STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G043	A. BUILDING _____ B. WING _____	08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ERWIN AVENUE HOME	100 ERWIN AVENUE ERWIN, NC 28339

(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	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) 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. This STANDARD is not met as evidenced by: Based on observation, record review and confirmed by interviews with staff the facility failed to develop formal training for 1 of 3 audit clients (#6) to address desensitization before dental procedures and inappropriate behaviors. The findings include: 1. Client #6's interdisciplinary team failed to consider training to address desensitization to help decrease her defensiveness during dental procedures. Review on 8/28/19 of client #6's dental record revealed she was seen by the Dentist on 7/19/19 and that she could not be examined because she would not tolerate having her mouth opened to examine her teeth. Further review revealed a physician order dated 6/27/19 to give Ativan 2 mg. by mouth 3 hours before dental procedures. Review on 8/29/19 of client #6's individual program plan (IPP) dated 3/27/19 revealed a toothbrushing program to brush her teeth 50% accuracy for 6 consecutive months that was implemented on 4/15/19. review on 8/29/19 of a progress summary dated 8/15/19 revealed " Two month decline in progress. Staff state she has been refusing to assist . Will discuss with team for recommendations due to recent dental exam.	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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" Her progress for the month of July was noted at 27%.

Interview on 8/29/19 with the behavior specialist confirmed client #6 has not been considered for desensitization training to decrease her defensiveness to dental treatment.

2. Client #6's interdisciplinary team failed to consider training to address her inappropriate behaviors of grabbing and hugging others.

During observations on 8/28/19 at 4:15pm client #6 grabbed direct care staff on the arm and hugged her arm repeatedly refusing to let go. Several times staff told her, "[client #6] Release, Release me arm, let go." After ward client #6 repeatedly grabbed the surveyor and would not release her arm.

During observations on 8/29/19 during the medication administration pass at 7:17am, client #6 repeatedly grabbed direct care staff who was trying to administer medications and would not release her arm.

Review on 8/29/19 of client #6's individual program plan (IPP) dated 3/27/19 revealed, "[Client #6] is prone to grabbing/hugging others and initially resists attempts to release her hold. Her persistent hugging is reported to have an obsessive/compulsive component." Further review of the IPP did not reveal a behavior support program (BSP).

Review on 8/29/19 of client #6's Psychological evaluation dated 3/27/19 revealed, " Values paper and reported likes having magazines from which she tears pages to arrange on her bed. She has

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W 227	Continued From page 2 been prone to obsessing search for magazines when she does not have one. She is prone to grabbing/hugging others and initially resists attempts to release her hold. Her persistent hugging is reported to have an obsessive/compulsive component." there were not recommendations in the Psychological evaluation to address these behaviors with a formal training program. Interview on 8/29/19 with the behavior support specialist confirmed client #6 has been noted to grab staff and that they have been instructed to tell her to release their arms from her grasp or to offer a handshake as a replacement. Further interview confirmed these behaviors are not currently addressed by a behavior support program (BSP).	W 227		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure written informed consent was obtained from the guardian for a restrictive Behavior Support Plans (BSP). This affected 1 of 3 audit clients (#4). The finding is: Written informed consent was not obtained for a restrictive BSP for client #4. Review on 8/28/19 of client #4's individual	W 263		

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W 263	Continued From page 3 program plan (IPP) dated 2/20/19 revealed she has target behaviors of Obsessive compulsive behaviors and severe disruption. Further review of the IPP revealed client #4 has been adjudicated incompetent and appointed a guardian of the person. Client #4's target behaviors are addressed by a BSP dated 11/20/18. Verbal consent was obtained by the guardian on 2/25/19. This program incorporates the use of Haldol 2mg., Latuda 40 mg. and Latuda 60 mg., Ativan 0.5 mg. and Cogentin 2 mg. Interview on 8/29/19 with the qualified intellectual disabilities professional (QIDP) and the behavior specialist revealed the team has not obtained written informed consent from client #4's legal guardian for the BSP dated 11/20/18.	W 263		
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. This STANDARD is not met as evidenced by: Based on observations and confirmed with record reviews and interviews, the facility failed to assure all medications were given as ordered. This affected 2 of 6 clients residing in the facility (#2, #6). The findings include: 1. Staff did not administer client #6's Polyethylene Glycol(Miralax) as ordered by the Physician. During observations of the medication administration pass on 8/29/19 at 7:17am direct	W 369		

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care staff administered Senna 8.6 mg. (2), Omeprazole 20 mg. (1) and Tegretol 200 mg. (1). Staff explained client #6 was ordered Polyethylene Glycol (Miralax) 17 grams to be given at 8am, however the bottle was empty.

Interview on 8/29/19 after the medication pass the direct care staff administering medication stated that medications are to be re ordered three days before the last dose. However, she indicated this was not done and she would have to contact Nursing later in the morning to reorder the Miralax. Further interview conformed staff are trained to administer medications an hour before or an hour after the physician ordered time.

Interview on 8/29/19 with a facility nurse confirmed client #6 is ordered Polyethylene Glycol (Miralax) 17 grams to be given at 8am. She confirmed medications are to be given an hour before or an hour after the physician ordered time. Further interview confirmed there was not a physician's order to cover the delayed time in administration.

2. Direct Care staff did not apply Lotrisone cream to client #2's feet.

During observations of the medication administration pass on 8/29/19 at 7:47am direct care staff administered to client #2 the following: Periactin 2mg. (1/2) Depakote 250 mg. (1), Depakote 500 mg. (1), Lactulose 15 ml., Lamictal 25 mg. (4), Synthroid 75mcg. (1), Oscal 500 mg. 91), Miralax 17 grams and Zantac 150 mg. (1). Staff explained client #2 is ordered Lotrisone cream to be applied to her feet twice daily at 8am and 8pm. She explained she was wearing compression stockings on both legs and that she

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W 369	Continued From page 5 had forgotten to apply the cream to her feet before she put on the compression stockings. During observations on 8/29/19 staff began preparing client #2 to leave for a dental appointment out of town at 8:05am and she departed with staff at 8:10am without receiving the Lotrisone cream to her feet. Interview on 8/29/19 with the facility nurse confirmed client #2 is ordered Lotrisone cream to her feet twice daily at 8am and 8pm for dry skin on her feet. Further interview confirmed medications are to be given an hour before or an hour after the physician ordered time. Further interview confirmed there was not a physician's order to cover the delayed time in administration.	W 369		