STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G149	A. BUILDING _____ B. WING _____	04/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON ROAD GROUP HOME	**800 WILMINGTON ROAD FAYETTEVILLE, NC 28304**

(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	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 3 of 4 audit clients (#4, #5, #6) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of meal preparation, and dining skills. The findings are: 1. Client #5 was not encouraged or assisted to participate with preparing food items for meals. Upon arrival to the home on 4/1/19 at 3:30pm, dinner meal items were prepared and in the refrigerator. These items included chicken pot pie with peas and carrots, potato salad and applesauce. A package of rolls was located on the kitchen counter. Staff C later placed the rolls in a bowl and prepared a beverage in a pitcher. During this time, clients were in other areas of the home. No clients were observed to be prompted, assisted or encouraged to participate with preparing any dinner food or beverage items. Interview on 4/1/19 with Staff C revealed third shift staff had prepared the pot pie and potato	W 249		

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

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W 249	Continued From page 1 salad on their shift. Upon arrival to the home on 4/2/19 at 6:30am, breakfast items were noted in bowls on the counter and in the refrigerator. These items included two cereal choices and yogurt. Just before breakfast at 7:00am, Staff F prompted client #5 into the kitchen to assist them. Once in the kitchen, the staff used the toaster to prepare toast while client #5 stood several feet away unengaged. The client was only prompted to place pitchers and serving dishes on the table. During later observations at 7:38am, Staff F prepared oatmeal on the stove without any participation from clients. No clients were observed to be prompted, assisted or encouraged to participate with preparing any breakfast food items. Interview on 4/2/19 with Staff F revealed she had placed breakfast items into bowls. When asked how clients assist with meal preparation tasks by placing drinks and food on the table and loading the dishwasher. When asked if the clients assist with preparing food on the stove, the staff stated, "I don't let them do stuff that is hot..." The staff added one client in the home likes to bake on the weekend. Review on 4/2/19 of client #5's IPP dated 1/15/19 revealed, "Being able to participate in meal preparation and household chores are important to [Client #5]." Additional review of the client's Adaptive Behavior Inventory (ABI) dated 1/19 indicated client #5 can prepare beverages requiring mixing and sandwiches with partial independence. The ABI also identified needs in the areas of preparing breakfast, lunch and dinner, preparing vegetables, meat dishes,	W 249		

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W 249	Continued From page 2 canned and frozen foods in the oven or microwave and preparing combination dishes. Interview on 4/2/19 with the Qualified Intellectual Disabilities Professional (QIDP) revealed clients in the home can assist with meal preparation by putting food into pots, opening cans or bottles, stirring or placing food in dishes. Additional interview indicated third shift staff will sometimes prepare dishes which take longer to cook like a pot roast; however, there remaining menu items should be left for preparation at dinner time with client participation. 2. Client #6's meal guidelines were not followed as indicated. During observations at the day program on 4/1/19 at 12:05 pm, client #6 was in the dining room and had already been served a plate of meatloaf, mashed potatoes with macaroni and cheese. The meatloaf was already cut into small bite sized pieces. Client #6 held a regular spoon in left hand and was unsuccessful with loading spoon to feed herself, causing spillage. No conversation or hand over hand assistance were observed between client #6 and Staff G. Staff G used the spoon to break up the food remaining on client #'s plate and started to feed client #6. Client #6 did not receive any prompts to feed herself. Interview on 4/1/19 with Staff G revealed that client #6 was not offered a maroon spoon to self feed and that client #6 normally did not have food spillage when feeding self. Review on 4/1/19 of client #6's IPP dated 11/27/18 revealed that adaptive equipment used during meals included maroon spoon, fork,	W 249		

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W 249	Continued From page 3 spoon, inner lip plate and mug with handle and straw. In addition, the IPP revealed that client #6 was "Capable of holding food and putting it in her mouth but requires assistance. Also holds cup with a straw. At times, will eat with her hands. Staff should encourage utensils." Interview on 4/2/19 with QIDP revealed that client #6 was capable of feeding self with left hand. 3. Client #4 was not encouraged or assisted to use knife to cup up meal. During observations at the home on 4/1/19 at 5:45 pm, client #4 sat at dining room table and had received a dinner plate of chicken pot pie, potato salad and applesauce. Client #4 was independent with feeding and did not display any problems with chewing his food. Client #4 was asked if he wanted second helpings and he responded yes. Staff D approached client #4 and asked if he needed assistance and he stated yes. Staff D took client #4's plate to the kitchen and cut up the food, then returned the plate to client #4. The client was not afforded the opportunity to cut up his food. Review on 4/2/19 of client #4's ABI dated 11/14/18 which evaluated eating skills, revealed that client #4 was partially independent with using knife for cutting. Interview on 4/2/19 with QIDP confirmed client #4 was capable of using a knife or fork, to cut up his food.	W 249		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2)	W 369		

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W 369	Continued From page 4 The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure all medications were administered without error. This affected 1 of 5 clients (#2) observed receiving medications. The finding is: 1. Client #2 was not given a full dose of Lactulose. During observation of medication administration in the home on 4/1/19 at 4:07, Staff D took four plastic 30 cc measuring cups and placed on counter. Staff D took a bottle of Lactulose medication and poured 30 cc into each of the measuring cups. Staff D took a large cup from the table and emptied each 30 cc measuring cup into the glass, then opened a 8 oz can of cola and poured it over the medication in the cup and stirred contents. After Staff D emptied each measuring cup, there was an undetermined amount of Lactulose remaining in at least three of the stacked cups. Interview with Staff D on 4/1/19 about the leftover Lactulose in the measuring cups, revealed that it normally happened. Review on 4/2/19 of client #2's physician's orders dated 2/4/19 revealed an order for Lactulose Sol 10 gm/15 give 120 ml by mouth three times a day, add to regular soda. Interview on 4/2/19 with the nurse revealed that	W 369		

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W 369	Continued From page 5 the Lactulose was not considered a full dose unless the measuring cup was free of all remaining medicine. The nurse indicated that staff had the option of pouring the mixing liquid into the cups to loosen the contents or turning the cup upside down, to produce a slow drip. 2. Client #2 was not observed to receive Synthroid as indicated. During observations of medication administration in the home on 4/1/19 at 4:07 pm, Staff D retrieved client #2's medication basket with pre pulled blister packs from the locked medication cabinet . Staff D was observed punching out blister packs of medications and placing the following pills in a small paper pill cup: Neurontin, Glycopyrrol, Hydrocort, Xifacan and Metaclopram. The medications were then transferred into a bowl of chocolate pudding. Client #2 refused several times to take his medications. Staff D sought assistance from Staff B, who successfully administered the meds to client #2. Client #2 was not observed to ingest any other medications at this time. Review on 4/2/19 of client #2's physician's orders dated 2/4/19 revealed an order for Synthroid 175 mcg, take 1 tablet by mouth daily at 4 pm. Interview with nurse on 4/2/19 revealed that when she reviewed the April 2019 Medication Administration Record (MAR), Staff D had initialed on 4/2/19 at 4 pm that Synthroid had been administered.	W 369		