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E 036	EP Training and Testing CFR(s): 483.475(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.	E 036		

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.

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E 036	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure the emergency preparedness (EP) plan included a testing program. The finding is: The facility did not have a testing program for the EP. Review on 5/6/19 of the facility EP revealed no testing of staff to determine the effectiveness of training on the EP. The facility did have a tabletop activity but not any testing of the EP itself to identify gaps or areas for improvement. Interview with the qualified intellectual disability professional (QIDP) on 5/7/19 confirmed there is no written testing of staff in regards to the EP.	E 036		
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 review and interviews, the facility failed to ensure staff were sufficiently trained to secure wheelchairs into the facility van. The finding is: Staff failed to demonstrate competency to secure individuals who use wheelchairs for mobility into the facility van. During observations at the facility on 5/7/19 staff	W 189		

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W 189	Continued From page 2 D rolled client #4's wheelchair into the back of the facility van. He was the third client who uses a wheelchair for mobility to be secured into the van. Staff D stated client #4's wheelchair did not have hooks on it to fasten the sure lock tiedowns onto the frame. Staff D tried without success several times to fasten the sure lock tiedowns onto client #4's wheelchair. She then asked another staff to come and assist her. During interview on 5/7/19 staff D stated she had completed training to secure wheelchairs onto the van. She stated client #4 was newly admitted and that his wheelchair was different. Review on 5/7/19 of staff D's training record revealed she had completed" NCHS Wheelchair Safety Tiedown" training on February 15, 2019. Interview on 5/7/19 with the qualified intellectual disabilities professional (QIDP) revealed staff D had completed this training but may need to be reinserviced.	W 189		
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:	W 249		

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W 249	Continued From page 3 Based on observations, record reviews and staff interview, the facility failed to ensure a pattern of interactions supported the active treatment plans for 1 of 3 audit clients (#2). The findings are: Direct care staff did not implement client #2's toothbrushing program as written. During observations in the facility on 5/6/19 at 6:25pm staff F took client #2 into the bathroom to brush her teeth. Staff F helped her retrieve her toothbrush, toothpaste from her grooming kit. Staff F assisted her in applying toothpaste to the toothbrush . She handed the toothbrush to client #2 who handed the toothbrush back. Staff F Took the toothbrush and lightly started brushing hand over hand client #2's bottom and top teeth. Client #2 stopped cooperating and staff F continued brushing her back top teeth. After a minute, client #2 stepped back. When staff F was asked how long client #2 brushed her teeth, she said, "about a minute." Review on 5/6/19 of client #2's individual program plan (IPP) dated 1/24/19 revealed a toothbrushing program to brush her teeth with 90% verbal cues or less for 2 consecutive review periods. Further review of the objective revealed, "The staff will give an initial cue [Client #2] it's time to brush your teeth. [Client #2] should brush her teeth a minimum of two minutes. If she does not brush for the required amount of time, staff should encourage her to brush a little longer." Review on 5/7/19 of client #2's dental visits revealed on 4/30/19 the Dentist was unable to thoroughly evaluate her oral hygiene but he could see signs of gingivitis. He recommended increased brushing.	W 249		

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W 249	Continued From page 4 Interview on 5/7/19 with the qualified intellectual disabilities professional (QIDP) revealed this objective is still current and should be trained as written.	W 249		
W 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interviews, the team failed to ensure medications used to assist in controlling inappropriate behaviors were used only as an integral part of the individual program plan (IPP) for 1 of 3 sampled clients (#2). The finding is: The interdisciplinary team failed to include the use of Lorazepam prior to physician appointments in client #2's behavior support plan (BSP). Review on 5/76/19 of client #2's record revealed a physician order dated 3/1/19 for Lorazepam 2 mg. to be administered to client #2 one hour prior to physician appointments. Further review of the physician orders revealed Lorazepam had been administered prior to physician appointments on 10/9/18 and on 10/24/18. Review on 5/6/19 of client #2's BSP dated	W 312		

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W 312	Continued From page 5 12/27/18 revealed the following target behaviors: self-injurious behavior, crying and non-compliance. The BSP included the following medications: Revia 50 mg., Oxcarbazepine 300 mg., and Clonazepam 1 mg. The use of Lorazepam prior to medical appointments was not included in the BSP. Interview on 5/7/19 with the qualified intellectual disabilities professional (QIDP) confirmed the use of Lorazepam was not included in client #2's BSP.	W 312		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to provide nursing services in accordance with the needs for 2 of 3 audit clients (#2, #4) relative to providing care for skin sores and a decubitus ulcer . The findings are: 1. Nursing services failed to ensure all staff working with client #4 followed specific instructions from the physician to provide consistent care for his decubitus ulcer. Review on 5/6/19 of a note from a regional hospital dated 11/18/19 revealed he was admitted to the hospital for an enlarging wound on his left thigh with obviously necrotizing tissue infection. A CAT scan revealed air in the soft tissue spaces. Further review of this note revealed client #4 was	W 331		

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treated for an emergent excision and drainage. The wound was cultured and determined to be a strep infection.

Review on 5/6/19 of the admission summary dated 4/11/19 for client #4 revealed he was admitted to the facility on 4/11/19 from a local nursing facility with a stage 4 decubitus ulcer that was approximately 5 centimeters in diameter with decreased exudate on his left thigh. Further review revealed client #4 is incontinent of bowel and bladder and wears a foley catheter. After admission on 4/15/19 he was seen at the emergency room for evaluation of the decubitus ulcer. The physician wrote orders to start client #4 on Augmentin and he was referred to a wound clinic several hours away.

Further review on 5/6/19 of physician notes for client #4 from the wound clinic revealed he continued to be prescribed Augmentin 875 mg. one tablet by mouth twice daily for 10 days.

Review on 5/6/19 of physician notes on 4/10/19 revealed staff were to pack client #4's wound at every diaper change and to turn him every two hours. The physician wrote an order that he could attend the vocational center but that he was to be out of his wheelchair, in bed turned every 2 hours off of his back. An additional order was written to supplement his regular diet with VHC Boost three times every day at meals.

Review on 5/7/19 of client #4's current physician orders dated 3/1/19 revealed he had orders for Oxycodone 5 milligram (10 as needed for pain, Ditropan 5 mg. (10 to aid with incontinence, Calcium 950 mg.(6), Oxybutin 5mg.(1), Stress form7 bec (1) for wound healing, Vitamin C 500

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mg.(1) and Vitamin B3 1,000 mg. (1).

During observations on 5/6/19 at 11:35am at the vocational center client #4 was lying in bed on his right side. He briefly got up and ate lunch at a table in the room where he was 1:1 with staff B. He was not given a dietary supplement by staff B with his lunch.

Interview on 5/6/19 with staff B at the vocational program revealed he was not very familiar with client #4. When asked why client #4 was lying down, staff B said he thought it was because he may have skin breakdown, but he was not certain where. When asked what instructions he was given for client #4's care, he stated he was to be off of his buttocks and turned every two hours. When asked how he knew which side to turn client #4 next, he stated the surveyor needed to talk with the nurse. When asked about the wound, staff B stated he was not very familiar with client #4 and the surveyor needed to talk to someone else.

During observations at the facility on 5/6/19 from 4:05pm -6:50pm staff assisted client #4 to his bedroom and he was assisted by staff F to get into bed. Client #4 laid on his bed in his bedroom from 4:05pm until 4:35pm on his left side when he went to take his medications. Client #4 went back to bed at 4:55pm lying on his left side until 6pm when he went to the kitchen to puree his food. After consuming his supper, client #4 went back to his bedroom and with assistance, went back to bed lying on his left side from 6:20pm-6:50pm when the surveyor left the facility.

During observations at supper on 5/6/19 client #4 was not offered his nutritional supplement as

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ordered by the physician.

Interview on 5/6/19 with staff F revealed she was not very familiar with client #4. Staff F stated she had been pulled to work at the facility from another home. When asked about the wound, she stated the nurses had demonstrated how to pack client #4's wound but she was not certain how often he was to change his position in bed or if there was any documentation about rotating his position in bed. She stated she was aware he had been seen at a wound clinic and that the wound looked "better" than it did when she started working in the facility after he was admitted.

Interview on 5/6/19 with staff E revealed she had been pulled to work in the facility and she was not familiar with client #4's wound and that she was not the medication technician on duty. Further interview revealed she usually saw client #4 at the vocational program.

Interview on 5/6/19 with staff D revealed she was not the medication technician and that she was relatively new working in the facility. She stated she had been told that client #4 had skin breakdown and that his dressing on his wound was to be changed often. She stated she was still learning and had not taken medication administration, so another staff would be dressing client #4's wound.

Interview on 5/7/19 with staff A revealed she had been an employee for 30 years. She stated client #4 had skin breakdown on his thigh and that he had been taking courses of antibiotics to help heal his skin breakdown. She stated the wound was on client #4's thigh reaching towards his groin and was about 5-9 centimeters wide. Staff A

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stated that the facility nurse had been to the facility and demonstrated how to pack the wound. Staff A stated she wet gauze in the same way the facility nurse had demonstrated, she also made certain the area was clean and then applied a dry bandage over the wound. Staff A stated client #4 was to be turned every two hours. Staff A stated she primarily worked third shift from 11pm-9am and that she woke client #4 up every 2 hours during the night and rotated his position in bed to ensure he was not on his back. Additional interview revealed client #4 had a follow up appointment with the wound infection specialist the following day.

Interview on 5/7/19 with the facility nurse revealed she has been out to the facility several times to reinservice staff but there has been a lot of turnover of staff and it was difficult to make certain everyone who worked with client #4 was trained to properly care for his decubitus ulcer.

Interview on 5/7/19 with the qualified intellectual disabilities professional (QIDP) revealed there has been a high rate of staff turnover at the facility. She stated the home manager was injured on 5/6/19 and now was out on leave. She confirmed it was difficult to ensure all staff were trained to care for client #4's specific nursing needs but that each of the staff working had some training on caring for client #4 and had been instructed to contact the facility nurse with any questions or concerns. Additional interview confirmed staff were told nutrition is very important for wound healing and that client #4 should receive all of his dietary supplements and medications.

2. Nursing services failed to ensure staff followed

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physician orders which necessitated client #2's bandages to be changed twice daily.

During observations on 5/6/19 in the vocational center from 11am-12:30pm client #2 wore gauze and arm sleeves that extended from her elbows to her fingertips on both arms.

During observations on 5/6/19 at the facility from 4:05pm until 6:50pm client #2 wore gauze and arm sleeves that extended from her elbows to her fingertips on both arms.

Interview on 5/6/19 with staff F revealed client #2 wears the gauze and arm sleeves because she has an order from the physician to wear these due to injuries she has sustained as a result of self -injurious behavior. Staff F stated she was the designated medication technician for the facility on 5/6/19. She stated client #2 has picked several sores on her arms and the gauze, arm sleeves and her behavior support program were being utilized to address this self-injurious behavior.

During observations in the facility on 5/7/19 client #2 was awakened at 6:20am by staff D. When client #2 exited her bedroom, she was wearing the gauze, arm sleeves on both arms.

Immediate interview with staff D revealed she was not the medication technician but that staff A would be changing client #2's bandages on 5/7/19.

During medication administration observations in the facility on 5/7/19, staff A and the surveyor asked client #2 if it was okay to watch bandages changes on her arm. She nodded, " Yes." During

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the bandage change, staff A immediately stated, "These are the same bandages I changed yesterday morning. I can tell by the way they are wrapped." Staff A carefully removed the bandages on client #2's arms which revealed numerous bleeding sores on both upper and lower arms. Staff A carefully washed off these areas with warm water, applied Thick Moisture Barrier Cream to both arms and carefully rewrapped both arms. She later reapplied the arm sleeves in her bedroom.

Review on 5/7/19 of client #2's behavior support program dated 12/27/18 revealed the following target behaviors: self-injury, crying and non-compliance. This plan included the use of Clonazepam and Oxcarbazapine.

Review on 5/7/19 of a note in the medication room from the nursing staff revealed, "Make sure [client #2]'s dressings are changed daily and that she is wearing her sleeves. If morning shift is not able to change the dressing, then the other shifts can change them."

Review on 5/7/19 of client #2's physician orders dated 2/27/19 revealed" BUE sleeves/arm protectors to be worn during waking hours as well as sleeping hours. Sleeves should be changed daily every morning during medication administration and after her pm shower/bath."

Interview on 5/7/19 with the facility nurse revealed direct care staff had been inserviced by nursing on client #2's protective arm sleeves. Further interview confirmed direct care are to follow instructions about changing these bandages twice daily.

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W 331	Continued From page 12 Interview on 5/7/19 with the QIDP revealed staff are to change client #2's bandages twice daily. Further interview revealed if staff are not changing these bandages at night after bath time, they are not in compliance with physician orders and need additional inservicing.	W 331		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure the diets were followed as prescribed by the physician for 2 of 3 audit clients (#1, #4). The findings are: 1. Direct care staff did not ensure client #1's food consistently was chopped as ordered by the physician. During observations on 5/6/19 of the supper meal at 6:00pm client #1 was assisted in serving pasta with small cut up pieces of ham, fruit cocktail and peas. The pasta and fruit cocktail was not cut up. During observations on 5/7/19 at 7:33am client #1 was assisted in her wheelchair to the dining room table. Staff D assisted client #1 is serving a entire piece of toast and an entire piece of patty sausage using a hand over hand method. Staff D also assisted client #1 in serving a bowl of cereal and pouring milk into a bowl. The toast and the patty sausage were uncut. Staff D was the only staff at the dining room table while staff G	W 460		

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assisted another client in the kitchen. Staff A was giving medications in the medication room. As client #1 started to consume the toast and the sausage, she put the sausage on the toast eating it together. Client #1 put half of this food into her mouth and began to cough several times. Staff A was at the medication closet and called to another staff to make certain someone was at the dining room table with client #1. Both staff D and staff G responded and went to client #1's placesetting. Staff G immediately remarked that client #1's food was to be cut into 1/4 inch pieces. Staff G asked client #1 to put the toast and sausage down and she began to cut up her food as she continued to cough. Staff G asked client #1 drink her water.

Review on 5/7/19 of client #1's individual program plan (IPP) dated 5/22/18 revealed client #1 is prescribed a 1500 calorie, low fat, low calorie chopped diet.

Review on 5/7/19 f client #1's medical evaluation dated 5/2/19 revealed she receives a weight loss diet with all foods cut into 1/4 inch to one inch pieces.

Interview on 5/7/19 with the qualified intellectual disabilities professional (QIDP) revealed client #1's food should be cut into 1/4 inch to one inch pieces as ordered. Further interview revealed she consumes food quickly and may be at risk for choking.

2. Direct care staff did not provide client #4 his dietary supplements as ordered by the physician.

During observations on 5/6/19 at 11:35am at the vocational center client #4 was lying in bed on his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G074	A. BUILDING _____ B. WING _____	05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLEY HEIGHTS HOME	2990 RESERVATION ROAD ABERDEEN, NC 28315

(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
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right side. He briefly got up and ate lunch at a table in the room where he was 1:1 with staff B. He was not given a dietary supplement by staff B with his lunch.

During observations at the facility on 5/6/19 at 4:40pm client #4 did not receive dietary supplement at the medication pass. During observations of the supper meal at 6:10pm client #4 was assisted in serving pasta with cut up pieces of ham, fruit cocktail and peas. He was not given a dietary supplement at the supper meal.

During observations on 5/7/19 at the medication pass at 8:05am client #4 did not receive a dietary supplement. Client #4 was assisted to serve toast, sausage and a bowl of cereal for breakfast at 8:10am. He was not offered dietary supplement.

Review on 5/7/19 of client #4's physician orders dated 4/10/19 revealed an order for "VHC Boost three times per day with meals."

Interview on 5/7/19 with the QIDP revealed the physician's order for client #4 to receive his dietary supplement was current and should be consistently implemented.