STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G132	A. BUILDING ______ B. WING ______	C 03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTY WOODS GROUP HOME	10100 MT. OLIVE ROAD MOUNT PLEASANT, NC 28124

(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 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on review of records and interviews, the facility failed to assure all allegations of neglect were reported immediately to the administrator and to other officials in accordance with State law for 1 of 5 clients residing in the group home (#3). The finding is: Review of internal facility documents on 3/7/19 revealed a facility investigative report started on 7/26/18. Review of the 7/26/18 investigation revealed at 8:03 AM on 7/26/18 the qualified intellectual disabilities professional (QIDP) received a phone call from the Director of Nursing (DON). Further review revealed the DON informed the QIDP client #3 had fallen out of the Hoyer lift after her bath at 6:30 AM. Subsequent review revealed neither the QIDP nor the DON had been notified of client #3's fall by the nurse on call (NOC). Continued review revealed on the morning of 7/26/18 it was the reporting actions of a staff transporter who alerted the group home (GH) Director about client #3's fall. The transporter had found an incident report on the morning of 7/26/18 left on a office desk about client #3's fall. Subsequent review also revealed it was the transporter who informed supervisory staff client #3 had a posterior red mark at the top of her back in the area of her rod placement.	W 153		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 153	Continued From page 1 Client #3 was transported to the local emergency department (ED) by the transporter. Additional review revealed a total of 2 hours had elapsed before supervisory staff were aware of client #3's fall. Client #3 had no injuries from the 7/26/18 fall as documented in the facility investigation. Continued review on 3/7/19 of the facility's investigative report of staff accounts pertaining to client #3's fall revealed she did not physically fall onto the floor because staff were able to slide the client onto the floor. Further review revealed while client #3 remained on the floor, staff called the NOC to report client #3's fall. Subsequent review revealed the NOC told staff to pick client #3 up off the floor (staff complied) and the NOC informed staff someone would be at the house to assess client #3. After the phone call with the NOC, staff performed a body check and noticed a red mark on client #3's back; however, staff failed to call nursing back to alert them about this finding. Ongoing review on 3/7/19 of the facility's investigative report revealed all involved employees have received disciplinary actions. Further review revealed the NOC should have immediately assessed client #3 upon receiving information from staff about client #3's fall on the morning of 7/26/18. Subsequent review revealed facility supervisory staff should have been immediately notified of client #3's fall by the NOC because the Hoyer lift could have been immediately removed from service to ensure no other clients sustained injures or falls. In addition, the facility's investigation noted had the NOC immediately notified supervisory staff about client #3's fall, the facility's investigation could have began sooner.	W 153		

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W 153	Continued From page 2 Continued review of the facility's investigative report revealed the following corrective staff training actions to ensure client safety: proper Hoyer lift usage, asking for assistance if needed when transferring clients, prompt reporting of all (initial and later) client incident findings to the NOC. Further review revealed 2 staff, the attending NOC and a direct care staff (DCS) member, involved in client #3's fall on 7/26/18 were terminated on 7/27/18. Review on 3/7/19 of the involved DCS's disciplinary action noted personnel policy "145 #28" which pertains to "Mistreatment, failure to report, neglect and abuse of clients will result in immediate termination" and "Termination" identified. In addition, review of the involved NOC's disciplinary action revealed "Suspension until investigation complete" and "Termination" identified with "personnel policy# Nurse Training" cited. Review of the facility's investigative report revealed the facility did immediately act to provide client #3 with emergency medical attention once they were aware of the fall. Further review revealed no North Carolina Incident Response Improvement System (IRIS) documentation pertaining to client #3's fall on 7/26/18. Phone interview on 3/7/19 with the QIDP along with an in-person interview with the GH Director revealed they did not think an IRIS report needed to be completed because client #3 did not have any injuries or areas of broken skin.	W 153		