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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 189 | STAFF TRAINING PROGRAM<br>CFR(s): 483.430(e)(1)<br><br>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and interviews, the facility failed to assure staff received ongoing training to assure competency in behavior management, medication administration and interactions. This potentially affected all clients residing in the facility. The findings are:<br><br>1. Staff were not trained not to mark the medication administration record when the medication was not provided.<br><br>During medication administration observations on 12/18/18 at 8:00am, client #3 was not provided with any topical medication.<br><br>Review on 12/18/18 of client #3's physician orders dated 11/14/18 revealed an order for Triamcinolone Aceton 0.25% Apply on skin three times a day."<br><br>Interview on 12/18/18 with the management confirmed that the medication is not being given. The manager indicated she "knows for a fact" it is not being given because they have not had it.<br><br>Further review on 12/18/18 revealed the medication administration record for the entire month of December is marked as giving the medication. | W 189 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeanne Thene, QP MA LCAS

TITLE

(X6) DATE: 1/10/19

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.

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G288 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOORE COUNTY HOME FOR AUTISTIC ADULTS | 1112 DEVONSHIRE TRAIL<br>ABERDEEN, NC 28315 |

| (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 189 | STAFF TRAINING PROGRAM<br>CFR(s): 483.430(e)(1)<br><br>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and interviews, the facility failed to assure staff received ongoing training to assure competency in behavior management, medication administration and interactions. This potentially affected all clients residing in the facility. The findings are:<br><br>1. Staff were not trained not to mark the medication administration record when the medication was not provided.<br><br>During medication administration observations on 12/18/18 at 8:00am, client #3 was not provided with any topical medication.<br><br>Review on 12/18/18 of client #3's physician orders dated 11/14/18 revealed an order for Triamcinolone Aceton 0.25% Apply on skin three times a day."<br><br>Interview on 12/18/18 with the management confirmed that the medication is not being given. The manager indicated she "knows for a fact" it is not being given because they have not had it.<br><br>Further review on 12/18/18 revealed the medication administration record for the entire month of December is marked as giving the medication. | W 189 | By January 18, 2019 all staff will be inserviced on medication administration, Behavior Support Plans and supports of client choices, self determination, self management and locking medication door.<br>More specifically, though not limited to client #3 medication regime and documentation for accuracy.<br>All MAR's and physician orders will be reviewed weekly by Home manager, bimonthly by Hab Specialist/QIDP and monthly by Registered Nurse.<br>All staff will be inserviced on keeping the medication room locked when not in use. The locking of the room will be monitored daily by the Home manager and documented weekly by Home Manager, Hab Specialist and QIDP. | 1/18/19 |

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.

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOORE COUNTY HOME FOR AUTISTIC ADULTS | 1112 DEVONSHIRE TRAIL<br>ABERDEEN, NC 28315 |

| (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 189 | Continued From page 1<br>Interview on 12/18/18 with the manager stated she has no idea why staff are marking it, they are not currently giving the medication because she thinks it was discontinued a long time back.<br><br>Review of the record did not reveal physician orders to discontinue the medication.<br><br>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.<br><br>During observations in the afternoon and evening on 12/17/18 and in the morning 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.<br><br>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 | W 189 | All staff will be inserviced on medication administration as ordered, and documentation of medication errors.<br>Home Manager will document weekly monitoring and observations Hab Specialist bimonthly and Nurse monthly. | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOORE COUNTY HOME FOR AUTISTIC ADULTS | 1112 DEVONSHIRE TRAIL<br>ABERDEEN, NC 28315 |

| (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 189 | Continued From page 2<br>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."<br><br>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.<br><br>3. Staff were not competently trained to implement Client #6's BSP consistently as written, specifically components addressing loud vocalizations.<br><br>During observations in the morning on 12/18/18 about 9:00am, client #6 yelled and spit. He was told repeatedly to go to his room. When loudly vocalizing he was not made to do anything but instead sent to his room.<br><br>Review on 12/18/18 of client #6's IPP dated 10/10/18 revealed a BSP dated 3/6/18. This BSP revealed that when client #6 vocalizes loudly, "Staff will ignore...if he is being disruptive to others, staff may redirect him to clean the baseboards, mopping an area or other busy chore."<br><br>Interview with staff on 12/18/18 revealed staff could not explain the components of the program | W 189 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 189 | Continued From page 3<br>but stated that sending him to his room was a part of the program. One staff was not sure if that was part of the program but admitted that is what they do. She did confirm she had received training on the behavior programs but could not remember the lady's name who trained her.<br><br>4. Staff were not competently trained in policies on interacting in a manner that supports client choice, self-determination and self-management (specifically, client #1 and #4 were not allowed to drink beverages at meal time as they desired.)<br><br>During meal time observations on 12/17/18 and 12/18/18, client #1 and #4 wanted more beverages and both were told they needed to eat more before getting more beverages.<br><br>Interview on 12/18/18 with staff, revealed all staff encourage clients to eat by withholding their beverages until they eat more.<br><br>Review on 12/18/18 of client #1's IPP dated 5/10/18 revealed nothing about withholding beverages until she ate more.<br><br>Review on 12/18/18 of client #4's IPP dated 9/22/18 revealed nothing about withholding beverages until he ate more<br><br>Interview on 12/18/18 with staff confirmed they were trained on staff interactions. Staff further indicated that they were not "withholding the beverages" but just encouraging the clients to eat.<br><br>5. Staff were not competently trained to assure the medication room was kept locked unless in there administering medications. | W 189 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 189 | Continued From page 4<br><br>During observations of the morning medication administration pass, the staff walked out of the room and down the hall between clients. A second staff took over at one point and also walked out and down the hall between clients. Both staff left the medication room unlocked when they left.<br><br>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.<br><br>Interview on 12/18/18 with management confirmed that the door should be locked when nobody is in there administering medications. She also indicated staff had in fact been trained on this.<br><br>6. Staff were not competently trained to assure all medications were given as ordered.<br><br>A. Client #1 and client #6 refused to take their medications during the morning medication administration.<br><br>During observations on 12/18/18 of the morning medication pass, client #1 and #6 refused to take their morning medications.<br><br>1., Review on 12-18-18 of client #1's physician's orders dated 12/1/18 revealed the following morning medications:<br><br>Inositol 500mg Tab Take two tablets by mouth daily<br><br>Aripiprazole (B-Abilify) Take One tablet by mouth | W 189 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 189 | Continued From page 5<br>daily<br><br>Naltrexone HCL 50mg<br><br>Take one tablet by mouth in the morning<br>(B-Revia)<br><br>Propranolol HCL ER 80mg Take one capsule by mouth in the morning<br>(B- Inderal LA)<br><br>Calcium 500 Mg with Vitamin D 200I<br>Take One tablet by mouth twice daily.<br><br>Triamcinolone Aceton 0.025 % Apply on skin 3 times a day (B-Artstocort)<br><br>Magnesium Oxide 400 mg Tab.<br>Take 1/2 tablet by mouth 2 times a day<br><br>Folic Acid 1mg tab<br>Take two tablets by mouth once daily (B--Folvite)<br><br>\|Cetirizine HCL 10 mg<br>Take one tablet by mouth in the morning<br>(B-Zyrtec)<br><br>Prenatal Tab<br>Take one Tablet by mouth in the morning<br><br>2. Review on 12-18-18 of client #6's physician order's revealed the following morning medications:<br><br>Sertraline HCL 100 mg. tab<br>Take one tablet by mouth every day<br>(B-Zoloft)<br><br>Clonidine HCL .1mg tab | W 189 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 189 | Continued From page 6 | W 189 | | |

Take one-half tablet by mouth in the morning

Risperidone 3 mg Take one tablet by mouth twice daily
(B-Risperdal)

Divalproex Sodium ER 500 mg
Take one tablet by mouth twice daily.
(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 daily

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.

7. Staff were not trained to consistently assure client #3 swallowed all of her medications.

During a morning medication pass on 12/18/18, client #3 did not swallow all of her crushed medications. She was handed all medications and assisted in trying to swallow dry crushed powder for all oral medications ordered. As she was assisted she spit much of it into a papertowel as staff assisted her in wiping her mouth as it came back up. Some of that spit up remains was put in water and re-administered. Other amounts was thrown away. 3 large chunks (appearing to

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 189 | Continued From page 7<br>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 all" at the end of the pass.<br><br>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."<br><br>Review of the physician's orders for 12/1/18-12/31/18 confirmed the following oral medications:<br><br>Amitriptyline HCL 50 mg Tab.<br>Take 1 tablet by mouth prior to procedure.<br>(B-Elavil)<br><br>Magnesium Oxide 400 mg tab.<br>Take 1/2 tablet by mouth 2 times a day<br><br>Vitamin D 5000 IU Cap<br>Take one Capsule by mouth once a week<br>(B-Drisdol)<br><br>Folic Acid 1mg Tab<br>Take two tablet by mouth once daily<br>(B-Folvite)<br><br>Cetirizine HCL 10mg<br>Take one tablet by mouth in the morning<br>(B-Zyrtec)<br><br>Prenatal Tab<br>Take one tablet by mouth in the morning.<br><br>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 | W 189 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOORE COUNTY HOME FOR AUTISTIC ADULTS | 1112 DEVONSHIRE TRAIL<br>ABERDEEN, NC 28315 |

| (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 189 | Continued From page 8<br>medication, afterall. No indication or note of medication error was made by staff. | W 189 | | |
| W 227 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(4)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>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 #6). The finding is:<br><br>1. Client #1's observed need to take her medications was not addressed in a program.<br><br>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 jerk 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 staff 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 obtaining lotion. Client #1 continued to refuse to | W 227 | By 1/18/19 clients# 1 and # 6 individual program plan will be revised to include specific objectives to address taking of medications.<br>All staff will be inserviced on the revision and monitored for implementation by Home Manager, Hab Spec and & IDP and documented weekly | 1/18/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______<br>B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOORE COUNTY HOME FOR AUTISTIC ADULTS | 1112 DEVONSHIRE TRAIL<br>ABERDEEN, NC 28315 |

| (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 | Continued From page 9<br>take her medications and fell to the floor. Eventually, the staff said she would write refused on it.<br><br>Interviews on 12/18/18 with 2 staff confirmed that sometimes client #1 refuses her medications. The staff did not know how to address the medication refusal. The staff stated they just keep trying different things when she refuses.<br><br>Review on 12/18/18 of client #1's IPP dated 5/10/18 revealed a plan for "non-compliance, SIB and Crying." The plan for non-compliance did not address not complying with the medication pass. There were no strategies and no goal to take her medications.<br><br>Further interview on 12/18/18 with management confirmed there is no written plan to address the need for her to take her medications.<br><br>2. Client #6's observed need to address spitting was not addressed in a program.<br><br>During observations on 12/18/18, client #6 began spitting at staff. He spit in their faces several times. He was told to go to his room but this would not stop his spitting. Staff stood by with a chair in the hallway after sending client #6 to his room.<br><br>Review on 12/18/18 of client#6's IPP dated 10/10/18 revealed a behavior support plan for non-compliance, vocalizations, self wetting but not for spitting.<br><br>Interview with staff on 12/18/18 revealed client #6 often gets agitated and spits and 2 staff revealed they did not know for sure if this is in his plan but | W 227 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G288 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOORE COUNTY HOME FOR AUTISTIC ADULTS | 1112 DEVONSHIRE TRAIL<br>ABERDEEN, NC 28315 |

| (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 | Continued From page 10<br>they try to deal with it by sending him to his room if he spits. Staff stated, often he wants to go to his room so it isn't a problem to get him there. | W 227 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility did not assure consistent implementation of the behavior support programs for 2 of 3 audit clients (#1 and #8). The findings are:<br><br>1. Client #1's behavior support plan (BSP) was not consistently implemented as written, specifically components addressing non-compliance and loud vocalizations.<br><br>During observations in the afternoon and evening on 12/17/18 and in the morning 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 almost constantly redirecting her. ( For example, when she wouldn't put her shoes on, she was continually and | W 249 | All staff will be inserviced on client #1 BSP components and appropiate implementation. Staff will be monitored daily for implementation and documented weekly by Home Manager bi monthly by HabSpec and monthly by QIDP. | 1/18/19 |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G269 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 249 | Continued From page 11<br>constantly asked to put her shoes on.) There were no pauses and no ignoring of attention seeking behaviors throughout the observations.<br><br>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.<br><br>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.<br><br>2. Client #6's BSP was not consistently implemented as written, specifically components addressing loud vocalizations.<br><br>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 | W 249 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G288 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 249 | Continued From page 12<br>room. When loudly vocalizing he was not made to do anything but instead sent to his room.<br><br>Review on 12/18/18 of client #6's IPP dated 10/10/18 revealed a BSP dated 3/6/18. This BSP revealed that when client #6 vocalizes loudly, "Staff will ignore...if he is being disruptive to others, staff may redirect him to clean the baseboards, mopping an area or other busy chore."<br><br>Interview with staff on 12/18/18 revealed staff could not regurgitate the components of the program but stated that sending him to his room was a part of the program. One staff was not sure if that was part of the program but admitted that is what they do. She did confirm she had received training on the behavior programs but could not remember the lady's name who trained her. | W 249 | | |
| W 269 | CONDUCT TOWARD CLIENT<br>CFR(s): 483.450(a)(1)(ii)<br><br>These policies and procedures must address the extent to which client choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, policies on client choice, self-determination and self-management were not consistently implemented by staff. This affected 2 of 3 audit clients. The findings are:<br><br>1. Client #1 and #4 were not allowed to drink | W 269 | By Jan.18,19 Clients #1 and #4 BSP will be reviewed and revised as needed and their IPP regarding drinking of beverages during meal time. All staff will be inserviced on any modifications and will be monitored and observed for appropriate implementation daily by Home Manager, Hab. Spec. and/or QIDP and documented accordingly | 1/18/19 |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 269 | Continued From page 13<br>beverages at meal time as they desired.<br><br>During meal time observations on 12/17/18 and 12/18/18, client #1 and #4 wanted more beverages and both were told they needed to eat more before getting more beverages.<br><br>Interview on 12/18/18 with staff, revealed all staff encourage clients to eat by withholding their beverages until they eat more.<br><br>Review on 12/18/18 of client #1's IPP dated 5/10/18 revealed nothing about withholding beverages until she ate more.<br><br>Review on 12/18/18 of client #4's IPP dated 9/22/18 revealed nothing about withholding beverages until he ate more.<br><br>Interview on 12/18/18 with management confirmed staff should not tell individuals they cannot drink when they want to drink. | W 269 | | |
| W 288 | MGMT OF INAPPROPRIATE CLIENT BEHAVIOR<br>CFR(s): 483.450(b)(3)<br><br>Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to assure all techniques to manage behavior were incorporated into the active treatment plan. This affected one audit client (#6). The finding is: | W 288 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 288 | Continued From page 14<br>The technique of sending client #6 to his room when he spits is not incorporated into an active treatment program.<br><br>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 room.<br><br>Review on 12/18/18 of client #6's BSP dated 3/6/18. This BSP did not address spitting.<br><br>Interview with staff on 12/18/18 revealed staff did not know what the plan said to do when client #6 spits, but that for spitting they send him to his room.<br><br>Interview with management on 12/18/18 confirmed the BSP did not include the technique of sending him to his room when he spits. | W 288 | Client #6 BSP and IPP will be reviewed and revised as needed to manage inappropriate behavior with appropriate techniques as specified in plan. All Staff will be inserviced on any changes and will be monitored and observed for appropriate implementation by Home Manager, Hab Specialist and documented weekly. | 1/18/19 |
| W 369 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(2)<br><br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and record reviews the 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:<br><br>1. Client #1 and client #6 refused to take their medications during the morning medication administration. | W 369 | All staff will be inserviced by nurse on medication administration to include, though not limited to appropriate documentation and will be monitored and observed by Home Manager daily and documented weekly by Home Manager, Hab Spec bimonthly and monthly by nurse | 1/18/19 |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______<br>B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOORE COUNTY HOME FOR AUTISTIC ADULTS | 1112 DEVONSHIRE TRAIL<br>ABERDEEN, NC 28315 |

| (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 369 | Continued From page 15<br><br>During observations on 12/18/18 of the morning medication pass, client #1 and #6 refused to take their morning medications.<br><br>A. Review on 12-18-18 of client #1's physician's orders dated 12/1/18 revealed the following morning medications:<br><br>Inositol 500mg Tab Take two tablets by mouth daily<br><br>Aripiprazole (B-Abilify) Take One tablet by mouth daily<br><br>Naltrexone HCL 50mg<br><br>Take one tablet by mouth in the morning (B-Revia)<br><br>Propranolol HCL ER 80mg Take one capsule by mouth in the morning<br>(B- Inderal LA)<br><br>Calcium 500 Mg with Vitamin D 200I<br>Take One tablet by mouth twice daily<br><br>Triamcinolone Aceton 0.025 % Apply on skin 3 times a day (B-Aristocort)<br><br>Magnesium Oxide 400 mg Tab.<br>Take 1/2 tablet by mouth 2 times a day<br><br>Folic Acid 1mg tab<br>Take two tablets by mouth once daily (B--Folvite)<br><br>Cetirizine HCL 10 mg<br>Take one tablet by mouth in the morning<br>(B-Zyrtec) | W 369 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G288 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 369 | Continued From page 16<br><br>Prenatal Tab<br>Take one Tablet by mouth in the morning<br><br>B. Review on 12-18-18 of client #6's physician order's revealed the following morning medications:<br><br>Sertraline HCL 100 mg. tab<br>Take one tablet by mouth every day<br>(B-Zoloft)<br><br>Clonidine HCL .1mg tab<br>Take one-half tablet by mouth in the morning<br><br>Risperidone 3 mg Take one tablet by mouth twice daily<br>(B-Risperdal)<br><br>Divalproex Sodium ER 500 mg<br>Take one tablet by mouth twice daily.<br>(B-Depakote ER)<br><br>Amoxicillin/Clavulan 875-125mg Tab<br>Take one tablet by mouth twice daily<br>(B-Augmentin)<br><br>Antacid tablet 500mg<br>Take one tablet by mouth twice daily<br><br>Orazepam .5mg tab<br>Take one tablet by mouth twice daily<br>(B-Ativan)<br><br>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. | W 369 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 369 | Continued From page 17<br>2. Staff did not assure client #3 swallowed all of her medications and that she received the ordered topical medication.<br><br>During a morning medication pass on 12/18/18, client #3 did not swallow all of her crushed medications. She was handed all medications and assisted in trying to swallow dry crushed powder for all oral medications ordered. As she was assisted she spit much of it into a papertowel as staff assisted her in wiping her mouth as it came back up. Some of that spit up remains was put in water and re-administered. Other amounts was thrown away. 3 large chunks (appearing to 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 all" at the end of the pass.<br><br>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."<br><br>Review of the physician's orders for 12/1/18-12/31/18 confirmed the following oral medications:<br><br>Amitriptyline HCL 50 mg Tab.<br>Take 1 tablet by mouth prior to procedure.<br>(B-Elavil)<br><br>Magnesium Oxide 400 mg tab.<br>Take 1/2 tablet by mouth 2 times a day<br><br>Vitamin D 5000 IU Cap<br>Take one Capsule by mouth once a week<br>(B-Drisdol) | W 369 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOORE COUNTY HOME FOR AUTISTIC ADULTS | 1112 DEVONSHIRE TRAIL<br>ABERDEEN, NC 28315 |

| (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 369 | Continued From page 18<br>Folic Acid 1mg Tab<br>Take two tablet by mouth once daily<br>(B-Folvite)<br><br>Cetirizine HCL 10mg<br>Take one tablet by mouth in the morning<br>(B-Zyrtec)<br><br>Prenatal Tab<br>Take one tablet by mouth in the morning.<br><br>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.<br><br>Further review revealed an order for triamcinolone Acaton .025% topical apply on skin 3 times a day (B-Aristocort).<br><br>During an interview on 12/18/18, management was asked about the topical and confirmed she is positive client #3 did 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. | W 369 | | |
| W 382 | DRUG STORAGE AND RECORDKEEPING<br>CFR(s): 483.460(l)(2)<br><br>The facility must keep all drugs and biologicals locked except when being prepared for administration.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and interviews, the facility failed to assure all medications were locked up | W 382 | By 1/18/19 all staff will be inserviced on requirement to keep all drugs and biologicals locked. (Please refer to tag 189) | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G288 | A. BUILDING ______ B. WING ______ | 12/18/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOORE COUNTY HOME FOR AUTISTIC ADULTS | 1112 DEVONSHIRE TRAIL<br>ABERDEEN, NC 28315 |

| (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 382 | Continued From page 19<br>until the point of administration. This potential affects all clients residing in the facility. The finding is:<br><br>The medication room was left unlocked between clients during the medication pass.<br><br>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.<br><br>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.<br><br>Interview on 12/18/18 with management confirmed that the door should be locked when nobody is in there administering medications. She also indicated staff had in fact been trained on this. | W 382 | | |