STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G140	A. BUILDING ______ B. WING ______	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEM ROAD HOME	702 STEM ROAD CREEDMOOR, NC 27522

(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
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.	E 039	E 039: QP will train all staff on the Facility Emergency Preparedness plan.Training will be monitoring by the Administator and Safety Chairperson to ensure staff are trained to conduct a full-scale community base or individual facility-based exercise or a tabletop emergency plan. In the future the Administrator wil ensure the requirement for home and client specfic training for emergency plan is met. SCANNED MAR 18 2019 MHL & C Section	03/31/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 2/10/19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G140	A. BUILDING ______ B. WING ______	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEM ROAD HOME	702 STEM ROAD CREEDMOOR, NC 27522

(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
E 039	Continued From page 1 *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is: The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise. Review on 1/28/19 of the facility's EP plan (dated 2018 Edition) did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 1/28/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility has not conducted a full-scale facility/community-based exercise or a tabletop	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G140	A. BUILDING ______ B. WING ______	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEM ROAD HOME	702 STEM ROAD CREEDMOOR, NC 27522

(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
E 039	Continued From page 2 exercise to test the effectiveness of their current emergency plan.	E 039		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure all staff were sufficiently trained to recording fluid intake and administer drugs to ensure clients receive necessary continuous medical treatment. This affected 2 of 4 audit clients (#1, #5). The findings are: 1. Staff were not adequately trained to ensure the proper use of non-skid mat during meals During observations in the home on 1/28-29/19, client #4 and #5 consumed their meals with a non-skid mat placed on a regular decorative mat. Both client plates were not stable during the meals Review of client #4's Individual program plans (IPPs) dated 9/18 revealed,"Use non-skid mat during meals. Review of client #5's IPP dated 1/19/18 revealed, "Use non-skid mat during meals." Staff interview on 1/29/19 revealed client #4 and #5 Non Skid mats should be placed directly on	W 192	W 192 The QP will inservice staff on the adaptive equipment for all person supported in the home. Monitoring meal-time will take place through Mealtime Assessments completed at least 2 times per week for the next 30 days by the clinical Team. In the future the team will ensure staff are properly trained on active treatment and implementing the PCP as written.	3/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G140	A. BUILDING ______ B. WING ______	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEM ROAD HOME	702 STEM ROAD CREEDMOOR, NC 27522

(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 192	Continued From page 3 the table. Interview on 1/29/19 with the qualified intellectual disabilities professional (QIDP) confirmed client #4's and #5's mat are supposed to be placed on the table. 2. Staff were not adequately trained on reporting blood pressure parameters During medication administration observations on 1/29/19 at the home, Staff was administering medication to client #2. Staff took the blood pressure and a reading of 142/90, a second reading was 132/89. However, the client was not still during those 2 assessment. Further observations revealed the staff called the nurse on call and reported that he was unable to get an accurate reading on client #2 since he was not still. Per the staff, the nurse instructed the staff to hold the medication until client is still. During observations at 8:25am, the staff administered the pill after the client was still and blood pressure was taken. Review on 1/29/19 of client #2's physician order revealed, "Inderal 20 mg tablet: Take 1 tablet by mouth every morning for tachycardia at 7:00am. Hold for blood pressure less than 90/60 or heart rate less than 60." Interview on 1/29/19 with the QIDP confirmed client#2's medication should not have been held. Interview on 1/23/19 with the facility nurse confirmed the physician's order were current and	W 192	The LPN will inservice staff on proper medication administration protocols to ensure all medications and blood pressure are proper read and administered in the time given. Medication monitoring will take place through Medication Observation completed at least 2 times per week for the next 30 days and then on aroutine basis. In the future th RN will ensure staff are properly trained to administer medication as prescribed.	3/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G140	A. BUILDING ______ B. WING ______	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEM ROAD HOME	702 STEM ROAD CREEDMOOR, NC 27522

(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 192	Continued From page 4 client #2's medication should have been administered after the first reading	W 192		
W 248	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on reviews and interviews the facility failed to assure outside services meet the needs of each client. This affected 2 of 3 audit clients (#2 and #4). The findings are: Clients #1 and #4 did not have current Individual program plans (IPP) available to at the home. During review on 1/28/19 of client #2's record at home revealed an individual program plan (IPP) dated 10/11/17. This was the most current IPP on file at the home. Review on 1/28/19 of client #4's record at home revealed an IPP dated 9/27/17. This was the most current BIP on file at the day program. During an interview on 1/28/19, with the Qualified Intellectual Disabilities Professional (QIDP) and home management confirmed client #2 and #4 did not current IPP since the charts are kept in the office.	W 248	W 248 The QP will ensure the current IPP for Client #2 and #4 and all other individuals are prvided for all settings. Chart monitoring will take place through Interaction Assessments completed by the Clinical Team at least 2 times per week for the next 30 days and then on a routine basis. In the future the QP will ensure all IPP are updated and available to staff in all settings.	3/31/19
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	W 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G140	A. BUILDING ______ B. WING ______	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEM ROAD HOME	702 STEM ROAD CREEDMOOR, NC 27522

(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 5 CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a technique to manage client #8's sleep behavior was included in a formal active treatment plan. This affected 1 of 3 audit clients. The finding is: The use of Trazodone was not included in an active treatment plan. Review on 1/28/19 of client #1's physician's orders signed 10/30/18 revealed the client ingests Trazadone 25mg once daily at bedtime for sleep. Additional review of the client's record did not include a formal treatment plan which incorporated the use of Trazadone. Interview on 1/29/19, with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 has sleep issues and ingests the Trazadone to address these issues. The QIDP acknowledged the medication should be included in a formal active treatment plan.	W 288	W 288 The Psychologist will ensure all restrictive drugs are incorporated into all individual's behavior support plans, including client #1. The Interdisciplinary team will monitor behavior support plans through regular chart reviews and annual PCP meetings to ensure we are in compliance. The QP will ensure in the future all behavioral interventions are reflected in a BSP, include current restrictive interventions.	3/31/19