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

PRINTED: 05/01/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G243	B. WING			04/	30/2019
NAME OF PROVIDER OR SUPPLIER WESTSIDE RESIDENTIAL				467	REET ADDRESS, CITY, STATE, ZIP CODE CREEK ROAD RUM, NC 28369	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 000	INITIAL COMMEN	TS	w c	000			
W 249	complaint survey of #NC00150594. PROGRAM IMPLE CFR(s): 483.440(d) As soon as the interferent action of the complaint of the c		W 2	249			
	Based on observareviews, the facility received a continuous consisting of needed identified in the indithe area of adaptivo of 5 audit clients (#Client #3 was not puring morning medione on 4/30/19 a #3 his medication of Additional observarian adaptive spoon	is not met as evidenced by: Ition, interviews and record If failed to ensure each client ous active treatment plan ed interventions and services Ividual program plan (IPP) in re equipment. This affected 1 f3). The finding is: Provided the use of his adaptive cation administration. Redication administration in the at 8:35am, staff spoon fed client using a plastic spoon. Itions revealed client #3 using Itions with Staff D providing hand Itinated the staff of the staff					
		v on 4/30/19, Staff D stated					
I ABORATOR'	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		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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		34G243	B. WING			04/3	30/2019
NAME OF PROVIDER OR SUPPLIER WESTSIDE RESIDENTIAL				46	REET ADDRESS, CITY, STATE, ZIP CODE 7 CREEK ROAD RRUM, NC 28369		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	during his medication. Review on 4/30/19 therapy (OT) evaluate "[Client #3] continue feeding self while use During an interview intellectual disabilitic confirmed client #3 spoon during medic DRUG ADMINISTR CFR(s): 483.460(k). The system for drug that all drugs are active physician's order that physician's order that physician's order than the physician's did not spray. During medication at the home on 4/30/1 administered client observations reveal any other medication. Review on 4/30/19	used his adaptive spoon on administration. of client #3's occupational ation dated 2/27/19 stated, es to need assistance with sing adaptive utensils." on 4/30/19, the qualified es professional (QIDP) is suppose to use his adaptive eation administration. (ATION (1) g administration must assure diministered in compliance with ers. s not met as evidenced by: ion, record review and y failed to ensure the system edications as ordered was affected 2 of 5 audit clients gs are: receive his cream and nasal administration observation in 9 at 8:35am, Staff D #3 nine pills. Further led client #3 did not receive ons, sprays or ointments. of client #3's physicians	W 2				
		/19 revealed the following:					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G243	B. WING		04	/30/2019
NAME OF PROVIDER OR SUPPLIER WESTSIDE RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 467 CREEK ROAD ORRUM, NC 28369		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH CORRECTIVE ACTION OF THE APPORT OF TH	OULD BE	(X5) COMPLETION DATE
W 368	area8am and Aze spray in each nostrice program interview confirmed client #3 Ketocanzole cream ordered. 2. Client #6 did not During medication a 4/30/19 at 7:31am, pills with water. Furthere was nothing a Review on 4/30/19 order's signed 2/15. "GNP Fiber Powder water daily 8am." During an interview confirmed client #6 powder mixed with DRUG ADMINISTR CFR(s): 483.460(k) The system for drugthat drugs used by direct care of the falabeled in accordance.	ream apply to affected elastine 0.15% Nasal spray 1 il once as directed8am." on 4/30/19, the facility's nurse should have received the and Azelastine nasal spray as receive his fiber powder. administration on the home on client #6 consumed fifteen rther observations revealed added to the water. of client #6's physicians /19 revealed the following: r Mix 1 tablespoon in 6oz of r on 4/30/19, the facility's nurse should have received the fiber water as ordered. RATION (7) g administration must assure clients while not under the icility are packaged and	W 3			
	Based on observat failed to ensure all labeled with the nar	tions and interviews, the facility drugs were packaged and me of the person prescribed in instructions on how to				

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W 374	how often to admini audit clients (#6). To Client #6's Incruse alabeled. During morning me observations in the Staff D administere drops along with his Further observation and Adair inhalers with the During an interview client #6's Incruse alabeled with his name Staff D "thought" the were thrown away. During an interview confirmed client #6's should have been keep labeled and not through the	ication and instructions as to ister the medication for 1 of 5. The finding is: and Advair inhalers were not dication administration home on 4/30/19 at 7:31am, d client #6 fifteen pills and eye is Incruse and Advair inhalers. Its revealed client #6's Incruse were not labeled. on 4/30/19, Staff D revealed and Advair inhalers should be me. Further interview revealed the boxes for client #6's inhalers on 4/30/19, the facility's nurse is Incruse and Advair inhalers tept in their boxes, which are bown away. PMENT (2) mish, maintain in good repair, ouse and to make informed use of dentures, eyeglasses, communications aids, braces, dentified by the m as needed by the client.	W 33				
		s not met as evidenced by: ion, record review and staff					

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W 436	interview, the facility clients (#6) was promanage the cleaninis: Client #6 was not puring observations client #6's contained had visible signs of the client #6's contained had visible signs of the client #6 should have the container. Review on 4/30/19 3/20/18 revealed hereview of client #6's have any training in dentures. During an interview intellectual disabilitic confirmed client #6	y failed to ensure 1 of 5 audit ovided and taught how to ag of his dentures. The finding rovided or taught how to ag of his dentures. s in the home on 4/30/19, r where his dentures are kept	W 4	36		