STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G151	A. BUILDING _____ B. WING _____	09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NO PLACE LIKE HOME	4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306

(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 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain a recordkeeping system that accurately reflected 2 of 4 audit clients (#2, #5). The findings are: Client #2 and Client #5's records were not maintained with correct information. a. Review of client #2's record revealed an objective plan for folding towels. In the objective statement, another client's name is used. Interview on 9/17/19 with the qualified intellectual disabilities professional (QIDP) confirmed this is a "clerical error" and another client's name should not have been in client #2's record. b. Review of client #5's record revealed she is supported with a Behavior Intervention Plan (BIP). Throughout the BIP, it refers to "he" and "him." Interview on 9/17/19 with the qualified intellectual disabilities professional (QIDP) confirmed this is a "clerical error" and another client's name should not have been in client #5's record.	W 111		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has	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	W 249		

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 review and interview, the facility failed to ensure 1 of 4 audit clients (#5) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the area of client supports. The finding is:

Client #5's behavior intervention plan (BIP) was not implemented.

During observations in the day program and home on 9/16/19 and 9/17/19, client #5 was observed to be sitting with her head in her hands looking away. Further observations also revealed client #5 having episodes of crying. Throughout the observations, staff were observed to provide client #5 with one-on-one attention or by giving her their personal cell phone to look at videos or listen to music on.

Review on 9/17/19 of client #5's IPP dated 1/10/19 revealed that client #5 exhibits behaviors. She will have outbursts that include crying.

Review on 9/17/19 of client #5's record revealed a BIP dated 10/31/16 (reviewed on 1/10/19). Review of the BIP revealed that client #5 should

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W 249	Continued From page 2 be provided with one-on-one attention when she has done something positive. The BIP revealed that client #5 has a identified behavior of verbal aggression (profanity, screaming, yelling, etc.). When she displays this behavior, staff are to say "[Client #5], please stop." If she does not stop, staff are to repeat the request. If the behavior continues, staff are to ask her to go to her bedroom. Interview with the qualified intellectual disabilities professional (QIDP) on 9/17/19 revealed that client #5 does exhibit verbal aggression. According to the QIDP, the "etc" as stated in the BIP refers to client #5 hiding her face and crying. The QIDP confirmed that staff did not follow the strategies as outlined in the BIP by providing client #5 with one-on-one attention for this behavior as well as giving her the cell phone.	W 249		
W 420	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(iv) The facility must provide each client with functional furniture, appropriate to the clients needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure functional furniture for the facility. This potentially affected all clients. The finding is: The couch and one bed were not functional or comfortable. During observations on 9/16 and 9/17/19, the couch was observed to have a sunken in end. The bed for client #4 had the head lower than the	W 420		

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W 420	Continued From page 3 feet and had movement in the frame. Review on 9/16/19 of #4's record did not reveal any reason why his head should be lower than his feet. Interview on 9/16/19 with a non-audit individual indicated he did not like to sit on the couch because he would sink into the one end. Interview on 9/17/19 with the director confirmed she was aware they needed a new couch but was not aware of client #4's bed issue.	W 420		