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		_		:		TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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: 02/13/2019

TITLE

	-	D HUMAN SERVICES				FORM	D: 02/13/2019 MAPPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		34G324	B. WING			02/	01/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				20	205 EAST INGRAM AVENUE		
	AD CHILDREN'S HOME			Μ	MOUNT GILEAD, NC 27306		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 227	Afternoon observation 1/31/19 from 3:30 Pm #2 to pace back and f minutes of the 120 mi Other activities during eating a snack for 5 m cleaning up his plate for computer for 20 minu minutes, washing his 5minutes and talking Continued morning of 7:00 AM on 2/1/19 rev around the group hom at his twin brother and Other activities of clie breakfast meal of pan loading his dishes in th his morning medication of 20 minutes. At no board or picture schee home or utilized with the to let client #2 know ' and to " keep client # Interview with the faci Disabilities Profession unaware of the recom board of activities and in the clients current I recommendations dat interview with the QIE confirmed client #2 st schedule to provide st communication skills	visual cue for each activity." as in the group home on to 5:30 PM revealed client forth in the living area for 65 nutes of observation time. this time frame included inutes, eating dinner and for 10 minutes, using a tes and watching TV for 10 hands and toileting for to staff for 5 minutes. oservations from 5:45 AM to vealed client #2 to pace the for 55 minutes hollering d other clients and staff. Int #2 were eating his cakes for 5 minutes, he dishwasher and taking ons for 10 minutes for a total time was a communication dule evident in the group client #2 to offer activities, or " what was expected of him" 2 engaged in activities". lity Qualified Intellectual hal revealed that she was imendations for a picture d schedule as recommended PP and the Psychological ted 11/5/18. Continued OP and Home manager hould be utilizing a picture tructure and enhance his		227			

Facility ID: 955424

If continuation sheet Page 2 of 5

	S FOR MEDICARE &					D. 0938-039		
· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED		
		34G324	B. WING		02	/01/2019		
NAME OF P	ROVIDER OR SUPPLIER		S	IREET ADDRESS, CITY, STATE, ZIP CODE				
			20	5 EAST INGRAM AVENUE				
			м	OUNT GILEAD, NC 27306				
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE		
W 227	EAD CHILDREN'S HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W 227					

Facility ID: 955424

If continuation sheet Page 3 of 5

PRINTED: 02/13/2019 FORM APPROVED

	-	D HUMAN SERVICES): 02/13/2019 I APPROVED		
CENTER	S FOR MEDICARE & M	MEDICAID SERVICES				OMB NO	0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		34G324	B. WING		-	02/0	01/2019		
NAME OF PF	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STA	TE, ZIP CODE				
MT GILEA	D CHILDREN'S HOME		205 EAST INGRAM AVENUE MOUNT GILEAD, NC 27306						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE		
W 227	breakfast meal of pancakes for 5 minutes, loading his dishes in the dishwasher and taking his morning medications for 10 minutes for a total of 20 minutes. At no time was a communication board or picture schedule evident in the group home or utilized with client #2 to offer activities, or to let client #2 know " what was expected of him" and to " keep client # 2 engaged in activities". Interview with the facility Qualified Intellectual Disabilities Professional revealed that she was unaware of the recommendations for a picture board of activities and schedule as recommended in the clients current IPP and the Psychological recommendations dated 11/5/18. Continued interview with the QIDP and Home manager confirmed client #2 should be utilizing a picture schedule to provide structure, enhance his communication skills and reduce disruptive behaviors.		W 227	D	EFICIENCY)				
	5.44 ANI 011 9/20/10,	at 0 5.42 AW 011 0/15/16							

Facility ID: 955424

If continuation sheet Page 4 of 5

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
34G324		B. WING			02/01/2019			
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
MT GILE	AD CHILDREN'S HOME				205 EAST INGRAM AVENUE MOUNT GILEAD, NC 27306			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX S	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
W 440	within the 5:00AM ho the clients are awake facility fire drills repor drills have been cond or at varied times du personnel. to allow tra how to conduct and re sleeping hours. Interview with the qua professional (QIDP) of not been conducted 3rd shift of personnel and clients on how to sleeping hours. Cont revealed 3rd shift fire	21/18. All of these times are ur and are conducted when in the home. Review of the ts revealed no 3rd shift fire lucted during sleeping hours	W	440				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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