PRINTED: 08/18/2019 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLETED	
		34G105	B. WING _			08/07/2019
NAME OF PROVIDER OR SUPPLIER 23RD STREET HOME			STREET ADDRESS, CITY, STATE, Z 804 EAST 23RD STREET NEWTON, NC 28658	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED		
E 015	CFR(s): 483.475(b)([(b) Policies and prodevelop and implem policies and proceduplan set forth in para assessment at paragand the communicat this section. The policies address the following: (1) The provision of and patients whether place, include, but a (i) Food, water, med supplies (ii) Alternate sources following: (A) Temperatures safety and for the sarprovisions. (B) Emergency light (C) Fire detections systems. (D) Sewage and water of the following are thospice-operated in the policies and procedution of the policies and profollowing: (iii) The provision of hospice employees a evacuate or shelter ilimited to the following:	cedures. [Facilities] must ent emergency preparedness ares, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ion plan at paragraph (c) of acies and procedures must be ed at least annually.] At a as and procedures must g: subsistence needs for staff ar they evacuate or shelter in are not limited to the following: ical and pharmaceutical as of energy to maintain the to protect patient health and afe and sanitary storage of thting. a extinguishing, and alarm avaste disposal. ice at §418.113(b)(6)(iii):] ares. a additional requirements for coatient care facilities only, cedures must address the subsistence needs for and patients, whether they an place, include, but are not	E	015		
100017001		/CLIDDLIED DEDDECENTATIVE'S SIGNATUR		TITLE		(Y6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DAT

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G105	B. WING		08/07/2019	
NAME OF PROVIDER OR SUPPLIER 23RD STREET HOME			8	STREET ADDRESS, CITY, STATE, ZIP CODE 804 EAST 23RD STREET NEWTON, NC 28658	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
E 015	following: (1) Temperatural and safety and for to of provisions. (2) Emergency (3) Fire detectionsystems. (C) Sewage and This STANDARD is Based on observation of subsistic clients and staff as emergency prepare provision of subsistic clients and staff as emergency plan (Elements). Observations conducted by immanager, revealed consisting of two gadrinking water was observations conducted on skiff and available supply bottles of water. Review of the facility conducted on 8/6/19 qualified intellectual (QIDP) on 8/7/19, remaintain a supply operson per day for the group home managoverified the facility's	rces of energy to maintain the res to protect patient health he safe and sanitary storage r lighting. on, extinguishing, and alarm waste disposal. s not met as evidenced by: ion, record review and r failed to implement the dness policy relative to the ence water supply needs for required in the facility's P). The finding is: ucted in the group home on interview with the group home an emergency water supply fullons plus 12-8 oz. bottles of available in the home. Further cted in the group home on the bottles of drinking water r water supply were utilized by g lunches for the day, leaving of two gallons plus 9-8 oz. y's emergency plan (EP), 9, verified by interview with the I disabilities professional evealed the facility should f one gallon of water for each three days. Interview with the er, conducted on 8/6/19,	E 015			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		34G105	B. WING		08/07/2019	
NAME OF PROVIDER OR SUPPLIER 23RD STREET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 804 EAST 23RD STREET NEWTON, NC 28658		, 33.31.20.3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
E 015 W 331	needs of the 6 client	s residing in the home as well f assigned to the home over a	E 0			
	CFR(s): 483.460(c)	vide clients with nursing				
	Based on observati interview, the facility services in accordar sampled clients (#1) (#5) relative to traini	not met as evidenced by: ons, record review and failed to provide nursing nce with the needs of 1 of 3 and 1 non-sampled client ng staff in client participation on administration process.				
	A. The facility failed accordance with the	to provide nursing services in needs of client #1.				
	revealed client #1 er administration area a included: Aspirin 81 to 1 tablet; Levetorace: Nifedipine 30 mg - 1 units- 1 tablet. Cont staff D to administer client #1 with no information purpose or possible received. Further of retrieve client #1's medications from a limited included in the staff D to administer client #1 with no information in the staff D to administer client #1 with no information in the staff D to administer client #1 medications from a lient product of the staff D to administration in the staff D to admi	cted on 8/7/19 at 7:10 AM ntered the medication and received medications that mg- 1 tablet; Ezetimibe 10mg- ta 250mg- 1/2 tablet; tablet and Vitamin D3 2000 inued observations revealed medications and to provide ormation related to the name, side effects of medications oservation revealed staff D to nedications, punch out pubble pack, mix medications feed client #1 all medications cup.				

, ,		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G105	B. WING		08/07/2019	
NAME OF PROVIDER OR SUPPLIER 23RD STREET HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 804 EAST 23RD STREET NEWTON, NC 28658	,	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
W 331	an individual service Review of the ISP is evaluation dated 1/punches out medice swallows pills whole trash appropriately administration reconserview for client #1 inventory (ABI) asseturther verified client place a pill in mouth with independence Interview on 8/7/19 facility qualified interprofessional (QIDP provide training to a	for client #1 on 8/7/19 revealed be plan (ISP) dated 1/22/19. The revealed a medication 16/19 that indicated client #1 ations with supervision, the equation of the revealed an adaptive behavior revealed an adaptive behavior revealed an adaptive behavior ressment dated 4/23/18 that the medication of the revealed an adaptive behavior revealed an adaptive behavior ressment dated 4/23/18 that the mathematical state of the revealed and the repealed of the revealed and the revealed all staff should clients during medication ive to the name, purpose and	W 33	.1		
	accordance with the Observations cond revealed client #5 to administration area included Amitiza 24 800mg- 1 tablet; Latablet. Continued of to administer medic provide no education possible side effect Staff D was observing wanted to help punitive revealed to help punitive staff D was observing the staff D was observed to help punitive the staff D was observed to help pun	d to provide nursing services in e needs of client #5. ucted on 8/7/19 at 8:00 AM o enter the medication and receive medications that a mcg - 1 capsule; Gabapentin amotrigine 25 mg - 2 tablets; 1 tablet; Thermotabs buffered and Vitamin D3, 2000 unit- 1 observations revealed staff D cations to client #5 and to on related to the purpose or is of medications received. ed to ask client #5 if the client ch out medications. Following client #5, staff D retrieved				

	TEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		34G105	B. WING			08/	07/2019
NAME OF PROVIDER OR SUPPLIER 23RD STREET HOME			STREET ADDRESS 804 EAST 23RD S NEWTON, NC				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD E S-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 369	bubble pack into a m medications to the cli observed to hand clie by staff. Client #5 wa medications followed Review of records for an ISP dated 12/18/1 client #5 revealed a r 12/13/18 that identified medications with han pills whole, obtains of appropriately. Interview on 8/7/19 w QIDP verified all staff clients during medications and purpose and so DRUG ADMINISTRA CFR(s): 483.460(k)(2) The system for drug at that all drugs, including self-administered, are self-administered, are self-administered client (# medications without expected client #5 to administration area at that included: Amitization area at the included: Amitization area and the included	d out medications from a ed cup and handed ent #5. Staff D was further ent #5 a cup of water poured as then observed to take by water. I client #5 on 8/7/19 revealed 8. Further record review for medication evaluation dated ed client #5 punches out dover assistance, swallows with the facility nurse and f should provide training to diministration relative to the side effects of medication. TION 2) administration must assure ing those that are e administered without error. Inot met as evidenced by: Inot, record review and failed to ensure 1 #5) was administered error. The finding is: Itted on 8/7/19 at 8:00 AM enter the medication and to receive medications	W				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		34G105	B. WING		,	08/07/2019
NAME OF PROVIDER OR SUPPLIER 23RD STREET HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 804 EAST 23RD STREET NEWTON, NC 28658			1 00.01.2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
W 369	Calc 500 mg-1 tablet tab - 1 tablet; Vitamin Continued observation administer medication with no information repossible side effects Staff D was observed wanted to help punct followed by no responsible was then observed the out medications from the cup and hand medications was further observed water poured by staff revealed client #5 to by water. Review of records of revealed physician of 5/20/19. Review of the revealed medications (1), Gabapentin 800 (2), Levothyroxin 100 (2), Levothyr	exin 100 mcg - 1 tablet; OYS it; Thermotabs buffered salt in D3, 2000 unit- 1 tablet. In D4 is and to provide client #5 Is alted to the purpose or Is of medications received. It to ask client #5 if the client In Out medications which was Inse from client #5. Staff D Is or retrieve medications, punch In a bubble pack into a med In a bubble pack into a med In a to hand client #5 a cup of It to hand client #5 a cup of It to hand client #5 a cup of It to hand client #5 dated In 8/7/19 for client #5 Irders for client #5	W 36	59		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		34G105	B. WING _			08/07/2019
NAME OF PROVIDER OR SUPPLIER 23RD STREET HOME		•	STREET ADDRESS, CITY, STATE, ZIP CODE 804 EAST 23RD STREET NEWTON, NC 28658	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 371	that clients are tauglimedications if the in determines that selfis an appropriate obdoes not specify oth. This STANDARD is Based on observati interview, the facility for drug administrati participate in medical provided training reliand side-effects of in 1 of 3 sampled client client (#5). The find A. The system for drassure client #1 was participate in medical provided training reliand side-effects of in Observations condurevealed client #1 eradministration area included; Aspirin 811 tablet; Levetorace Nifedipine 30 mg - 1 units- 1 tablet. Contistaff D to administer client #1 with no information of the purpose or possible received. Further of retrieve client #1's medical provided the contistance of the continuation of the continuatio	administration must assure nt to administer their own terdisciplinary team administration of medications jective, and if the physician erwise. not met as evidenced by: ons, record review and failed to assure the system on provided the opportunity to ation self-administration or ated to the name, purpose nedications administered for ts (#1) and 1 non-sampled	W3	71		

34G105 B. WING 08/	07/2019	
NAME OF PROVIDER OR SUPPLIER 23RD STREET HOME STREET ADDRESS, CITY, STATE, ZIP CODE 804 EAST 23RD STREET NEWTON, NC 28658	, 33.6.7.23.13	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
with apple sauce, to feed client #1 and throw away the cup. Review of records for client #1 on 8/7/19 revealed an individual service plan (ISP) dated 1/22/19. Review of the ISP revealed a medication evaluation dated 1/16/19 that indicated client #1 punches out medications with supervision, swallows pills whole, obtains own drink, disposes trash appropriately and signs the medication administration record (MAR). Continued record review for client #1 revealed an adaptive behavior inventory (ABI) assessment dated 4/23/18 that further verified client #1 is able to dispense pills, place a pill in mouth and drink water from a cup with independence. Interview on 8/7/19 with the facility nurse and qualified intellectual disabilities professional (QIDP) verified all clients should be provided the opportunity to participate in their medication administration at the skill level that each client is capable. Further interview with QIDP on 8/7/19 verified client #1 is capable of participation in medication administration with at least hand over hand assistance during most tasks. B. 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. For example: Observations conducted on 8/7/19 at 8:00 AM revealed client #5 to enter the medication administration area and receive medications including Amitiza 24 mag -1 capsule; Gabapentin		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G105	B. WING		08/07/2019
NAME OF PROVIDER OR SUPPLIER 23RD STREET HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 804 EAST 23RD STREET NEWTON, NC 28658		,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
W 371	Continued observat administer medicati no education related side effects of medio observed to ask click help punch out medications, punch bubble pack into a response from clien medications to the cobserved to hand click by staff. Client #5 with medications followers. Review of records from ISP dated 12/18. Client #5 revealed as 12/13/18 that identifications with hapills whole, obtains appropriately. Interview on 8/7/19 QIDP verified all click opportunity to partical administration at the capable. Further in client #5 is capable	itamin D3, 2000 unit- 1 tablet. ions revealed staff D to ons to client #5 and to provide d to the purpose or possible cations received. Staff D was ent #5 if the client wanted to lications. Following no t #5, staff D retrieved ed out medications from a med cup and handed client #5 a cup of water poured vas then observed to take d by water. or client #5 on 8/7/19 revealed /18. Further record review for medication evaluation dated fied client #5 punches out and over assistance, swallows own drink and disposes trash with the facility nurse and ents should be provided the sipate in their medication e skill level that each client is terview with QIDP verified of participation in medication at least hand over hand	W 371		