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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G011	A. BUILDING _____ B. WING _____	01/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOST CHILDREN'S CENTER	5300 HIGHWAY 200 CONCORD, NC 28025

(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 implement interventions support communication objectives in the Individual Support Plan (ISP) for 2 sampled clients (#7 and #8). The findings are: A. The facility failed to implement interventions to support the communication goal for client #7. The finding is: Review of client #7's ISP dated 4/20/18 revealed a communication program goal stating "client #7 will go in to designated area when presented with pictures representing events in his daily routine and transitions." Further review of the record revealed communication with client #7 will be enhanced with the " use of TEACCH picture schedule for all transitions." Observations in the group home on at 5:15 PM 1/7/2019 revealed client #7 to transition to the group home from the school bus. On entering the group home client #7 began screaming, jumping around, and throwing items in the group home and was escorted to his rom by staff. Continued	W 249	Staff to be inserviced/trained on all residents communication procedures/programs to ensure they are properly being carried out as written. monitored: weekly by GHD monthly by QA quarterly by QIDP RECEIVED APR 15 2019 DHSR NH L & C Black Mountain / WRO	3/9/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Azzarello — TITLE: Executive Director — (X6) DATE: 4/12/19

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
	34G011	A. BUILDING _____ B. WING _____	01/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOST CHILDREN'S CENTER	5300 HIGHWAY 200 CONCORD, NC 28025

(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 1 observations at 5:35 PM revealed client #7 to go to the dinner table for his dinner meal. After his dinner meal client #7 was asked by staff to participate in an activity from the activity closet. Client #7 ventured elsewhere in the group home, however after much coaxing to the closet, client #7 began to slam the door of the activity closet shut screaming loudly at staff and peers, refusing any participation in activities. Subsequent observations at 7:30 AM on 1/8/19 revealed staff entering client #7's room and asking him to get up and come to the bathroom to get ready for school. Client #7 protested and began screaming and hitting the walls. At no time during these observations were picture symbols or a TEACCH schedule utilized with client #7 for transitions to one place to another, or to one activity to another. Interview with the Qualified Intellectual Disabilites Professional (QIDP) on 1/8/19 revealed staff should have utilized picture symbols and a TEACCH schedule at every opportunity to aid with communication and to offer transitional tools for client #7 to help him to accomplish his program goal. B. The facility failed to implement interventions to support the communication goal for client #8. The finding is: Review of client #8's current ISP (plan of Care) revealed a communication program goal stating "client #8 will move to designated area when presented with pictures representing events in his daily routine and transitions." Further review of the record revealed communication with client #8 will be enhanced with the "use of voice output devices for direct selection of desired activities for client #8 ".	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G011	A. BUILDING _____ B. WING _____	01/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOST CHILDREN'S CENTER	5300 HIGHWAY 200 CONCORD, NC 28025

(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 Observations in the group home on at 7:00AM on 1/8/18 revealed client #8 to be seated in his wheelchair in front of the TV in a great room screaming and crying. Continued observations at 7:08 AM revealed a staff to ask him what he wanted to do. Further observations revealed staff to take client #8 to a voice output device located on a piano and ask client #8 to push the device for a choice od activity. Continued observations revealed the voice output device was not working. Subsequent observations revealed staff to ask surveyor for suggestions to which this surveyor answered " what does he like to do?" Staff responded" listen to his music" which staff then proceeded to set up for client #8 in his room. At no time during these observations were picture symbols utilized with client #8 for transitions to one place to another, or to one activity to another, or a working voice output machine utilized with client #8 to allow him to select activities. Interview with the Qualified Intellectual Disabilites Professional (QIDP) on 1/8/19 revealed staff should have utilized picture symbols and a working voice output device at every opportunity, to aid with communication and to offer transitional tools for client #8 to increase his communication and to accomplish his program goal.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263	All guardians will be sent a formal consent form policy for security cameras to be signed for their approval and placed in all residents charts. monitoring: weekly by GHD monthly by QA quarterly by QIDP & Human Rights Committee	3/9/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G011	A. BUILDING _____ B. WING _____	01/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOST CHILDREN'S CENTER	5300 HIGHWAY 200 CONCORD, NC 28025

(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 263	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations, review of records and interviews, the specially constituted committee referred to as the human rights committee (HRC) failed to ensure informed written consent was obtained for the use of video cameras in the home. The finding is: Throughout observations in the group home during the 1/7/19 - 1/8/19 survey revealed the use of video cameras installed in the home's ceilings located in common areas such as hallways, sensory, dayroom, and dinning. Interview on 1/7/19 with the direct care staff (2), substantiated by interview with the home manager and the qualified intellectual disabilities professional (QIDP), revealed video cameras were new in the group home and were only recently installed in the home. Review on 1/8/19 of facility HRC minutes dated 10/18 revealed they approved use of the video cameras in the group home. In addition, review of client records revealed no informed written consent documentation from legal guardians pertaining to the use of video cameras in the group home. Interviews on 1/7/19 and 1/8/19 with the QIDP verified the HRC approved use of video cameras in the group home for the overall safety of the facility and the clients. The QIDP verified they did not obtain the initial informed written consent from client guardians and also confirmed the use of video cameras in the group home is not part of any residing client's behavior support plan.	W 263	Staff will be inserviced/trained on all resident's feeding guidelines to insure proper utensils are available to all residents at every meal. monitoring: weekly by GHD monthly by QA quarterly by QIDP	3/9/19
W 482	DINING AREAS AND SERVICE	W 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G011	A. BUILDING _____ B. WING _____	01/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOST CHILDREN'S CENTER	5300 HIGHWAY 200 CONCORD, NC 28025

(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 482	Continued From page 4 CFR(s): 483.480(d)(1) The facility must serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician. This STANDARD is not met as evidenced by: Based on observation and interview, staff failed to provided appropriate dining utensils to 2 of 3 of sampled clients (#9 and #7) and 1 non-sampled client (#3) to enable them to eat at their develpomemtal levels. The findings are: Observations in the home on 1/7/18 during the evening meal revealed staff to serve a menu of chicken nuggetts, french fries and salad to clients in the home. At approximately 5:35 PM client #7 was observed to sit at the dining room table and eat all above items with his hands. At no time were any utensils present at the table or offered by staff to client #7 to eat his dinner meal. Continued observations revealed staff to assist client #3 to eat her dinner meal with only a fork. There were no other utensils offered to client #3 to eat her dinner meal. Subsequnet observations of the breakfast meal in the home on 1/8/19 at approximately 8:00 AM revealed client # 9 to eat her breakfast meal of waffles and bacon using her hands. No eating utensils were present on the table or offered to client #9 to eat her breakfast meal. Interview with the QIDP and the house manager on 1/8/19 revealed the clients are usually provided with utensils at the table if they do not get them in the kitchen before their meals. Continued interview revealed all clients should	W 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G011	A. BUILDING _____ B. WING _____	01/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOST CHILDREN'S CENTER	5300 HIGHWAY 200 CONCORD, NC 28025

(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 482	Continued From page 5 have received a set of silverware with which to eat their meals.	W 482		