

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

PRINTED: 04/18/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/18/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>MY PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1050 HOGAN STREET</b> <b>FAYETTEVILLE, NC 28301</b>	
(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 000	INITIAL COMMENTS	W 000		
{W 249}	<p>A revisit was conducted on 4/18/19 for all previous deficiencies cited on 2/26/19. Some deficiencies have been corrected, and one standard level tag was recited.</p> <p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 4 audit clients (#2, #4) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of family style dining and implementation of formal objectives in the home living area. The findings are:</p> <p>1. Staff did not implement client #2's objective to strip her bedding as the IPP described.</p> <p>During morning observations in the facility on 4/18/19 at 7:18am staff #A stripped client #2's bed of the sheets that were wet and took them to the laundry room. Staff #A then sprayed the mattress with disinfectant and wiped down the mattress. During this time, client #2 was in the</p>	{W 249}		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/18/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>MY PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1050 HOGAN STREET</b> <b>FAYETTEVILLE, NC 28301</b>		
(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}	<p>Continued From page 1 bathroom with the door closed.</p> <p>Immediate interview with staff #A on 4/18/19 confirmed client #2 was in the bathroom dressing. Additional interview confirmed client #2 has an objective to strip the sheets from her bed and take the sheets to the laundry room. Staff #A stated she was going to help client #2 with her bed since she was in the bathroom dressing.</p> <p>Review on 4/18/19 of client #2's IPP dated 11/14/18 revealed a formal objective to strip her bed of sheets and blankets which was implemented on 3/28/19. This objective has 6 steps. The program stated data was to be taken on Thursdays.</p> <p>Interview on 4/18/19 with client #2 confirmed she was working on an objective to strip her bed and that data was to be taken on Thursdays. She told the surveyor this was the day of the week she works on that objective.</p> <p>Interview on 4/18/19 with the Administrator confirmed that client #2 has a new formal objective to strip her bed sheets and blankets. The administrator also confirmed this program is trained on Thursday mornings.</p> <p>2. Staff did not verbally cue client #4 to use his utensils at mealtime.</p> <p>During observations of the mealtime on 4/18/19 at 7:44am client #4 finished eating his cereal and took his bowl, fork and knife to the kitchen counter. Staff #A and the Residential Manager (RM) were at the dining room table. Client #4 came back to the dining room table, sat down and ate a whole piece of bacon with his fingers.</p>	{W 249}			

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

PRINTED: 04/18/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>04/18/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>MY PLACE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1050 HOGAN STREET</b> <b>FAYETTEVILLE, NC 28301</b>		
(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 2 Neither staff #A or the Residential Manager prompted client #4 to get utensils, cut up the bacon and consume it with a fork.  Review on 4/18/19 of client #4's adaptive behavior inventory (ABI) dated 4/1/19 revealed he needs verbal cues to use utensils other than a spoon. The ABI indicated client #4 will feed himself consistently using a spoon.  Interview on 4/18/19 with the Administrator revealed client #4 needs verbal cues to remind him to cut up his bacon and to use a fork.	{W 249}		