DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2019 FORM APPROVED OMB NO 0938-0391

| TAG REGULATORY OR LSC IDENTIFYING INFORMATION | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 100 | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ATE SURVEY OMPLETED | |
|--|--|--|---|---------|--|--|----------------------------|--|
| SMOKY ICF/MR GROUP HOME SMOKY ICF/MR GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE 115 STORYBOOK LANE SYLVA, NC 28779 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 115 STORYBOOK LANE SYLVA, NC 28779 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE) | | | 34G032 | B. WING | | | 06/18/2010 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X COMPLET OF COMPLET OF COMPLET OF COMPLET OF COMPLET OF CREED OF COMPLET OF CREED OF COMPLET OF CREED OF C | Control of the Control of Control | | | | 115 STORYBOOK LANE | CODE | 5/16/2019 | |
| | PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREF | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| W 340 NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by. Based on observation, interview and record review, nursing staff failed to assure adequate training to ensure preventive hygiene measures for 1 of 3 sampled clients (#1). The finding is: Observations on 6/17/19 at 4:15 PM in the group home revealed client #1 to be using a wheelchair for all activities and to have padded, open fingered gloves on both hands. Client #1 was observed propelling the wheelchair with the gloved hands throughout the afternoon, as well as having a snack, opening packages, talking on the house phone, assisting with laundry, as well as assisting in the kitchen with dinner preparation. All of these activities were completed with the gloves on. Continued observations at 6:20 PM revealed client #1 being assisted by staff B with placing eating utensils for all clients so to be defined the dinner items with the gloves on, and then removing the gloves prior to eating. Continued observation on 6/18/19 at 8:00 AM revealed client #1 being assisted by staff C with placing eating utensils for all clients except client #6, on the dining table with gloves on. Further | | Nursing services must other members of the appropriate protection measures that include training clients and shealth and hygiene in the state of the appropriate protection measures that include training clients and shealth and hygiene in the state of t | ust include implementing with the interdisciplinary team, we and preventive health de, but are not limited to staff as needed in appropriate methods. In not met as evidenced by: on, interview and record failed to assure adequate reventive hygiene measures lients (#1). The finding is: 7/19 at 4:15 PM in the group tr #1 to be using a wheelchair to have padded, open oth hands. Client #1 was the wheelchair with the shout the afternoon, as well opening packages, talking on sisting with laundry, as well then with dinner liese activities were ploves on. Continued PM revealed client #1 being ith placing eating utensils for dining table with the gloves tions at 6:30 PM revealed or utensils used by all clients ems with the gloves on, and oves prior to eating. On on 6/18/19 at 8:00 AM ing assisted by staff C with list for all clients except client | W3 | The QIDP will meet with si importance of practicing grundering all activities of daily training will specifically add handwashing and food han practices for both clients a as specifically address the remind Client #1 to remove prior to preparing, serving Evidence of this training where a MCH In-service Training see the attached document. To ensure continued imple proper hygiene practices, the and/or group home manage complete a random site ob least three times each week for all residents. This will be on the Observation Tracking (please see attached form) RECEIN JUN 2 4 DHSR NH L | taff to review ood hygiene reliving. The dress proper indling and staff as well eneed to the his gloves or eating food. It is be found on Sheet (please it). Immentation of the QIDP, AP er will servation at the for 90 days be documented in form the company of the property of the proper | | |

(X6) DATE

Executive Director

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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| | | | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--------------------|---|-------------------------------|----------------------------|
| | | 34G032 | B. WING | | 06. | /18/2019 |
| NAME OF PROVIDER OR SUPPLIER SMOKY ICF/MR GROUP HOME | | | | STREET ADDRESS, CITY, STATE, ZIP C 115 STORYBOOK LANE SYLVA, NC 28779 | ODE | 10/2013 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | I SHOULD BE | (X5) COMPLETION DATE |
| W 340 | observations from 8 #1 to assist with bre preparation with the #1 was observed pl serving utensils use eating the breakfast staff were observed remove the gloves. Review of the reconcevealed a habilitation. The HP contained a assessment dated 4 #1 was independent Interview with the quiprofessional (QIDP) client #1 prefers to vibegins to develop bl from propelling the vibad been using the interview with the Quiremoving the gloves health and hygiene, | ge 1 8:10 to 8:35 AM revealed client eakfast preparation and lunch gloves on. At 8:35 AM, client ating all breakfast items with ed by all clients and then a meal with the gloves on. No prompting the client to d for client #1 on 6/18/19 on plan (HP) dated 4/4/19. It comprehensive functional 1/3/19 which indicated client at with washing his hands. It will be a comprehensive functional 1/3/19 which indicated that wear the gloves because he isters on his hands/fingers wheelchair and indicated he gloves since 2/19. Continued 1/10 Confirmed that not a during activities related to fails to assure appropriate entive health measures for all | W 3 | 40 | | |

MCH IN-SERVICE TRAINING SIGNATURE SHEET

| Presenter(s): Pate(s) of Training: | | | | | | | | |
|---------------------------------------|-------|------|-------|--|--|--|--|--|
| Name | | | | | | | | |
| Name | Title | Name | Title | | | | | |
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By signing this form, I agree that I have attended this training class in its entirety. The information was presented in a language I understand and I had the opportunity to ask questions of the trainer.

HYGIENE MONITORING

| SIGNATURE OF QIDP, AP OR GROUP HOME MANAGER | | | | | |
|--|--|--|--|--|--|
| DID CLIENT #1 REMOVE GLOVES PRIOR TO MEAL PREP, SERVING AND/OR EATING? (yes or no) | | | | | |
| DID HANDWASHING OCCUR PRIOR TO MEAL PREP, SERVING AND EATING? (yes or no) | | | | | |
| CLIENTS OBSERVED | | | | | |
| DATE | | | | | |