STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G260	A. BUILDING _____ B. WING _____	04/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCKEEL LOOP ROAD HOME	5910 FARMWOOD LOOP ROAD WILSON, NC 27893

(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 CFR(s): 483.430(e)(1) 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. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure staff were sufficiently trained regarding the use of client #4's gait belt. This affected 1 of 5 audit clients. The finding is: Staff were not sufficiently trained regarding the use of client #4's gait belt. During afternoon observations in the home on 4/1/19 at 4:30pm, Staff B was holding onto client #4's gait belt while she was walking down the hallway of the home. During observations after dinner in the home on 4/1/19, Staff A was holding onto client #4's gait belt while she was walking into the kitchen to put her dirty dishes into the dishwasher. Further observations revealed client #4 pulling away from Staff A, while Staff A pulled client #4 back towards her. During an immediate interview, Staff A revealed she was holding onto client #4's gait belt because she will steal food. Staff A stated holding onto client #4's gait belt to prevent her from stealing food is part of her "plan." During observations in the home on 4/2/19, Staff D was holding onto client #4's gait belt as she	W 189		

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

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W 189	Continued From page 1 was walking from out of her room, down the hallway into the living room. During an interview on 4/2/19, Staff D stated, "It's a habit of mine" to hold onto client #4's gait belt so she does not fall. Review on 4/2/19 of client #4's IPP stated, "What I Can Do Well: Ambulatory." Further review revealed, "Mobility/Gross Motor: I ambulate independently...." Review on 4/2/19 of client #4's nursing evaluation dated 6/5/18 revealed, "Ambulatory Skills: [Client #4] ambulates independently." During an interview on 4/2/19, the qualified intellectual disabilities professional (QIDP) confirmed no inservice or training occurred with staff regarding training on how to use client #4's gait belt.	W 189		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 5 audit clients (#4) individual program plan (IPP) included specific information to address the usage of a gait belt. The finding is: Client #4's IPP did not include guidelines to address the usage of a gait belt.	W 240		

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W 240	Continued From page 2 During afternoon observations in the home on 4/1/19 at 4:30pm, Staff B was holding onto client #4's gait belt while she was walking down the hallway of the home. During observations after dinner in the home on 4/1/19, Staff A was holding onto client #4's gait belt while she was walking into the kitchen to put her dirty dishes into the dishwasher. Further observations revealed client #4 pulling away from Staff A, while Staff A pulled client #4 back towards her. During an immediate interview, Staff A revealed she was holding onto client #4's gait belt because she will steal food. Staff A stated holding onto client #4's gait belt to prevent her from stealing food is part of her "plan." During observations in the home on 4/2/19, Staff D was holding onto client #4's gait belt as she was walking from out of her room, down the hallway into the living room. During an interview on 4/2/19, Staff D stated, "It's a habit of mine" to hold onto client #4's gait belt so she does not fall. Review on 4/2/19 of client #4's IPP stated, "What I Can Do Well: Ambulatory." Further review revealed, "Mobility/Gross Motor: I ambulate independently...." Review on 4/2/19 of client #4's nursing evaluation dated 6/5/18 revealed, "Ambulatory Skills: [Client #4] ambulates independently." During an interview on 4/2/19, the qualified	W 240		

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W 240	Continued From page 3 intellectual disabilities professional (QIDP) confirmed there was no specific information in client #4's IPP to address the usage of a gait belt. Further interview with the QIDP revealed client #4 did not have any falls in the home while ambulating.	W 240		
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 observation, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of self help skills and medication administration. This affected 1 of 5 audit clients (#4). The finding is: Client #4 did not use her adaptive spoon during medication administration. During the medication administration observations throughout the survey on 4/1 - 2/19, client #4 was observed consuming her pills with a plastic spoon. During meal time observations throughout the survey on 4/1/ - 2/19, client #4	W 249		

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W 249	Continued From page 4 was observed consuming her meals with an curved adaptive spoon. During an interview on 4/2/19, Staff E stated client #4 does not use her adaptive spoon during medication administration. Review on 4/1/19 of client #4's IPP dated 6/4/18 stated, "I was seen by OT on 3/3/18. I continue to need the "Good Grips" style built up spoon...for my right hand, curved 30 - 35 degrees...." Review on 4/2/19 of client #4's habilitation evaluation dated 6/5/18 revealed, "...an adaptive...spoon...were implemented to ensure [Client #4] was getting the food on the utensils properly." During an interview on 4/2/19, the facility's nurse confirmed client #4 should be using her curved adaptive spoon during medication administration.	W 249		
W 356	COMPREHENSIVE DENTAL TREATMENT CFR(s): 483.460(g)(2) The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on record/document review and interview, the facility failed to ensure client #5 received dental treatment in a timely manner for relief of pain and infections. This affected 1 out 3 audited client. The finding is:	W 356		

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W 356	Continued From page 5 Client #5 did not receive dental treatment in a timely manner. Review on 4/2/19 of the client's record noted a dentist assessment form dated 4/10/18 with a comment "Extract tooth #6, tooth unrestorable "Further review, revealed a dental assessment form dated 10/18/18 with a comment "Extract tooth #6, tooth unrestorable," Addition review revealed the tooth had not been extracted as of 4/2/19 Interview on 4/2/19 with the facility's nurse via phone revealed client #5 tooth was not extracted on timely manner as recommended by the dentist. Interview on 4/2/19 with the qualified intellectual disabilities professional (QIDP) revealed the facility did not follow the dentist recommendation regarding client #5's tooth.	W 356		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the system of administrating medications as ordered was implemented. This affected 1 of 5 audit clients (#4) The finding is: Client #4 did not receive her Omeprazole as	W 368		

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W 368	Continued From page 6 ordered. During medication administration observation in the home on 4/2/19 at 7:03am, Staff E administered client #4's Omeprazole 20mg along with four other pills. Further observations revealed client #4 had consumed her breakfast at 6:18am. Review on 4/2/19 of client #4's physician orders signed 2/1/19 stated, "Omeprazole 20mg Take One Capsule by mouth...take on empty stomach 6am." During an interview on 4/2/19, the facility's nurse confirmed client #4 should have taken her Omeprazole 30 minutes before she ate her breakfast.	W 368		
W 374	DRUG ADMINISTRATION CFR(s): 483.460(k)(7) The system for drug administration must assure that drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all drugs were packaged and labeled with the name of the person prescribed the medication, with instructions on how to administer the medication and instructions as to how often to administer the medication for 1 of 5 audit clients (#3). The finding is: Client #3's Iron pill bottle was not labeled.	W 374		

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W 374	Continued From page 7 During afternoon observations in the home on 4/1/19 at 4:52pm, Staff B administered client #3 her Iron pill along with 3 other pills. During an interview on 4/1/19, Staff B revealed client #3's Iron pill bottle should have a label on it. During an interview on 4/1/19, the qualified intellectual disabilities professional (QIDP) revealed client #3's Iron pill bottle did not have a label on it. During an interview on 4/1/19, the facility's nurse confirmed client #3's Iron pill bottle should have a label on it.	W 374		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure only authorized persons have access to keys to the drug storage area. The finding is: A key to the facility's drug storage area were accessible to anyone in the home. During medications observations in the home on 4/1/19 at 5:04pm, Staff A stated the spare medication room key was hanging on the wall, but it is now kept in a black magnetic box. Further observations revealed the magnetic box was unlocked and kept on the side of a metal file cabinet in the hallway where the medication room	W 383		

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W 383	Continued From page 8 is located. During an immediate interview, Staff A confirmed the spare medication room key is kept in the magnetic box. During an interview on 4/1/19, the qualified intellectual disabilities professional (QIDP) revealed the spare medication room key is kept in the unlocked black magnetic box, attached to the file cabinet and it is accessible to anyone in the home.	W 383		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that the infections control prevention procedures were carried out. This potentially affected all clients residing in the home The findings are: Precautions were not taken to promote client health and prevent possible cross-contamination. 1. Client #5 was not prompted to use clean silverware. During evening observations in the home on 4/1/19, client #5 was propelling her wheelchair to the table while taking her dishes and silverware to the table for dinner. While propelling her wheelchair her silverware dropped to the floor;	W 455		

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W 455	Continued From page 9 another client picked them up and handed it back to her. Additional observations revealed client #5 using the silverware to consume her dinner. At no time was client #5 prompted to get clean silverware. During an interview on 4/1/19, Staff B revealed client #5 should have been prompted to get clean silverware. During an interview on 4/1/19, the qualified intellectual disabilities professional (QIDP) stated client #5 should have been prompted to get clean silverware. 2. Client #4 was not prompted to sanitize her hands. During dinner observation in the home on 4/1/19, client #4 had fingers of both her hands in the mouth prior to serving herself her dinner. Additional observations revealed the fingers of client #4's hands had drool on them. Further observations revealed client #4 handling the spoon to serve herself the squash and then other clients and staff handing the same serving spoon for the squash. At no time was client #4 prompted to sanitize her hands. During an interview on 4/1/19, Staff B stated client #4 should have been prompted to sanitize her hands prior to her serving herself during dinner. During an interview on 4/2/19, the QIDP confirmed client #4's hand should have been sanitized prior to her serving herself.	W 455		

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W 455	Continued From page 10 2. During observations in the home on 4/2/19 at approximately 7:52am, client #3 was not wearing gloves when she obtained the trash from the bathrooms and areas throughout the home. Client #3 took trash from each room and poured into a large trash bag and handed over to client #1 . Client #1 took the big trash bag to the kitchen and staff #2 helped her with hand sanitizer. The bathroom trash cans contained items such as dirty disposable gloves, used tissues and etc. Client #3 was noted to handle the door knob to bathroom door and the cereal box from the table to the kitchen. At no time was client #3 encouraged to wear gloves or wash her hands. During an interview on 4/2/19, the qualified intellectual disabilities professional (QIDP) revealed client #3 should have washed her hand after emptying the trash cans.	W 455		