STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G023	A. BUILDING _____ B. WING _____	09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PITT CO GROUP HOME #1	6570 FAIRWAY DRIVE GRIFTON, NC 28530

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure privacy was provided for 1 of 3 audit clients (#2). The finding is: Client #2 was not afforded privacy while toileting. During observations in the home on 9/10/19 at 5:49pm, client #2 was observed sitting on the toilet, pants down, with the bathroom door open. During the time client #2 was sitting on the toilet, two staff and a housemate passed by the opened bathroom door. At no time was the client prompted to close the door. Review on 9/10/19 of client #2's IPP dated 5/17/19 revealed that Client #2 "needs prompting with closing the door." Further review of the IPP indicated that client #2 is supported with a service goal for bathroom guidelines. These guidelines state that when staff observe client #2 going to the bathroom, staff are to follow him and will remind him if needed to close the door. Interview on 9/11/19 with Staff A revealed that client #2 should be prompted to close the bathroom door for privacy. Staff A revealed they cannot always catch client #2 when he goes to the bathroom. However, if they see him in the bathroom with the door open, he should be prompted to close the door.	W 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 130	Continued From page 1 Interview on 9/11/19 with the Executive Director (ED) revealed that staff should be following the bathroom guidelines to ensure client #2 is allowed privacy when he is in the bathroom.	W 130		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the Individual Program Plan (IPP) for 2 of 3 audit clients (#2, #6) included information to support their independence with using assistive devices. The findings are: 1. Client #6's IPP did not include specific information regarding the use of an assistive pouring device. During 2 of 2 observations in the home on 9/10/19 and 9/11/19, client #6 utilized a device positioned on the edge of his glass which beeped, altering him to stop pouring his drink once his glass was full. Interview on 9/11/19 with Staff A revealed the device alerts client #6 when his glass is full while pouring his drinks. Additional interview with Staff C indicated the device was not utilized with the client at the day program. Review on 9/11/19 of client #6's IPP dated	W 240		

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W 240	Continued From page 2	W 240		

4/25/19 revealed he has "Advanced Glaucoma". Additional review of the plan noted, "On 8/21/18 [Client #6] was referred to Occupational Therapist for evaluation of self-feeding due to visual deficits. Suggestions for assistive devices and techniques to increase independence in self-feeding were requested as he is requiring increased assistance as his eyes worsen." Further review of the plan did not include specific information regarding the use of an assistive pouring device.

Interview on 9/11/19 with the Executive Director (ED) confirmed client #6 utilizes the device to assist with his pouring. The ED acknowledged specific information regarding the device needs to be included in the client's IPP.

2. Client #2's IPP did not include specific information regarding the use of his hearing aids.

During observations in the home on 9/10/19 at 4:35pm, client #2 exited the bathroom after taking his shower. After getting dressed, he did not have his hearing aids in his ears. Throughout the evening observations until 6:15pm, client #2 was observed walking up to staff while staff were conversing with him, moving the chair in the living room closer to the TV while watching it, and participating in family style dining with his peers and staff. At no point was client #2 prompted to wear his hearing aids.

Interview on 9/11/19 with Staff A revealed that client #2 wears his hearing aids at the day program but staff in the home are "more lenient in the evenings because they know he gets tired of having to wear them and because they can hand

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W 240	Continued From page 3 signal to him." In addition, Staff A states he wears them in public for safety reasons. Review on 9/11/19 of client #2's IPP dated 5/17/19 revealed that his hearing was evaluated on 9/22/15 and he has moderately-severe hearing loss bilaterally. Due to his hearing loss and the use of bilateral hearing aids, staff should talk to client #2 at a close distance and in a tone that he can hear. In addition, a service goal for the hearing aids state "[Client #2] is eager to wear the hearing aids" and "he has learned to remove his hearing aids properly." Further review of the IPP did not include specific information regarding when client #2 should be wearing his hearing aids. Interview on 9/11/19 with the ED confirmed client #2 should be wearing his hearing aids "pretty much all the time, especially if he is doing something like watching TV." The ED acknowledged that specific information regarding when client #2 should be wearing his hearing aids should be included in the IPP or a protocol.	W 240		
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.	W 249		

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W 249	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure client #6 received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of implementation of vision guidelines. This affected 1 of 3 audit clients. The finding is: Client #6's vision guidelines were not consistently implemented. During lunch observations at the day program on 9/10/19 at 12:27pm, client #6 ate his lunch using a regular plate with a plate guard attached and a dycem mat underneath. He was also provided with paper cups for his three drinks and white plastic utensils. During the meal, Staff C sat nearby and provided verbal prompts to assist the client with eating. During dinner and breakfast observations in the home on 9/10/19 and 9/11/19, client #6 consumed his lunch using a regular white plate with attached plate guard and a bright red placemat with a dycem underneath. The client's cups were clear and showed each colored beverage. Interview on 9/11/19 with Staff C revealed client #6 only uses a plate guard and dycem mat to assist him with eating at the meal. The staff indicated no additional devices were utilized at the client's meals. Interview on 9/11/19 with Staff A revealed client #6's vision has worsened in recent months causing him not to see items very well. Additional interview indicated they have been using the	W 249		

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W 249	Continued From page 5 bright red placemat in the home to allow him to see his plate better and clear cups to see his drinks. Review on 9/10/19 of client #6's IPP dated 4/25/19 revealed he has "Advanced Glaucoma". Additional review indicated, "He should use a plate with raised side or plate guard to prevent spillage and a Dycem. It is also recommended that he use multi-colored plates and cups to help with differentiation." Interview on 9/11/19 with the Executive Director (ED) confirmed staff should be consistently using suggested items at meals to assist client #6 with his vision issues.	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. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure all medications were administered without error. This affected 1 of 3 clients (#2) observed receiving medications. The finding is: Client #2 did not receive his Miralax as ordered. During observations of medication administration in the home on 9/11/19 at 6:46am, Staff B poured an undetermined amount of Miralax powder into the bottle cap from the Miralax bottle. Closer observation of the powder inside of the bottle cap	W 369		

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W 369	Continued From page 6 revealed enough to cover the bottom surface of the bottle cap. The staff mixed the powder in 8 ounces of water and presented it to client #2. During an interview on 9/11/19, when asked how much Miralax was poured into the bottle cap, Staff B replied, "About an ounce." Review on 9/11/19 of client #2's physician's orders dated 8/29/19 revealed an order for "Miralax, 1 scoop, 8 oz H20 (package directions) QOD..." Interview via cell phone on 9/11/19 with the facility's nurse revealed one scoop would generally equal one dose which would mean filling the Miralax bottle cap to the line identified on the inside of the cap. The nurse indicated they may need to clarify the order to specify the meaning of "a scoop".	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 and interviews, the facility failed to ensure the potential for cross-contamination was prevented. This potentially affected all clients residing in the home. The finding is: Potential for cross-contamination was not prevented. During observations in the home on 9/11/19 at	W 454		

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W 454	Continued From page 7 6:20am, staff A was observed assisting two of the residents with preparing breakfast. Staff A was observed to open a package of raw sausage links, and remove several of the links with her bare hands and place them on a pan. She touched several surfaces and items in the kitchen with her hands (cabinets, counters, tongs). She looked at one of the residents and told him "You didn't brush your hair this morning." She proceeded to take her hand and brush his hair down. Staff A then picked up the remaining sausage links and placed them on the pan. At no time did Staff A wash her hands. Interview on 9/11/19 with Staff A revealed that when handling foods and during meal preparation, staff and residents are to wash and dry their hands thoroughly. Interview on 9/11/19 with the Executive Director (ED) revealed that she did not believe that formal training with staff on handling food/raw meats and hand washing had occurred. However, the ED stated that it is the expectation that staff are to wash their hands when handling foods and during meal preparation.	W 454		