 AM revealed staff assisting client #1 with punching out his pill packs of medications consisting of Vitamin D, Naltrexone, Risperidone, Topiramate, Hydrocortisone, Certavite, Tegretol XR, Omeprazole, and Levetiracetam into a clear medication dispenser box unit. Further observations revealed within the clear medication dispenser box unit was a conical shaped apparatus where the punched pills were	W 455		

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supposed to fall into the medication cup located underneath. Continued observations revealed much of client #1's punched pills fell within the inside compartments of the medication dispenser box unit instead of into the medication cup and the medication technician retrieved the pills into the bare palm of her hand, placed the pills into a medication cup and administered them to client #1.

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W 455	Continued From page 8 manger verified gloves were present in the medication area for staff use. Further interview revealed all staff are trained to properly administer medications to clients. Continued interview on 1/15/19 with the qualified intellectual disabilities professional (QIDP) on 1/15/19 revealed staff should have obtained and used gloves and not her bare hands to retrieve the pills. In addition, the QIDP verified all staff are properly trained to safely administer medication to clients.	W 455		