STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G048	A. BUILDING ______ B. WING ______	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKWELL 1 & 2	HIGHWAY 152 EAST 6330 ROCKWELL, NC 28138

(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 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: The person centered plan (PCP) for 1 of 4 sampled clients (#1) 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 #1 did not participate in activities to promote increased engagement, self-independence. Observations on 1/24/19 at 4:40 PM - 5:40 PM revealed client #1 sitting in a recliner in the living room. Further observations during this time revealed the television was on, Michael Jackson music was played as well and staff verbally prompted clients to dance and exercise. Continued observations revealed client #1 to comply with staff's verbal prompt at 5:41 PM to come to the kitchen. Subsequent observations revealed at 5:45 PM, client #1 to briefly press the food processor's button with hand over hand assistance to prepare her food and by 5:52 PM client #1 was noted sitting at the dining table consuming her dinner meal. Interview on 1/24/19 with staff (1) at 5:30 PM revealed client #1 mostly sits in her recliner and often falls asleep in it.	W 227		

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 227	Continued From page 1	W 227		

Morning observations on 1/25/19 at 7:20 AM revealed client #1 in the kitchen helping with the meal preparation of her breakfast food. Further observations at 7:25 AM - 7:40 AM revealed client #1 consuming her breakfast meal. Continued observations at 7:45 AM - 8:10 AM client #1 was noted to be in the recliner in the living room with playing cards in her hands. Further observations revealed client #1 was in the medication area at 8:15 AM - 8:30 AM and returned afterwards to the living room area. Continued observations at 8:30 AM - 8:50 AM revealed client #1 in the living room area sitting in her recliner.

Interview on 1/25/19 with staff (1) at 8:00 AM revealed while client #1 mostly sits in her recliner in the living room, the other clients residing in the home mostly sit in the living room listening to music or watching television.

Review on 1/25/19 of client #1's PCP dated 4/27/18 revealed the following programs: communication, oral hygiene, physical movement (ball toss), behavior support program, allow assistance to rub her fingers, transfer laundry items into hamper, independently move lunch bag into cooler, produce money in exchange for an object.

Review on 1/25/19 of client #1's adaptive behavior inventory (ABI) dated 4/19/18 identified the following need assessments: meal prep/setting the table, arts & crafts, exercising, hobbies, sports.

Interview on 1/25/19 with the qualified intellectual disabilities professional (QIDP) verified client #1 is in need of more goals to promote increased

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W 227	Continued From page 2 engagement in self-independence activities.	W 227		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: The facility failed to assure the person centered profiles (PCP's) for 1 of 5 clients in the group home (#11) included opportunities for client choice and self-management regarding dinner preparation and assisting with food preparations as evidenced by observation, interview and record verification. The finding is: Based on observations in the home on 1/24/19 at 5:00 pm, client #11 sat down at the table with the other clients to eat dinner. The food was being passed around to each client when staff came over to the table, obtained some of the broccoli in a small bowl and took it to the kitchen. A few minutes later, staff came into the dining room with a bowl containing pureed food and served client #11 by putting a light creamy mixture that apparently contained broccoli, and then assisted client #11 with hand over hand assistance in placing mashed potatoes onto his plate. Review of client #11's PCP dated 6/7/18 revealed a goal to "Tolerate hand over hand assistance to scoop food into food processor." Further review of the adaptive behavior inventory (ABI) dated 6/4/18 revealed client #11 has "no independence" and a "need" for meal preparation specifically to "scoop food into blender." Interview on 1/25/19 with the qualified intellectual	W 247		

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W 247	Continued From page 3 disabilities professional (QIDP) revealed client #11 should have been given the opportunity to participate in pureeing his food.	W 247		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility's drug administration system failed to assure all drugs were administered without error for 1 of 4 sampled clients (#1) and 1 non-sampled client (#2). The findings are: A. Client #1 did not receive medications as prescribed. Morning breakfast observations at the dining table on 1/25/19 at 7:25 AM a staff member measured out Polyethylene Glycol 2250 powder and assisted client #1 with pouring the powder into her container of milk. Further observations revealed the involved staff member to verbally instruct a direct care staff (DCS) member to monitor client #1 to ensure she drinks all of her milk as the involved staff member exited the breakfast area site. Interview on 1/25/19 at 7:50 AM with the involved staff revealed she usually works at another home and was only helping out at the home this morning because of the home's limited availability of staff. Further interview revealed, first, she was instructed by the qualified intellectual disabilities	W 369		

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W 369	Continued From page 4 professional (QIDP) to administer client #1's Polyethylene Glycol at the breakfast table because this is client #1's preference and, secondly, because client #1 usually requires a lengthy time frame to consume her Polyethylene Glycol mixture. Continued interviews revealed there is no physician order to administer client #1's Polyethylene Glycol at the dining table. Interview on 1/25/19 at 8:05 AM with DCS (1) revealed they administer client #1's Polyethylene Glycol in the medication area and not at the dining table. Review on 1/25/19 of client #1's current physician orders revealed an order for Polyethylene Glycol 3350 dissolve 17 GM (one capful to the line) in 8 ounces of liquid and to consume by mouth twice a day for constipation; however, there was no physician order to administer her Polyethylene Glycol at the dining table. Review on 1/25/19 of client #1's adaptive behavior inventory (ABI) dated 4/19/18 revealed "...comes to medication area when asked" and is rated "3" for "...Total independence; performs all of the task thoroughly without assistance" and also rated an "S" for "strength." Further review revealed "...comes to medication area without prompt" and also rated "3" for "... Total independence; performs all of the task thoroughly without assistance" and "S" for "strength." Interview on 1/25/19 with the facility nurse and the QIDP verified there is no physician order for staff to administer client #1's Polyethylene Glycol at the dining table. Further interviews verified medication technicians should remain with all clients to ensure clients consume their	W 369		

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medications as prescribed.

B. Client #2 did not receive medications as prescribed.

Morning breakfast observations at the dining table on 1/25/19 at 7:15 AM a staff member measured out Lactulose solution into a medication cup and assisted client #2 with pouring the Lactulose solution into client #2's container of milk. Further observations revealed the staff member to proceed to administer medication to another client seated alongside client #2 at the dining table. Continued observations revealed client #2 to finish consuming her breakfast of waffles and eggs at 7:14 AM and not her milk. Subsequent observations revealed a DCS member to verbally redirect client #2 to drink all of her milk of which she eventually did although no DCS were noted present.

Interview on 1/25/19 at 7:50 AM with the involved medication technician revealed she usually works at another home and was only helping out at the home this morning because of the home's limited availability of staff. Further interview revealed, first, she was instructed by the QIDP to administer client #2's Lactulose at the breakfast table because this is client #1's preference and, secondly, because client #2 usually requires a lengthy time frame to consume her Lactulose solution mixture. Continued interviews revealed there is no physician order to administer client #2's Lactulose solution at the dining table.

Interview on 1/25/19 at 8:05 AM with DCS (1) revealed they administer client #2's Lactulose in the medication area and not at the dining table.

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W 369	Continued From page 6 Review on 1/25/19 of client #2's current physician orders revealed an order for Lactulose solution and to give 15 ml by mouth daily; however, there was no physician orders to administer her Lactulose solution at the dining table. Review on 1/25/19 of client #2's adaptive behavior inventory (ABI) dated 9/18/18 revealed "...comes to medication area when asked" and is rated "2" for "...Partial independence; performs some but not all of task independently" and "N" for "...A skill that can be considered for training..."" Interview on 1/25/19 with the facility nurse and the QIDP verified there is no physician order for staff to administer client #2's Lactulose solution at the dining table. Further interviews verified medication technicians should remain with all clients to ensure clients consume their medications as prescribed.	W 369		