

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2019
NAME OF PROVIDER OR SUPPLIER FLOWE DRIVE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 628 FLOWE DRIVE CHARLOTTE, NC 28213		
(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 227	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on review of records and interview, the team failed to ensure the individual habilitation plan (IHP) for 1 of 3 sampled clients (#5) included objective training to address needs relative to medical/dental desensitization. The finding is:</p> <p>Review of records for client #5 on 6/4/2019 revealed a dental evaluation dated 8/8/18. Review of the 8/8/18 dental evaluation revealed documentation of plaque and white spots. Further review of the 8/18/18 dental consult revealed the recommendation for sedation in order to conduct a full exam and cleaning as patient was uncooperative for exam. Review of nursing notes for client #5 revealed documentation on 8/8/18: Dental evaluation. Some plaque, gums red and inflamed. Uncooperative for exam, referred to CMC dental for sedation. Subsequent review of records for client #5 revealed a behavior support plan (BSP) dated 8/13/18 for target behaviors of verbal aggression, physical aggression, property destruction, non-compliance, intentional toileting accidents, invading others personal space and elopement. Additional review of the 8/13/18 BSP revealed non-compliance behavior defined as refusing to cooperate with essential tasks for health and safety: taking medications, hygiene and self-care. Further record review revealed no</p>	W 227			

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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W 227	Continued From page 1 dental consult or treatment since 8/8/18. Interview with the facility nurse on 6/4/2019 verified client #5 had not received dental services since 8/8/18. The facility nurse further reported she had been trying to schedule client #5 an appointment for dental services with the use of sedation although no appointment had been able to be made. Interview with the facility qualified intellectual disabilities professional (QIDP) verified client #5 has behavioral episodes at medical and dental appointments. Further interview with the QIDP verified client #5 did not have a desensitization objective or program relative to medical or dental services to support the client with behavior management interventions during medical/dental appointments.	W 227			
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 observation, record review and interview, the system for drug administration failed to assure 3 of 3 clients (#2, #3 and #5) observed during medication administration were provided the opportunity to participate in medication self-administration or provided training related to the name, purpose and side-effects of medications administered. The findings are:	W 371			

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W 371	<p>Continued From page 2</p> <p>A. The system for drug administration failed to assure client #5 was provided the opportunity to participate in medication self-administration or provided training related to the name, purpose and side-effects of medications administered.</p> <p>Observations conducted on 6/5/19 at 6:45 AM revealed client #5 entered the medication administration area and received medications as ordered per the current administration record and physician orders. Continued observations conducted during the medication administration for client #5 revealed the staff administering medication (staff F) did not provide client #5 with information related to the purpose or possible side effects of medications received, nor was client #5 offered the opportunity to participate in self-administration of medications. Staff F was observed to retrieve client #3's medications, punch out medications from a bubble pack and hand medications to the client in a med cup. Staff was further observed to hand the client a cup of water poured by staff. Client #5 was observed to take medications followed by water.</p> <p>Review of records for client #5 on 6/5/19 revealed a daily living skills assessment dated 7/6/18. Review of the 7/6/18 assessment revealed client #5 is able to dispense pills and get water to take with medication with hand over hand assistance.</p> <p>B. The system for drug administration failed to assure client #3 was provided the opportunity to participate in medication self-administration or provided training related to the name, purpose and side-effects of medications administered.</p> <p>Observations conducted on 6/5/19 at 6:57 AM revealed client #3 entered the medication</p>	W 371			

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W 371	<p>Continued From page 3</p> <p>administration area and received medications as ordered per the current administration record and physician orders. Continued observations conducted during the medication administration for client #3 revealed the staff administering medication (staff F) did not provide client #3 with information related to the purpose or possible side effects of medications received, nor was client #3 offered the opportunity to participate in self-administration of medications. Staff F was observed to retrieve client #3's medications, punch out medications from a bubble pack and hand medications to the client in a med cup. Staff was further observed to hand the client a cup of water poured by staff. Client #3 was observed to take medications followed by water and request staff to "give me a little more" and staff poured additional water into the clients cup.</p> <p>Review of records for client #3 on 6/5/19 revealed a daily living skills assessment dated 3/13/19. Review of the 3/13/19 assessment revealed client #3 is able to dispense pill medication and get water to take with medication with supervision. Further review of the 3/13/19 assessment revealed supervision is identified as a level of skill that the individual performs the activity with gestures, verbal direction and modeling or demonstration. Additional review of the 3/13/19 assessment revealed documentation that client #3 participates in med administration by punching out her medications.</p> <p>C. The system for drug administration failed to assure client #2 was provided the opportunity to participate in medication self-administration or provided training related to the name, purpose and side-effects of medications administered.</p>	W 371			

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W 371	<p>Continued From page 4</p> <p>Observations conducted on 6/5/19 at 7:12 AM revealed client #2 entered the medication administration area and received medications as ordered per the current administration record and physician orders. Continued observations conducted during the medication administration for client #2 revealed the staff administering medication (staff F) did not provide client #2 with information related to the name, purpose or possible side effects of 4 of 5 medications received. Staff F was observed to retrieve client #2's medications, assist the client with punching pill medications from a bubble pack and hand medications to the client in a med cup. Staff was further observed to hand the client a cup of water poured by staff. Client #2 was observed to take medications followed by water. Staff was subsequently observed to measure client #2's FOS Powder into a cup and stir with water, poured by staff that was handed to the client.</p> <p>Review of records for client #2 on 6/5/19 revealed a daily living skills assessment dated 1/9/19. Review of the 1/9/19 assessment revealed client #2 is able to identify the name of medications with supervision. Further review of the 3/13/19 assessment revealed supervision is identified as a level of skill that the individual performs the activity with gestures, verbal direction and modeling or demonstration. Additional review of the 3/13/19 assessment revealed client #2 gets water to take with medication with independence.</p> <p>Interview with Staff F on 6/5/19 verified clients #2, #3 and #5 are capable of participation in medication administration with at least hand over hand assistance during most tasks. Additional interview with Staff F revealed she does not identify the name of many medications to clients</p>	W 371			

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W 371	Continued From page 5 due to the medication names being hard to pronounce. Interview with the facility nurse, the facility qualified intellectual disabilities professional (QIDP) and home manager verified all clients should be provided the opportunity to participate in their medication administration at the skill level that each client is capable.	W 371		