STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G149	A. BUILDING _____ B. WING _____	R 06/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON ROAD GROUP HOME	**800 WILMINGTON ROAD FAYETTEVILLE, NC 28304**

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W 000	INITIAL COMMENTS A revisit was conducted on 6/21/19 for all previous deficiencies cited on 4/ 2/19. All of the deficiencies were recited and a new area of noncompliance was found. The facility remains out of compliance.	W 000		
{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 reviews and interviews, the facility failed to ensure an objective contained in the individual program plan (IPP) for 1 of 3 audit clients (#3) was implemented as prescribed related to self administration of medication. The finding is: The med tech did not involve client #3 in skills mastered to participate in self administration of medication. During observations on 6/21/19 at 7:31 am in the home, client #3 came to the med room to begin the med pass. The med tech pulled all meds from client #3's basket and pushed all meds from the bubble pack, without client #3's assistance. In addition, a water pitcher was removed from the	{W 249}		

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 249}	Continued From page 1 refrigerator and poured into a cup by the med tech, adding Miralax powder and stirred the contents in the cup for client #3. The med tech, then handed the cup to client #'3. The med tech was observed to take the pills that were placed in a med cup, and pour the pills into client #3's mouth. Client #3 was observed to lift the cup to her mouth to drink. The med tech took the pitcher of water, refilled the cup with more water and gave the cup back to client #3 to have more fluids. Review on 6/21/19 of client #3's IPP dated 6/13/19 revealed that client #3 was able to come to the med room when asked; assist in pushing med from pack, pouring water, taking pills and discarding trash. In addition, the review of the adaptive behavior inventory (ABI) dated February 2019 revealed that client #3 was assessed as being partially independent with punching pill from med card and totally independent, without assist with pouring water from pitcher, placing pills in her mouth and drinking from a cup. Interview on 6/21/19 at 9:45 am, with nurse A and nurse B at the day program revealed that when allowing a client to self administer medication, the client should be asked to punch the pills, pour with hand over hand assistance, if needed and hold cup of fluid, to drink.	{W 249}		
{W 369}	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.	{W 369}		

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{W 369}	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all drugs were administered without error. This effected 1 of 3 clients (#1) observed receiving medication. The findings are: Client #1's Flonase and Linzess were not administered as ordered. During observations at the home, on 6/21/19 at 6:15 am, revealed that staff A and staff B, working third shift indicated that no medications had been given for the 6:00 am med pass. An additional observation, revealed that the med tech did not arrive to the home until 6:35 am. The med tech started medication administration at 7:10 am with client #1. At 7:26 am, client #1 ingested 1 tablet of Linzess 290 mcg (microgram) and never received a dose of Flonase Spray, in each nostril. Review on 6/21/19 of client's #1 physician's order dated February 2019 revealed an order for Linzess 290 mcg to take one tablet daily by mouth at 6:00 am as well to receive one spray of Flonase 50 mcg in each nostril at 8:00 am. Interview on 6/21/19 with the med tech at 7:45 am confirmed that client #1 received the dose of Linzess outside of the medication administration window and that the Flonase was not in stock at the facility. The med tech reviewed the medication administration record (MAR) and determined that it was last given on 6/20/19 and that the nurse was contacted to reorder the medication. The med tech relayed that the nurse had a bottle of Flonase at the day program that she would give it to client #1 when he arrived today.	{W 369}		

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{W 369}	Continued From page 3 Interview on 6/21/19 at 9:45 am with nurse A and nurse B revealed that if a medication was not available at the group home, staff should call the nurse, who would call the pharmacy and supplier. The medication would be available to be picked up the same day. In addition, if meds were scheduled for 6:00 am, then should be given by 7:00 am.	{W 369}		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, interviews and policy review, the facility failed to follow their infection control guidelines, between patient contact and when testing glucose for 2 of 3 audit clients (#1 and #3). The findings are: The med tech performed a finger stick blood sugar test on client #3, in the absence of gloves. During observations on 6/21/19 at 7:31 am in the group home, client #3 came to the med room to get her 8:00 am medications. The med tech first performed a blood pressure test on client #3 then took client #3's right index finger and pierced it with a lancet, to remove blood to test. The med tech was not wearing any gloves. The med tech was not aware that client #3's pierced finger had started to bleed and that there was a dime size pool of blood on the floor at client #3's feet. Client #3 gripped her right index finger, to prevent more bleeding as the med tech continued to conduct	W 454		

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W 454	Continued From page 4 the med pass. When client #3 took the last medication, the med tech was made aware of the blood on the floor. The med tech, took an alcohol swab, with bare hands and attempted to wipe up the blood, smearing it on the tile floor. The swab was then discarded in the trash can. The med tech did not clean her hands before she exited the med room behind client #3. Review on 6/21/19 of the facility's Infection Control Procedures, revised November, 2008 revealed that: a. "Procedures will be followed to prevent cross-contamination: handwashing, changing of gloves, or when performing tasks where cross contaminations occurs." b. "Employees will wash their hands after each direct personal contact for which handwashing is warranted." c. "Single, use disposal gloves when touching blood and all body fluids, nonintact skin, and mucous membranes." d. "Direct care staff will also practice good handwashing after coming into contact with body fluids." 2. The med tech did not wash or sanitize hands between patient contact, during medication administration with clients #1 and #3. a. During observation at the group home on 6/21/19 at 7:10 am, client #1 was seated in a wheelchair and was wheeled inside the med room. The med tech, touched a key to open the door, then wheeled client #1 into the med room. The med tech took a key to open the medicine cabinet and removed a basket of medications for client #1. Twelve pills were pushed from bubble packs, then placed in a pill cup and crushed. The	W 454		

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W 454	Continued From page 5 med tech removed applesauce from the refrigerator, placed the applesauce and medication into a cup. The med tech was then observed to reposition client #1 who had slouched to the right side of the chair, then fed the medication to client #1. No handwashing was observed with the med tech during the medication administration. The med tech transported client #1 from the med room at 7:26 am. b. During observation at the group home on 6/21/19 at 7:31 am, client #3 walked into the med room behind the med tech, who unlocked the door with a key. The med tech then took a key to unlock the med cabinet and removed a basket containing client #3's glucometer machine. The med tech was not observed washing her hands between contact with clients and did not wear gloves before conducting a finger stick blood test with client #3. Interview on 6/21/19 at 7:45 am with the med tech revealed that she washed her hands before starting med pass. The med tech further added that the evening shift did not stock the med room with gloves at the end of their shift and that she did not secure gloves before starting the med pass. Interview on 6/21/19 at 9:45 am with nurse A and nurse B revealed that the med tech's hands should be washed before starting med pass and also should be sanitized in between each person. Gloves should be used whenever given eye drops. nasal sprays, topical creams, applying lotions and with finger stick test. If blood spillage occurred, the med tech should get gloves, use a bleach solution, then clean the area.	W 454		