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
	34G152	A. BUILDING ______ B. WING ______	05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRICKLAND BRIDGE HOMES A & B	1818 STRICKLAND BRIDGE ROAD FAYETTEVILLE, NC 28304

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E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on documentation and interviews, the facility failed to develop an alternate means for communicating with facility staff, regional and local governments during an emergency. The finding is: The facility failed to an alternate means for communicating with staff, regional and local governments during an emergency. Review on 5/6/19 of the facility's emergency preparedness (EP) did not include information about the use of an alternate communication device. During an interview on 5/6/19, the home manager (HM) revealed that neither home had an alternate communication device, which should be used in emergencies.	E 032		

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 032	Continued From page 1 During an interview on 5/7/19, management staff confirmed neither home had an alternate communication device, which should be used in emergencies.	E 032		
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	E 036		

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E 036	Continued From page 2 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. 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. A 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 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure 1 of 6 audit clients (#2) had the right to appropriate fitting	W 137		

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W 137	Continued From page 3 clothing. The finding is: Client #2 did not wear clothes which fit appropriately. During observations at the day program on 5/6/19, client #2 wore ill fitting pants which were low on her hips, in which her buttocks were visible. Further observations from 10:52am until 11:39am, client #2 sat in a chair in her classroom at the day program and her buttocks were visible to anyone in the room. Client #2 on seven separate occasions pulled down the back of her shirt to cover her buttocks; the shirt did not stay in place. During observations in the home on 5/7/19, client #2 was sitting in her wheelchair wearing a ill fitting pair of cargo shorts. Additional observations revealed her buttocks and her disposable brief were visible to anyone in the home. At no time was client #2 assisted with changing her clothing. Review on 5/6/19 of client #2's individual program plan (IPP) dated 9/18/18 stated, "...[Client #2] can dress and undress herself. She can make clothing selections." Review on 5/6/19 of client #2's adaptive behavior inventory (ABI) dated 9/13/19 revealed she is totally independent in all aspects of dressing herself. During an interview on 5/7/19, the qualified intellectual disabilities professional (QIDP) revealed client #2 "goes to the store and purchasing her own clothes with staff assistance." Further interview revealed client #2's siblings also will come and bring her clothing.	W 137		

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W 249	Continued From page 4	W 249		
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 area of dining skills. This affected 2 of 6 audit clients (#4, #9). The findings are: 1. Clients #4 and #9 were not prompted to use a knife. During lunch observations at the day program on 5/6/19, clients #4 and #9 picked up their individual chicken patties with their fingers and consumed them by biting it. Further observations revealed there were no knives located in the classroom where they were eating their lunches. At no time did staff provide clients #4 and #9 with a knife. During an interview on 5/7/19, Staff A revealed both clients #4 and #9 can independently use a knife to cut their own food. Review on 5/7/19 of client #4's adaptive behavior	W 249		

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W 249	Continued From page 5 inventory (ABI) dated 1/15/19 revealed she is totally independent in using a knife to cut her food. Review on 5/7/19 of client #9's ABI dated 3/18/19 indicated he is totally independent with using a knife to cut his food. During an interview on 5/7/19, the qualified intellectual disabilities professional (QIDP) revealed both clients #4 and #9 are able to use a knife independently to cut their food. 2. Client #9 was not prompted to use a microwave. During lunch observations at the day program on 5/6/19, client #9's food was put in the microwave and then the microwave was turned on by staff. Further observations revealed staff removing client #9's food and taking it to him while he sat at the table. At no time was client #9 prompted to use the microwave to heat up his food. During an interview on 5/6/19, Staff B revealed client #9 is able to use a microwave. Further interview revealed client #9 should have been prompted to use the microwave to heat up his food. Review on 5/7/19 of client #9's ABI dated 3/18/19 revealed he has total independence in using a microwave. During an interview on 5/7/19, the QIDP confirmed client #9 should have been prompted to use the microwave.	W 249		
W 368	DRUG ADMINISTRATION	W 368		

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W 368	Continued From page 6 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 observations, record reviews and interviews, the facility failed to assure all physician's orders were consistently implemented as written. This affected 1 of 6 audit clients (#11). The finding is: The physician order to elevate client # 11's legs while at home was not consistently implemented by staff. Throughout observations in the home on the afternoon and evening of 5/6/19 and the morning of 5/7/19, client #11's legs were not elevated when not in her bed. Her legs were tied together with a strap of material/canvas. The edema in her legs was visible and there was an indentation where the strap went around her legs. Her legs dangled from her chair and were tied together to prevent injury from their dangling from an ill fitting wheelchair. She wore TED hose during observations. Review on 5/6/19 of client #11's individual program plan (IPP) dated 6/28/19 revealed she should continue to follow her "current schedule for lower extremity elevation per MD orders." Review on 5/6/19 of the most recent physician's orders dated 2/2/19 revealed, "Keep [client #11's] legs elevated when at home."	W 368		

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W 368	Continued From page 7 Interview with the nurse and qualified intellectual disability professional (QIDP) on 5/6/19 confirmed the doctor's orders should have been implemented consistently as written.	W 368		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to furnish and maintain in good repair a wheelchair for 1 of 6 audit clients (#11). The finding is: Client #11's wheelchair was not in good repair and she was not furnished with an appropriately fitting wheelchair while waiting for a new wheelchair. Throughout observations in the home and day program on 5/6 and 5/7/19, client #11 sat in an ill fitting wheelchair. She leaned hard to the right almost leaning out of the chair. There was a strap that fit around her chest and a strap "tied" around her legs. The chair seemed small for her larger size and did not provide her upper body support. Periodically, multiple staff kept going to her and attempting to lift her up or position her more centered and upright. However, she would soon fall back to the side. The strap that was tied	W 436		

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W 436	Continued From page 8 in a bow around her legs left an indentation in her already very swollen legs. The chair did not have a headrest or legrests. Review on 5/6/19 of the positioning protocol dated 3/12/19 noted that a headrest should always be intact to her wheelchair. The physical therapy evaluation dated 3/30/19 noted, "repair power wheelchair." Review on 5/6/19 of a physical therapy note dated 4/18 also discussed a need for a new wheelchair. Interview with the qualified intellectual disability professional (QIDP) on 5/6/19 confirmed the indentation on the leg of client #4 was an indication that the tying her legs together was not the best idea. She further confirmed that client #11 needed a new wheelchair. The QIDP and the quality assurance director confirmed the need for a new chair and indicated the delay was due to waiting for medicaid approval. Interview on 5/6/19 with the guardian of client #11 revealed she had discussed the need of a new wheelchair with the facility and there had been nothing done to date. She stated client #11 had been in that chair for about 6 months. She further stated that she went to client #11's last cardiology appointment and the cardiologist who will be doing a procedure next week on her legs for circulation had stated that without a new wheelchair where her legs could be lifted the procedures would be no good. Interview on 5/6/190 and 5/7/19 with client #11 indicated she was very unhappy with her wheelchair and very uncomfortable.	W 436		

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W 436	Continued From page 9 Interview with the group home manager on 5/6/19 confirmed that she was familiar with what the cardiologist had said about the surgical procedure being a waste if client #11 had to continue to sit in that chair. *After the survey, the physical therapist called and confirmed he was aware of the need for a new wheelchair for client #11 and he understood that the chair looked ill fitting. He stated the new chair was very expensive and had not yet been approved by Medicaid.	W 436		