STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G307	A. BUILDING _____ B. WING _____	05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLEA GROUP HOME	5691 MACK LINEBERRY ROAD CLIMAX, NC 27233

(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, record review and staff interviews the facility failed to ensure objectives contained in the Habilitation Plans (HP) for 3 of 3 sampled clients (#2, #4 and #6) were implemented as prescribed related to medication administration and dining. The findings are: A. The facility failed to ensure a medication administration objective listed on the 4/25/19 HP for client #2 was implemented as prescribed. Observations on 5/7/19 at 7:35 AM during the medication pass revealed client #2 to receive Atomoxitine, Depakote, Pexeva, Lorazepam and Eucerin cream for his morning medications. Continued observations revealed Staff A to remove all medications from cellophane packets, put all of medications into a medication cup, and give them to client #2 to take. No teaching of medication names, purpose, or side effects of medications was given to client #2. Further observation revealed at no time was client #2 prompted to locate his picture on his medication basket or to retrieve his medication basket during the administration of his medications.	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 249	Continued From page 1 Record review on 5/7/19 for client #2 revealed a HP dated 4/1/19 containing an objective which stated "client #2 will retrieve his medication tray by utilizing his picture on his medication tray, with 1 verbal prompt." Interview with the facility qualified intellectual disabilities professional (QIDP) confirmed client #2 should have been prompted to locate his medication tray as written in his program goal. Continued interview on 5/7/19 confirmed all clients should be taught names, purpose and side effects of their medications at each administration of their medications. B. The facility failed to ensure a medication administration objective listed on the 4/1/19 HP for client #6 was implemented as prescribed. Observations on 5/7/19 at 7:49 AM during medication pass revealed client #6 to receive Depakote, Fluoxetine, Abilify, and Palperidone, for his morning medications. Continued observations revealed Staff A to remove all medications from cellophane packets, put all of medications into a medication cup, and give them to client #6 to take. No teaching of medication names, purpose, or side effects of medications was offered to client #6. Further observation revealed at no time was client #6 prompted to locate his picture on his medication basket or to retrieve his medication basket during the administration of his medications. Record review on 5/7/19 for client #6 revealed a HP dated 4/1/19 containing an objective which stated "client #6 will retrieve his medication tray by utilizing his picture on his medication tray, with	W 249		

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W 249	Continued From page 2 1 verbal prompt." Interview with the facility QIDP confirmed client #2 should have been prompted to locate his medication tray as written in his program goal. Continued interview on 5/7/19 confirmed all clients should be taught names, purpose and side effects of their medications at each administration of their medications. C. The facility failed to ensure an objective listed on the 4/11/19 HP for client #4 was implemented as prescribed related to making food choices. Observations on 5/6/19 at 6:15 PM observations during the supper meal of pasta and ham pasta salad, peas and fruit revealed client #3 to receive one helping of each the foods listed above. Continued observations at 6:20 PM revealed client #3 requested a second serving of the pasta and ham salad by taking the wrap off of the pasta salad to which group home manager staff B responded "you have already had a serving." Continued observations revealed client #3 to again ask for a second serving of pasta salad by reaching for the whole dish of salad, to which staff B responded "No you can have a rice cake" which client #3 was given. Further observations revealed Staff B to remove the pasta salad from client #3's reach. Record review on 5/7/19 revealed a HP dated 4/11/19 with an objective for client #3 to "independently communicate his desire for preferred food items daily for 180 days". Continued record review revealed a current doctor's order for a regular diet no restrictions". Further record review revealed facility nurse's note for client #3 dated 3/16/19 stating no	W 249		

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W 249	Continued From page 3 restrictions on diet, tolerates all foods, request a second helping of a preferred food item at each meal". Interview with Staff B revealed she did not know that client #3 had a program to make a preferred food choice daily. Continued interview revealed she has been "unclear whether to give clients seconds or not at mealtime." Subsequent interview with the QIDP confirmed client #3's request for pasta salad should have been encouraged and supported by staff, and his program goals should have been implemented as written in client #3's (HP).	W 249		
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, record interview the facility failed to assure a specifically diet was followed for 1 of 3 sampled clients (#1) . The finding is: Observations in the group home on 5/6/19 revealed a supper meal of pasta salad with ham, peas, fruit and crackers. Continued observations of the super meal for client #1 revealed staff to assist him to serve all dinner items on to his plate. Further observations revealed staff to break up client #1's crackers into pieces of 1" in size. Subsequent observations revealed client to eat some of his cracker pieces leaving some on his plate.	W 460		

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W 460	Continued From page 4 Observations of the breakfast meal on 5/7/19 at 7:30 AM revealed client #1 was assisted by staff with serving his breakfast items of a whole piece of toast, eggs, and cereal. Continued observations revealed staff to cut up client #1's toast into pieces of 1/1/2" each. Further observations revealed client #1 to attempt to cut his toast independently into smaller pieces without success. Subsequent observations revealed staff did not further assist client #1's to cut his toast into smaller edible pieces. Record review on 5/7/19 for client #1 revealed a Habilitation Plan (HP) dated 4/1/19 with current physician orders for "a finely chopped diet" for client #1. Interview with the facility qualified intellectual disabilities professional (QIDP) on 5/7/19 confirmed client #1 is to receive a finely chopped diet at each meal per the physician's orders. Continued interview with the QIDP revealed "finely chopped diet" according to facility policy are food pieces no larger than 1/8"-1/4" in size. Further interview with the QIDP confirmed client #1's crackers and toast should have been chopped into pieces of 1/8-1/4" in size to comply with the physician's order of a "finely chopped diet for client #1.	W 460		