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

PRINTED: 12/21/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT C AND PLAN OF	PF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE: COMPI	
		34G268	e. WING			12/	18/2018
	ROVIDER OR SUPPLIER OUNTY HOME FOR AUT	ISTIC ADULTS		11	REET ADDRESS, CITY, STATE, ZIP CODE 12 DEVONSHIRE TRAIL BERDEEN, NG 28316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X6) COMPLETION DATE
W 189	CFR(s): 483.430(e)(1 The facility must provinitial and continuing employee to perform) Ide each employee with training that enables the I his or her duties effectively,	w	189			
	Based on observation failed to assure staff assure competency is medication administration potentially/affected a facility. The findings of th	not met as evidenced by: ons and interviews, the facility received ongoing training to n behavior management, ation and interactions. This if clients residing in the are: ned not to mark the ation record when the provided. Iministration observations on client #3 was not provided ication. of client #3's physician 8 revealed an order for n 0.25% Apply on skin three B with the management edication is not being given. ed she "knows for a fact" it is nuse they have not had it.				•	
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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 80 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event (D: 1XCX11

FADINY ID: 932244

CENTERS FOR MEDICARE & ME BTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X	1) PROVIDER/SUPPLIER/CLIA			UNHN	<u> </u>
	IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE	BURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER	***************************************	[8	STREET ADDRESS, CITY, STATE, ZIP CODE	1 12	/18/2018
MOORE COUNTY HOME FOR AUTIST	TIC ADULTS	1	1112 DEVONSHIRE TRAIL ABERDEEN, NC 28316		
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efficiently, and competen	each employee with ning that enables the or her duties effectively, atily. The as evidenced by: and interviews, the facility sived ongoing training to havior management, and interactions. This ents residing in the nect to mark the record when the ded, stration observations on t#3 was not provided in. The management the management tion is not being given. The wealed the record for the entire ited as giving the		By January 18, 3019 all will be inserviced on my cation administration, Be support Plans and support Plans and support Client choices, self determined to client thousand an agement of locking medication door. More specifically, thousand the client #3 medication regime and door accuracy. All MAR's and physician orders will be reviewed weekly by Homemanage of IDP and monthly by Hab Special DIDP and monthly by Registered Nurse. All staff will be inserved weekly by the medication not will be monitored use. The locking of the room will be monitored laily by the Home manager, that y Home manager, that specialist and GIDP.	thavior prission in and gh ment fron	19/19

Any deficiency statement ending with an asteriak (*) 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 an days following the date of survey whether or not a plan of correction is provided. For numing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made evaluable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

TITLE

(X8) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

01/10/2019

PRINTED: 12/21/2018 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (XS) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED 34G268 B. WING 12/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONBHIRE TRAIL MOORE COUNTY HOME FOR AUTISTIC ADULTS ABERDEEN, NC 28316 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X6) COMPLETION DATE PREFIX TAG REGULATORY OR LCC IDENTIFYING INFORMATION) TAG DEFICIENCY) W 189 W189 All Staffwill be inserviced Continued From page 1 Interview on 12/18/18 with the manager stated on medication administration she has no idea why staff are marking it, they are as ordered and documentation not currently giving the medication because she thinks it was discontinued a long time back. of medication errors. Home Manager will document weekly monitoring and observations Hab Spectalist to monthly and Nurse monthly. Review of the record did not reveal physician orders to discontinue the medication. 2. Staff were not competently trained to consistently implement client #1's behavior support plan (BSP) as written, specifically components addressing non-compliance and loud vocalizations. During observations in the afternoon and evening on 12/17/18 and in the moming on 12/18/18, client #1 was continually prompted to comply with tasks at hand and periodically expressed episodes of loud vocalizations. She was almost constantly seeking attention verbally or physically from others. Staff were repeatedly redirecting her, (For example, when she wouldn't put her shoes on, she was repeatedly asked to put her shoes on. When she continually pointed to her socks she was told several times her socks are pretty.) There were no pauses and no ignoring of attention seeking behaviors throughout the observations. Review on 12/18/18 of client #1's Individual program plan (IPP) dated 5/10/18 revealed a behavior program for client #1 dated 3/20/17. This plan addressed non-compliance, crying, self-injurious behavior, loud vocalizations, and decrease the use of mittens. Review of the intervention strategies revealed the following: "Non-Compliance -Give [Client #1] an instruction. If she does not comply within one minute, staff

will repeat the instruction. If she does not comply

P.005/022

(FAX)910 491 1000

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	ES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DA1	<u>IO. 0938-039</u> TE BURVEY MPLETED
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the activity important to compliance she may exist will light that are defended in the compliance of the compliance of the compliance of the compliance of the complex of t	itional minitional min	ute, staff will put her through duated guidance. It is the staff may entice ding her of reinforcement oliantLoud Vocalizations: happropriate verbalizations, gain attention from others. NO CORRECTIONS, her any undo attention.) ctivities or programs." 12/18/18 revealed that we and attention seeking attention seeking attention seeking attention seeking attention change.) The staff regurgitate her plan's they do the best they can at experimentally trained to BSP consistently as emponents addressing loud in the morning on 12/18/18 #8 yelled and spit. He was to his room, When loudly made to do anything but	W 189			

(FAX)910 491 1000

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(6×3)	NO. 0938-039 PATE SURVEY COMPLETED
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I to the second	Continued From page but stated that sending part of the program. Of that was part of the prowhat they do. She did training on the behavior remember the lady's not a staff were not compon interacting in a manchoice, self-determinated (specifically, client #1 adrink beverages at medically and beverages and both we more before getting more self-determinated in the self-de	g him to his room was a One staff was not sure if ogram but admitted that is confirm she had received or programs but could not ame who trained in policies mer that supports client ilon and self-management and #4 were not allowed to all time as they desired.) rvations on 12/17/18 and #4 wanted more are told they needed to eat one beverages. vith staff, revealed all staff to by withholding their tomore. client #1's IPP dated g about withholding more. client #4's IPP dated g about withholding they reactions. Staff further not "withholding the ouraging the clients to	W 18			

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/21/2018 RM APPROVED IO: 0938-0391
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W 189	Continued From page	4	w	189		•	
	administration pass, it room and down the his second staff took over walked out and down Both staff left the med when they left. An interview on 12/18 left the room unlocked been taught to lock the clients. Interview on 12/18/18 confirmed that the document of the second stage on the second stage on this. 6. Staff were not come all medications were good and the second stage of the	or should be locked when inhistering medications. If had in fact been trained petently trained to assure given as ordered. #6 refused to take their emorning medication in 12/18/18 of the morning t#1 and #6 refused to take ons. 8 of client #1's physician's evealed the following					
	daily	ce two tablets by mouth					
1.	Aripiprazole (B-Abilify)	Take One tablet by mouth		- 1		,	

FORM CMS-2567(02-99) Prévious Versions Obsolete

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Facility ID: 932244

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	CORRECTION CONTER OR SUPPLIER COUNTY HOME FOR AUTISTIC ADULT SUMMARY STATEMENT OF DI (EACH DEFICIENCY MUST BE PRE REGULATORY OR LSC IDENTIFYIN Continued From page 5 daily Naitrexone HCL 50mg Take one tablet by mouth in the m (B-Revia) Propranolol HCL ER 80mg Take of mouth in the morning (B- Inderal LA) Calcium 500 Mg with Vitamin D 20 Take One tablet by mouth twice do Triamcinolone Aceton 0.025 % Aptimes a day (B-Artstocort) Magnesium Oxide 400 mg Tab. Take 1/2 tablet by mouth 2 times a Folic Acid 1mg tab Take two tablets by mouth once de (B-Zyrtec) Prenatal Tab Take one tablet by mouth in the magnesium of tablet by mouth every day Take one tablet by mouth every day	30mg Take one capsule by					
	Calcium 500 Mg with Vitamin D 2001 Take One tablet by mouth twice daily.						
	Triamcinolone Aceton times a day (B-Artstoo	0.025 % Apply on skin 3 ort)				,	
	Folic Acid 1mg tab Take two tablets by mo	outh once daily (B-Folvite)					
	Cetirizine HCL 10 mg Take one tablet by mor (B-Zyrtec)	uth in the morning			·		
	Prenetal Tab Take one Tablet by mo	uth in the morning					
1	2. Review on 12-18-18 order's revealed the fol medications:	of client #6's physician lowing morning					
	Clonidine HCL .1mg tal	ģ					

, DEPART CENTER	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 12/21/2018 RM APPROVED D. 0938-0391
	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X9) DAT	E SURVEY IPLETED
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MOORE C	OUNTY HOME FOR AUT	ISTIC ADULTS	I .	112 DEVONBHIRE TRAIL BERDEEN, NC 28315		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEPICIENCY)	BE	(X8) COMPLETION DATE
	Take one-half tablet be Risperidone 3 mg Take twice daily (B-Risperdai) Divalproex Sodium Eff Take one tablet by moderate (B-Depakote ER) Amoxicillin/Clavulan 8 Take one tablet by moderate and tablet by moderate and tablet for moderate and tablet for moderate and tablet by moderate and tablet for moderate and tablet and take any further interview with sometimes.	y mouth in the morning to one tablet by mouth R 500 mg buth twice daily. R55-125mg Tab buth twice daily uth twice daily uth twice daily 12/18/18 confirmed the y of their medications. staff revealed this happens of her medications.	W 189			
	client #3 did not swallo medications. She was and assisted in trying t powder for all oral med was assisted she spit r as staff assisted her in came back up. Some o put in water and re-adr	handed all medications				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/21/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE BURVEY IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED 34G268 B. WNG 12/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONSHIRE TRAIL MOORE COUNTY HOME FOR AUTISTIC ADULTS ABERDEEN, NC 28316 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (XB) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 189 Continued From page 7 W 189 be quarter size pieces) fell to the floor in the process. Staff did not indicate she knew they fell. In fact, she stated, "Good you got it ail" at the end of the pass. After that, the staff was asked to pick up the pieces of medication from the floor. She picked up two and then the third was also pointed out to her. She stated, "Well she got most of it." Review of the physician's orders for 12/1/18-12/31/18 confirmed the following oral medications: Amitriptyline HCL 50 mg Tab. Take 1 tablet by mouth prior to procedure. (B-Elavil) Magnesium Oxide 400 mg tab. Take 1/2 tablet by mouth 2 times a day Vitamin D 5000 IU Cap Take one Capsule by mouth once a week (B-Drisdol) Folio Acid 1mg Tab Take two tablet by mouth once daily (B-Folvite) Cethrizine HCL 10mg Take one tablet by mouth in the morning (B-Zyrtec) Prenatal Tab Take one tablet by mouth in the morning. After pointing out the dropped medications to the

staff after the observation on 12/18/18 she acknowledged that the client did not get all of her

PRINTED: 12/21/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE BURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING . 34G268 B. WNG 12/18/2018 -NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONSHIRE TRAIL MOORE COUNTY HOME FOR AUTISTIC ADULTS ABERDEEN, NC 28316 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE W 189 Continued From page 8 W 189 medication, afterall. No indication or note of medication error was made by staff. W 227 w227 By 1/18/19 clients 1 and & INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) individual program plan will be revised to include specific The Individual program plan states the specific objectives to address taking of medications, All staff will be inserviced objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. on the rension and manitored for implementation by Home Manager, Hab Spec and 510P and documented weekly This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all needs were addressed with specific objectives in the individual program plans (IPPs). This affected 2 of 3 audit clients (#1 and #3). The finding is: 1. Client #1's observed need to take her medications was not addressed in a program, During observations on 12/18/18 at the 7:32AM medication administration pass, client #1 refused to take her medications. She was distracted and active. Touching everything around her and refusing to participate in the medication pass. She was physically assisted to do some parts and would lark away from parts of the preparation. The client picked up lotion and wanted some but the staff said, "You can have some if you take your medications." Later the steff went to get another staff. The second staff came in and blocked client #1 in with her body whenever she would try to leave. She took the lotion and said. "Okay, if you get some lotion will you then take your medications?" The staff assisted her with abtaining lotion. Client #1 continued to refuse to

FORM CMS-2567(02-99) Previous Versions Obsolate

Event ID: 1XCX11

Facility ID: 932244

If continuation sheet Page 9 of 20

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W 227	Continued From pag	n 9	181	~^·		######################################	
	take her medications		VV	227			
	sometimes client #1 : The staff did not know	he steff stated they just keep					
	•				,		
	5/10/18 revealed a pl and Crylng." The pla address not complyin	of client #1's IPP dated an for "non-compliance, SIB n for non-compliance did not g with the medication pass. gies and no goal to take her					
	Further interview on a confirmed there is no need for her to take h	12/18/18 with management written plan to address the er medications.					
	2. Client #8's observe was not addressed in	ad need to address spitting a program.		•			
	spitting at staff. He sp times. He was told to would not stop his spi	on 12/18/18, client #6 began bit in their faces several go to his room but this tilng. Staff stood by with a fier sending client #6 to his					
	Review on 12/18/18 o 10/10/18 revealed a b non-compliance, voca not for spitting.	f client#6's IPP dated ehavior support plan for fizations, self wetting but					
	often gets agitated and	12/18/18 revealed client #6 d spits and 2 staff revealed sure if this is in his plan but		}			

		ID HUMAN SERVICES			FOR	ED: 12/21/2018 IM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: WAS A GRAPH OF PROVIDER OR SUPPLIER MOORE COUNTY HOME FOR AUTISTIC ADULTS (CA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 227 Continued From page 10 they try to deal with it by sending him to his room if he spits. Staff stated, often he wants to go to		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DAT	O. 0938-0391 E SURVEY PLETED	
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W 249	they try to deal with it if he spits. Staff state his room so it isn't a p PROGRAM IMPLEME CFR(s): 483.440(d)(1). As soon as the interdiction of the light of the spits of the state of the	by sending him to his room d, often he wants to go to roblem to get him there. ENTATION sciplinary team has adividual program plan, ve a continuous active nsisting of needed lices in sufficient number sort the achievement of the the individual program or met as evidenced by: s, record reviews and did not assure consistent behavior support programs (#1 and #6). The findings support plan (BSP) was nented as written, s addressing ud vocalizations. the afternoon and evening morning on 12/18/18, ly prompted to comply with adically expressed	W 22		ents ally e	Y18/19
1	constantly seeking atte from others. Staff were	ample, when she wouldn't				

PRINTED: 12/21/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES . FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/BUPPLIER/GLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 34G288 B. WNG 12/18/201B NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONSHIRE TRAIL MOORE COUNTY HOME FOR AUTISTIC ADULTS ABERDEEN, NC 28316 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (XA) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREPIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEF(CIENCY) W 249 Continued From page 11 W 249 constantly asked to put her shoes on.) There were no pauses and no ignoring of attention seeking behaviors throughout the observations. Review on 12/18/18 of client #1's individual program plan (IPP) dated 5/10/18 revealed a behavior program for client #1 dated 3/20/17. This plan addressed non-compliance, crying, self-injurious behavior, loud vocalizations, and decrease the use of mittens. Review of the intervention strategies revealed the following: "Non-Compliance -Give [Client #1] an instruction. If she does not comply within one minute, staff will repeat the instruction. If she does not comply in one additional minute, staff will put her through the activity using graduated guidance. It is important to note that the staff may entice compliance by reminding her of reinforcement she may earn if compliant...Loud Vocalizations: Staff will ignore her inappropriate verbalizations, that are designed to gain attention from others (NO EYE CONTACT, NO CORRECTIONS. etc.)...(Do NOT give her any undo attention.) ... return to ongoing activities or programs. Interview with staff on 12/18/18 revealed that client #1 is more active and attention seeking lately (since a medication change.) The staff Interviewed could not regurgitate her plan's strategies but stated they do the best they can at getting her to comply. 2. Client #6's BSP was not consistently

implemented as written, specifically components

During observations in the morning on 12/18/18 about 9:00am revealed client #6 yelling and spitting. He was told repeatedly to go to his

addressing loud vocalizations.

DEPART	TMENT OF HEALTH AN	ID HUMAN SERVICES				PRINTE	ED: 12/21/2018
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MOORE	COUNTY HOME FOR AUT	ISTIC ADDITS		1	1112 DEVONSHIRE TRAIL		
	·	Torrest.		1	ABERDEEN, NC 28316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	itë Të	(XB) COMPLETION DATE
W 249	room. When loudly verto do anything but inside to do anything but inside to do anything but inside the control of the control	calizing he was not made lead sent to his room. f client #6's IPP dated SP dated 3/6/18. This BSP ent #6 vocalizes loudly, is being disruptive to each him to clean the an area or other busy 12/18/18 revealed staff ne components of the at sending him to his room am. One staff was not the program but admitted	W	249			
	her. CONDUCT TOWARD CFR(s); 483.450(s)(1)(CLIENT (ii) cedures must address the hoice will be decision-making, mination and e extent possible. t met as evidenced by: record reviews and elient choice, self-management were ented by staff. This ents. The findings are:	W 2	***	By Jan. 18,19 Clients # 1. and #4 BSP will be reviously dispersed as needed as their IPP regarding dispersed as their IPP regarding meanifered and end on any medification and will be manifered an another and the served for appropriate impropriate in the spec and for OIPP and tub. Spec and for OIPP and tub. Spec and for OIPP and	nd Hind J ser- ens	418/19

CENTER	TMENT OF HEALTH AN RS FOR MEDICARE &			·	PRINTED: 12/21/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT AND PLAN O	of deficiencies f correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE GONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		34 G 268	B. WNG		40/40/0040
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/18/2018
MOORE	COUNTY HOME FOR AUT	ISTIC ADULTS		1112 DEVONSHIRE TRAIL ABERDEEN, NC 28315	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDEFICIENCY)	DRF CONFIGURA
W 269	beverages at meal tim	e as they desired.	W 26	38	
	12/18/18, client #1 and beverages and both w more before getting m	ere told they needed to eat ore beverages.			
	encourage clients to e beverages until they e	at more.			
	Review on 12/18/18 or 5/10/18 revealed nothing beverages until she at	ng about withholding a more.			
	Review on 12/18/18 of 9/22/18 revealed nothin beverages until he ate	ng about withholding more.			
W 288	Interview on 12/18/18 confirmed staff should cannot drink when they MGMT OF INAPPROP	not tell individuals they want to drink,	W 288	3	
	CFR(s): 483.450(b)(3)				
	Techniques to manage behavior must never be an active treatment pro	s used as a substitute for			
	This STANDARD is no Based on observations Interviews, the facility for techniques to manage of incorporated into the ac affected one audit clien	o, record review and all alled to assure all control were all control were all all all all all all all all all al			

PRINTED: 12/21/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES DMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X9) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 34G268 B. WNG 12/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONSHIRE TRAIL MOORE COUNTY HOME FOR AUTISTIC ADULTS ABERDEEN, NC 28316 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG W 288 W288 Client # 6 BSP and IPP will be Continued From page 14 The technique of sending client #6 to his room reviewed and revised as needed when he spits is not incorporated into an active to manage irapproplate lockena treatment program. with appropriate techniques as During observations in the morning on 12/18/18 specified in dan. All Haff will about 9:00am revealed client #6 yelling and spltting. He was told repeatedly to go to his be inserviced an any changes room. and will be monitored and obs-Review on 12/18/18 of client #6's BSP dated d for copropiate implement 3/6/18. This BSP did not address splitting. Iten by Home Manager, 4 Interview with staff on 12/18/18 revealed staff did not know what the plan said to do when client #6 pecialist and documented spits, but that for spitting they send him to his room. Weeklu. Interview with management on 12/18/18 confirmed the BSP did not include the technique of sending him to his room when he spits. All staffwill be inseniced W 369 **DRUG ADMINISTRATION** CFR(s): 483,460(k)(2) by nurse on medication ministration to include. The system for drug administration must assure trough not limited to appropriate that all drugs, including those that are self-administered, are administered without error. dacementation and will be This STANDARD is not met as evidenced by: monitored and observed Based on observations and record reviews the Home Manager daily and facility failed to assure all medications were given without error. This affected 3 of 4 the clients observed getting medications in the morning (#1. #3 and #6). The finding is: 1. Client #1 and client #6 refused to take their medications during the morning medication administration.

CENTER	MENT OF HEALTH AN RS FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/21/2011 RM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4		LE CONSTRUCTION	(X3) DAT	<u>(O. 0938-039</u> 'E 9URVEY APLETED
		34G268	B. WING	·			
	ROVIDER OR SUPPLIER COUNTY HOME FOR AUT	ISTIC ADULTS			STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONSHIRE TRAIL ABERDEEN, NC 28316	172	<u>2/18/2018</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y must be preceded by full SC identifying information)	ID PREFI TAG	IX,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIESE OF THE APPR	98	(XI) COMPLETION DATE
W 369	Continued From page	15	1	369	Ð	***************************************	
	During observations of medication pass, clien their morning medicates	on 12/18/18 of the morning at #1 and #6 refused to take lons,	♦				
	A. Review on 12-18-18 of client #1's physician's orders dated 12/1/18 revealed the following morning medications: Inositol 500mg Tab Take two tablets by mouth daily		ADDRESS AND			·	
			1				F
	Aripiprazole (B-Abilify) dally						
	Naitrexone HCL 50mg						
	Take one tablet by mor (B-Revia)	uth in the moming		1			
	Propranoiol HCL ER 8 mouth in the morning (B- inderal LA)	Omg Take one capsule by			. •		
	Calcium 500 Mg with V Take One tablet by mo	Ttamin D 2001 with twice dally					
	Triamcinolone Aceton (times a day (B-Artstoco	1.025 % Apply on skin 3 ort)					
	Magnesium Oxide 400 Take 1/2 tablet by mou	mg Tab. ith 2 times a day					
<u> </u>	Folic Acid 1mg tab Fake two tablets by mo	uth once daily (BFolvite)		***************************************			
7	Cetirizine HCL 10 mg fake one tablet by mou B-Zyrtec)	th in the morning					

PRINTED: 12/21/2018 . DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G288 B. WNG 12/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONBHIRE TRAIL MOORE COUNTY HOME FOR AUTISTIC ADULTS ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X8) COMPLETION DATE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY W 369 Continued From page 16 W 369 Prenatal Tab Take one Tablet by mouth in the morning B. Review on 12-18-18 of client #6's physician order's revealed the following morning medications: Sertraline HCL 100 mg. tab Take one tablet by mouth every day (B-Zoloft) Clonidine HCL .1mg tab Take one-half tablet by mouth in the morning Risperidone 3 mg Take one tablet by mouth twice dally (B-Risperdal) Divalproex Sodium ER 500 mg Take one tablet by mouth twice dally. (B-Depakote ER) Amoxicillin/Clavulan 875-125mg Tab Take one tablet by mouth twice daily (B-Augmentin) Antacid tablet 500mg Take one tablet by mouth twice dally Orazepam .5mg tab Take one tablet by mouth twice daily (B-Ativan) Interview with staff on 12/18/18 confirmed the clients did not take any of their medications. Further interview with staff revealed this happens sometimes.

		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 12/21/2018 DRM APPROVED			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-0381 (X3) DATE SURVEY COMPLETED			
		34 G2 88	B. WNG			12/18/2018				
Name of P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE		171 10170110			
MOORE COUNTY HOME FOR AUTISTIC ADULTS				1112 DEVONSHIRE TRAIL ABERDEEN, NC 28315						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE			
W 369	Staff did not assure client #3 swallowed all of her medications and that she received the ordered topical medication.		W	369						
	client #3 did not swalle medications. She was and assisted in trying powder for all oral medwas assisted she spit as staff assisted her in came back up. Some put in water and re-adwas thrown away. 3 to a quarter size pieces process. Staff did not in fact, she stated, "Go of the pass.	handed all medications to swallow dry crushed dications ordered. As she much of it into a papertowel wiping her mouth as it of that spit up remains was ministered. Other amounts arge chunks (appearing to) fell to the floor in the indicate she knew they fell.								
	up two and then the th her. She stated, "Well	rom the floor. She picked ird was also pointed out to she got most of it."								
	Review of the physicia 12/1/18-12/31/18 confi medications:	n's orders for rmed the following oral								
	Amitriptyline HGL 50 m Take 1 tablet by mouth (B-Elavil)									
	Magnesium Oxide 400 Take 1/2 tablet by mou									
	Vitamin D 5000 IU Cap Take one Capsule by n (B-Drisdol)									

PRINTED: 12/21/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/QUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF GORRECTION IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED 34G268 B. WING 12/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONSHIRE TRAIL MOORE COUNTY HOME FOR AUTISTIC ADULTS ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX ID PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LEC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) **W 369** Continued From page 18 W 369 Folic Acid 1mg Tab Take two tablet by mouth once daily (B-Folvite) Cetirizine HCL 10mg Take one tablet by mouth in the morning (B-Zyrtec) Prenatal Tab Take one tablet by mouth in the morning. After pointing out the dropped medications, staff in an Interview on 12/18/18 confirmed that meant she did not get all of her medication as ordered. Further review revealed an order for triamcinolone Acaton .025% topical apply on skin 3 times a day (B-Aristocort). During an interview on 12/18/18, management was asked about the topical and confirmed she is positive client #3 dld not get this medication and has not been receiving it, despite the documentation on the MAR revealing that said it had been being given in the mornings. She could not reveal a physician's order to discontinue the medication. w382 By 1/18/19 all staff will be inservicedon requirement W 382 DRUG STORAGE AND RECORDKEEPING CFR(s): 483,460(l)(2) to heep all drugs and bibliogicals locked.
(Please refer to tag 189) The facility must keep all drugs and biologicals locked except when being prepared for

FORM CM8-2567(02-99) Praylous Versiona Obsolata

administration.

This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure all medications were locked up

Event ID: 1XCX11

Facility ID: 932244

if continuation sheet Page 16 of 20

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/V/01 x 21 0 mr = 1	7.7.8.18.18.18.18.18.18.18.18.18.18.18.18.1		VQ. 0938-03
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	(X3) DA	(X3) DATE SURVEY COMPLETED	
		B. WNG		dmienina		
NAME OF PROVIDER OR SUPPLIER			8		12/18/2018	
MOORE C	COUNTY HOME FOR AL	UTISTIC ADULTS	1º			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	HITTE	(X5) COMPLETION DATE
	until the point of administration. This potential affects all clients residing in the facility. The finding is: The medication room was left unlocked between clients during the medication pass. During observations of the morning medication administration pass on 12/.18/18, the staff walked out of the room, leaving the door unlocked and the cabinet unlocked. She walked down the hall between client medication administration passes. A second staff took over at one point and also left the area completely unlocked and walked out and down the hall between clients also. Both staff left the medication room unlocked when they left. An interview on 12/18/18 with one of the staff who left the room unlocked revealed she had never been taught to lock the medication room between clients. Interview on 12/18/18 with management confirmed that the door should be locked when nobody is in there administering medications.		W 382		OPRIATE	
	She also indicated sta on this,	aff had in fact been trained				