STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G306	A. BUILDING _____ B. WING _____	04/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYDNOR STREET GROUP HOME	134 SYDNOR STREET MOUNT AIRY, NC 27030

(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 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations and interview, the system for drug administration failed to assure all clients were provided with information regarding the names, purpose and possible side effects of prescribed drugs for 4 of 4 clients observed during medication administration (#3, #4, #5 and #6). The findings are: A. The system for drug administration failed to assure client #3 was provided teaching related to the name, purpose or possible side effects of medications received during the administration of medication on the morning of 4/24/19. Observations conducted on 4/24/19 at 7:03 AM revealed client #3 was verbally prompted by staff to come to the medication administration area where he received medications including Vitamin E 200 units, Vimpat 100 mg., Olanzapine 10 mg., Topiramate 50 mg., Propranolol 20 mg.-two tablets, Lorazepam 1 mg. by mouth and Flonase nasal spray-one spray to each nostril. Staff was not observed to provide information to client #3 regarding the names, purpose or possible side effects of medications administered. Interview conducted with the nurse by telephone on 4/24/19 revealed staff should provide	W 371	RECEIVED MAY 13 2019 DHSR NH L & C Black Mountain / WRO	

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

Joshua Dunn | Executive Director / QIDP | 5/9/19

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.

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W 371	Continued From page 1 information and teaching to client #3 for all medications administered at each opportunity. B. The system for drug administration failed to assure client #4 was provided teaching related to the name, purpose or possible side effects of medications received during the administration of medication on the morning of 4/24/19. Observations conducted on 4/24/19 at 7:15 AM revealed client #4 was verbally prompted by staff to come to the medication administration area where he received medications including Aripiprazole 5 mg. and Sertraline 50 mg., which was placed in a spoon by staff and given to client #4 whole with water. Staff was not observed to provide information to client #4 regarding the names, purpose or possible side effects of medications administered. Interview conducted with the nurse by telephone on 4/24/19 revealed staff should provide information and teaching to client #4 for all medications administered at each opportunity. C. The system for drug administration failed to assure client #6 was provided teaching related to the name, purpose or possible side effects of medications received during the administration of medication on the morning of 4/24/19. Observations conducted on 4/24/19 at 7:40 AM revealed client #6 was verbally prompted by staff to come to the medication administration area where he received medications including Loratadine 10 mg., lorazepam 0.5 mg., Benztropine 0.5 mg., Divalproex 250 mg.-two tablets, Omeprazole 20 mg. and Risperidone 1 mg.. Staff was not observed to provide	W 371	Staff will be provided retraining for proper Medication Administration procedures. LPN/Nurse will monitor Weekly.	6/23/19

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W 371	Continued From page 2 information to client #6 regarding the names, purpose or possible side effects of mediations administered. Interview conducted with the nurse by telephone on 4/24/19 revealed staff should provide information and teaching to client #6 for all medications administered at each opportunity. D. The system for drug administration failed to assure client #5 was provided teaching related to the name, purpose or possible side effects of medications received during the administration of medication on the morning of 4/24/19. Observations conducted on 4/24/19 at 7:45 AM revealed client #5 was verbally prompted by staff to come to the medication administration area where she received medications including Vitamin B-12 500 mcg., Citerizine 10 mg., Cranberry capsule 250 mg., Omeprazole 20 mg., Tamsulosin 0.4 mg., topiramate 10 mg., Furosemide 20 mg. one-half tablet, Olanzapine 5 mg. and Calcium 500 mg. chewable tablet. Staff was not observed to provide client #5 with information regarding the names, purpose or possible side effects of medication administered. Interview conducted with the nurse by telephone on 4/24/19 revealed staff should provide information and teaching to client #5 for all medications administered at each opportunity.	W 371		
W 448	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills, including accidents.	W 448		

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W 448	Continued From page 3 This STANDARD is not met as evidenced by: Based on review of facility records and staff interview, the facility failed to investigate all problems with evacuation drills completed on third shift during the past review year. The finding is: On 4/23/19, a review of the facility's evacuation drill reports for the past survey year was conducted. This review revealed an evacuation drill was conducted on 6/22/18 during third shift with a documented evacuation time of 7 minutes and 6 seconds. Staff notation on this report documented client #1 and client #2 "did not want to get out of bed " and client #2 then "did not want to come back inside". Continued review of the facility's evacuation drill reports revealed an evacuation drill was conducted on 7/24/18 during third shift with a documented evacuation time of 3 minutes. Staff notation on this report documented "one client refused to go outside". Further review of the evacuation drill reports for the past survey year revealed no documentation indicating the facility had investigated any problems that were noted by staff to have occurred during the evacuation drills. Interview conducted on 4/24/19 with the qualified intellectual disabilities professional (QIDP) revealed the facility had not conducted an investigation into the problems staff had noted as having occurred during the evacuation drills on 6/22/18 or 7/24/18.	W 448	Fire Drills will be reviewed quarterly during Health & Safety meetings. Grayhome Manager will monitor on a quarterly basis.	6/28/19
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the	W 474		

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W 474	Continued From page 4 developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure all food was served in a form consistent with developmental level for 1 of 3 sampled clients (#1). The finding is: Observations conducted on 4/23/19 during the supper meal revealed client #1's meal consisted of baked chicken, parmesan pasta and salad, which had been processed to a ground consistency. Observations conducted on 4/24/19 during the breakfast meal revealed client #1 was assisted by staff to serve himself a cheese omelet, two slices of toast with jelly and beverages. Continued observations during he breakfast meal revealed client #1 cut his omelet into three large pieces with his for, took one very large bite of the omelet, then placed the omelet between two whole slices of toast. Client #1 was then observed to pick up the toast with the omelet inside and eat it sandwich-style, taking large bites. Staff was observed to be sitting beside client #1 at the dining table, however, no prompting or redirection was offered by staff related to the consistency of client #1's breakfast meal. Review of the record for client #1, conducted on 4/24/19 and 4/25/19, revealed a physician's order dated 3/26/19 which prescribed a low cholesterol, low fat, mechanical soft diet with chopped/ground food. Interviews conducted on 4/24/19 with the qualified intellectual disabilities professional and the house manager, as well as telephone interview with the nurse verified staff	W 474	Staff will be retrained on client diets and meal Consistency. LPN/Nurse will Monitor weekly to ensure diets are followed.	6/23/19

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W 474	Continued From page 5 should have provided/assisted client #1 to receive a mechanical soft diet with chopped/ground meats as ordered by the physician. These interviews further verified whole pieces of toast were not consistent with client #1's ordered diet consistency.	W 474		