STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G313	A. BUILDING _____ B. WING _____	04/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK DRIVE GROUP HOME	1305 PARK DRIVE 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 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 and interviews, the facility failed to ensure staff were sufficiently trained relative to the behavior management of 1 of 4 sampled clients (#6). The finding is: Observations in the group home on 4/24/19 at approximately 6:55 AM revealed staff A to assist client #6 to the medication room. Staff A was observed to walk with client #6 while verbally prompting the client of the need to go to the medication room for a topical for the client's mouth due to dry, chapped lips and a burn injury to the clients lip. A review of facility incident reports on 4/24/19 revealed two incidents of occasions that client #6 obtained burn injuries to the lip are of her mouth from drinking a hot beverage on 3/31/19 and 4/15/19. Further review of internal documentation revealed on 3/31/19 client #6 obtained a burn injury to the lip area in the group home after obtaining a hot pot of coffee, pouring it into a cup and drinking it excessively. Additional documentation of the 3/31/19 incident revealed an internal investigation, nursing assessment and IRIS report relative to the incident. Review of an incident report dated 4/15/19 revealed client #6 drank staff's hot coffee and burned mouth, client stole drink but only got a sip. Documentation revealed staff to take coffee from client and called	W 189	RECEIVED MAY 13 2019 DHSR NH L & C Black Mountain / WRO	

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

Executive Director / QIDP | 5/8/19

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 189	Continued From page 1 nursing. Review of records for client #6 on 4/24/19 revealed client #6 to have a diagnosis of severe intellectual disability, obsessive compulsive behavior and polydipsia. Additional record review revealed a behavior intervention plan revised on 12/15/18. Review of the 12/15/18 behavior plan revealed target behaviors of non-compliance, verbal aggression, physical aggression to include "aggression-liquid seeking" when staff must intervene to prevent drinking related to polydipsia, wandering/AWOL, and stealing: taking liquids that do not belong to her. Interview with the facility administrator on 4/24/19 verified client #6 had obtained two injuries related to hot beverages on 3/31/19 and 4/15/19. Further interview with the facility administrator revealed staff had not been retrained on client #6's behavior plan since the incidents. Interview with nursing on 4/24/19 verified client #6 was assessed by nursing after both lip injuries on 3/31/19 and 4/15/19, incidents occurred at different locations and resulted in minor burn injury with treatment of a oral topical recommended by the pharmacist. Additional interview with nursing staff revealed after the 3/31/19 incident a note was entered into the communication log in the group home for staff to utilize a thermos for hot beverages to prevent a hot pot from sitting on the counter of the group home accessible to the client. Nursing verified this strategy had not been provided to staff at the vocational site. Nursing and the facility administrator further verified a formal in-service had not been provided to staff in the group home relative to the new intervention identified by nursing. Although there was no observation	W 189	Staff will be retramed on the behavior interventian plan. Staff will also be retramed on client Safety, supervision, reporting ~~Prodeca~~ Procedures across all domains including grouphome and day program. Grayhome Manager will monitor every two weeks for client Safety..	6/24/19

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W 189	Continued From page 2 during the survey on 4/23-24/19 of client #6 seeking beverages without supervision, there had been no retraining of staff relative to the client's behavior management plan after two burn incidents.	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: Based on observation, record review and interview, the facility failed to ensure a communication objective contained in the individual support plan (ISP) was implemented as prescribed for 1 of 4 sampled clients (#1) related to communication. For example: Observations in the group home during the 4/23-24/19 survey revealed client #1 to be non-verbal. Further observations throughout the survey revealed various staff (A,B,D,E,F,G) to direct client #1 verbally and at various times with a communication board that revealed object cues that included wash hands, trash, eat, medications, shower and laundry. Staff (A,B,D,E,F,G) were observed to support client #1 with transitions at various times by verbally prompting the client and pointing to items on the	W 249		

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W 249	Continued From page 3 communication board that stayed on a side table in the living room. Staff (A,B,D,E,F,G) were also observed to verbally prompt and physically walk with client #1 to the identified activity without use of the communication board. At no time was client #1 ever observed to take a physical cue off the communication board during a transition or to return a physical cue to the communication board. Review of client #1's record on 4/23/19 revealed an individual support plan (ISP) dated 6/21/18. Review of the ISP revealed a communication objective implemented 12/3/18. Review of the communication objective revealed client #1 will utilize object/picture cues to prepare for activities with 90% accuracy for three consecutive months. Further review of the communication objective revealed staff will present client #1 with the object/picture of the task that he is needed to complete. Client #1 will take the object cue with him to the task. Once the task is completed, client #1 will return the object to the board with staff assistance. Interview with the facility administrator/qualified intellectual disabilities professional (QIDP) verified client #1's communication objective remains current and should have been implemented as written. Further interview verified client #1 was to take the object cues from the communication board and return the object cues after completing the designated activity.	W 249	Staff will be provided re-training on the object/picture program. First and Second Shift leads will monitor Daily to ensure program is followed.	6/24/19
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 4 This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to investigate fire drills specific to the reason for the extended time needed for home evacuation. The finding is: Review of the facility fire drill reports from 4/2018 through 3/2019 revealed staff had documented extended times to evacuate clients in the home on third shift with no identified reasons or issues with evacuation. Further review revealed the following fire drills conducted during the 4/2018 to 3/2019 time period: 4/23/18 - 1:23 minutes - 1st shift - 3 staff - 6 clients 5/30/18 - 1:53 minutes - 2nd shift -2 staff - 6 clients 7/25/18 - 4:23 minutes - 3rd shift -2 staff - 6 clients 8/23/18 - 0:54 minutes - 1st shift - 3 staff - 6 clients 9/26/18 - 0:36 minutes - 2nd shift -4 staff - 5 clients 10/23/18 - 5:00 minutes -3rd shift -3 staff - 6 clients 11/23/18 - 1:45 minutes -1st shift - 3 staff - 4 clients 12/23/18 - 0:48 minutes -2nd shift -3 staff - 4 clients 1/23/19 - 4:08 minutes - 3rd shift - 3 staff - 6 clients 2/28/19 - 1:30 minutes - 1st shift - 3 staff - 6 clients 3/23/19 - 1:36 minutes - 2nd shift - 3 staff - 5 clients	W 448	Fire Drills will be reviewed quarterly during Health and Safety Meetings. Group home Manager will monitor on a quarterly basis.	6/24/19

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W 448	Continued From page 5 Interview with the facility administrator/qualified intellectual disabilities professional (QIDP) on 4/24/19 verified there was no written documentation regarding reasons for the extended fire drill evacuation times at the facility, specific to third shift. Further interview with the facility administrator and QIDP confirmed the need to investigate the reasons causing the delayed evacuations in order to ensure all clients living in the home are able to safely and timely evacuate the facility.	W 448		