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W 000	INITIAL COMMENTS Intake #NC 00154455 allegations were unsubstantiated; however, unrelated non-compliance, W227, W331 and W340, were cited on 9/12/19.	W 000		
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 record reviews and interviews the team failed to ensure the individual habilitation plan (IHP) for 1 of 6 clients (#1) included objectives to meet identified needs relative to non-compliance behaviors. The finding is: Interview during the 9/12/19 complaint survey with the qualified intellectual disabilities professional (QIDP) revealed client #1 to have needs relative to non-compliance. Continued interview with the QIDP revealed client #1 falls on his knees or to the ground as a gesture of refusal or noncompliance at various times such as when requested to participate in his daily living activities, doing chores, walking to the mailbox, or going on outings or at other times, especially outside of the group home. Interview with Staff A on 9/12/19 at 1:30 PM revealed client #1 falls approximately one time monthly onto his knees or to the floor when he does not want to do chores, go on outings or	W 227		

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

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W 227	Continued From page 1	W 227		

attend to his daily living tasks and goals. Continued interview with Staff A revealed staff does not have any set interventions in place to help client #1 when he exhibits this behavior. Subsequent interview with Staff A revealed staffs only intervention for falling behavior of client #1 was to wrap their arms around the client's arm and pull him to a standing position after he falls to the ground. However, per Staff A and verified by the QIDP, all staff members were retrained on 7/10/19 and instructed not wrap their arms around client #1 to lift him off the ground after he drops, but to offer their hand instead to assist client #1 to stand up. Subsequent interview with Staff A on 9/12/19 confirmed the change in how staff helps client #1 to stand up after a fall was a result of client #1 sustaining a bruised left arm on 7/9/19 when assisted by a staff member who pulled client #1 up by his arm to a standing position.

Review of records for client #1 on 9/12/19 revealed an individual habilitation plan (IHP) dated 4/11/19 which included a behavior support plan (BSP) dated 1/31/19. Review of the BSP on 9/12/19 revealed target behaviors of aggression, property destruction, self- injury such as hitting or biting, or agitation such as yelling or repetitive speech. Continued review of the BSP revealed preventative and interactive techniques to provide knowledge and guidelines for staff to follow in assisting client #1 in training surrounding the identified needs/behaviors. Further review of client #1's IHP revealed no goal to address needs regarding non-compliance and injury that client #1 sustains at times by falling on his knees as a result of his noncompliance. Subsequent record review also revealed there was no consistent documentation of client #1's falls over the past 6

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W 227	Continued From page 2 months. Interview with the QIDP on 9/12/19 confirmed client #1 needs a thorough assessment of his monthly "falling" connected to non-compliance and the addition of an active treatment program to address client #1's non-compliance.	W 227		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure 1 of 6 clients (#1) reported to have sustained recent left arm bruises had documentation of nursing assessments, all treatments used, and client progression in his record. The finding is: Observations at the group home on 9/12/19 at 12:15 PM revealed all 6 clients had returned from a grocery shopping trip with staff C & E. Further observations at 12:20 PM revealed all 6 clients, which included client #1, exited the van with no ambulation/mobility difficulties or problems carrying plastic grocery bags of purchased items into the kitchen area of the home. Continued observations from 12:25 PM to 1:45 PM revealed client #1 engaged in various activities as he moved throughout the home with no episodes of falling. Ongoing observations on 9/12/19 throughout the complaint survey revealed client #1 did not use any assistive devices to ambulate. Additional observation on 9/12/19 of client #1	W 331		

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W 331	Continued From page 3	W 331		

revealed the client to wear jersey shorts with a short-sleeved T-shirt. There was no visible bruising, swelling or area(s) of visible physical injury observed on the client. Subsequent observations of client #1 from 4:30 PM to 4:40 PM revealed client #1's arms and legs were free from scratches, bruises or apparent injuries and he had sustained no episodes of falling.

Review on 9/12/19 of facility internal reports revealed an incident/accident report dated 7/9/19 noting staff C & M had observed bruises on client #1's left arm. Continued review revealed staff notified facility management and management instructed staff to immediately take client #1 to Wake Forest Baptist Health emergency department (ED), which occurred at 8:30 PM. Further review revealed while client #1 immediately received an x-ray at the hospital ED, and was seen by an ED physician, no injury/medical problem was found or noted. Subsequent review revealed client #1 was released from the ED on 7/9/19 and arrived back to the group home at 11:44 PM with written discharge instructions to follow up with his primary care physician (PCP).

Review on 9/12/19 of client #1's individual habilitation plan (IHP) dated 4/11/19 revealed he was admitted 1/4/19. Continued review of client #1's IHP and verified by the qualified intellectual disabilities professional (QIDP), revealed a Wake Forest Baptist Health encounter report dated 7/9/19. Further review of the 7/9/19 report for client #1 revealed a diagnosis of "left upper arm pain" and "traumatic ecchymosis of left upper arm." Subsequent review of the 7/9/19 report for client #1 revealed "XR Humerus Left" imaging tests.

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W 331	Continued From page 4 Ongoing review on 9/12/19 of client #1's IHP revealed a Novant Health encounter report dated 7/14/19. Continued review of the 7/14/19 report revealed a diagnosis of "Contusion of left elbow" and imaging tests for "XR Humerus Min 2 view Left" and "XR Wrist 2 views left." Further review on 9/12/19 of client #1's IHP and verified by the QIDP, revealed a follow up medical consult report dated 7/19/19 for client #1's left arm. Continued review of client #1's 7/19/19 medical consult report revealed physician findings of continuous left arm swelling. Subsequent review of client #1's 7/19/19 medical consult revealed labs were done, and a venous Doppler to rule out deep vein thrombosis was ordered. Subsequent review of client #1's IHP revealed a medical consult report dated 7/31/19 which noted an ultrasound of the left arm was performed on 7/31/19 and results would be forwarded to client #1's PCP that day. Consequently, while no results or documentation of client #1's 7/31/19 ultrasound was found or provided on 9/12/19. Interview the QIDP confirmed client #1's PCP did promptly receive the ultrasound results and rendered needed care. Ongoing reviews on 9/12/19 of client #1's IHP revealed no nursing progress notes were found or provided regarding client #1's 7/9/19 left arm bruises. further review revealed no progress notes regarding client #1's 7/14/19 and 7/19/19 hospital visits for his left arm swelling and bruising. Further review of client #1's IHP revealed recent nursing documentation dated 7/31/19 for client #1's quarterly nursing assessment.	W 331		

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Interview conducted over the phone with the facility nurse on 9/12/19 and verified by the QIDP, confirmed staff had notified the nurse on 7/9/19 of client #1's left arm bruises. Continued interview confirmed the facility nurse had informed staff to transport client #1 to the local emergency department (ED) for immediate medical attention. The facility nurse further revealed while client #1 was treated on 7/9/19 at the local ED and released back to the home on 7/9/19, she did not perform or conduct any follow-up nursing assessment or documentation regarding client #1 until 7/31/19, for the quarterly nursing assessment.

Subsequent interview with the facility nurse also revealed she did not need to do any nursing documentation regarding client #1's 7/9/19 left arm bruises because client #1 had received immediate ED treatment on 7/9/19. The facility nurse additionally revealed that ED physician treatment supersedes her nursing oversight responsibility and therefore eliminated the need for her to do any nursing documentation of the 7/9/19 ED visit. Subsequent interviews also revealed the facility nurse had not documented client #1's progression regarding his 7/14/19 hospital treatment nor his 7/19/19 follow-up medical consult.

Continued interview with the facility nurse revealed while staff have verbally informed her of client #1's intermittent unsteady gait and falls, she however has deferred client #1's unsteady gait and issues with balance to the PCP and the QIDP to address. Interview with the QIDP on 9/12/19 confirmed the facility must provide clients with nursing services in accordance with their health needs. The QIDP further confirmed client #1's

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W 331	Continued From page 6 record should contain all documentation relative to nursing care, all treatments used and client progression.	W 331		
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, record review and interview, nursing services failed to assure staff were properly trained in written documentation, relative to incident/accident reports, to support appropriate client health care needs. The finding is: Observations on 9/12/19 at the group home at 12:15 PM revealed all 6 clients had returned from a grocery shopping trip with staff C & E. Further observations at 12:20 PM revealed all 6 clients, which included client #1, exited the van with no ambulation/mobility difficulties or problems carrying plastic grocery bags of purchased items into the kitchen area of the group home. Continued observations from 12:25 PM to 1:45 PM revealed client #1 engaged in various activities as he moved throughout the home with no episodes of falling. Ongoing observations on 9/12/19 throughout the complaint survey revealed client #1 did not use any assistive devices to ambulate.	W 340		

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Additional observations on 9/12/19 of client #1 revealed the client to wear jersey shorts with a short-sleeved T-shirt. There was no visible bruising, swelling or area(s) of visible physical injury observed on client #1 during observations. Subsequent observations of client #1 from 4:30 PM to 4:40 PM revealed the client's arms and legs were free from scratches, bruises or apparent injuries and he had sustained no episodes of falling.

Review on 9/12/19 of facility internal reports revealed an incident/accident report dated 7/9/19 noting Staff C & M had observed bruises on client #1's left arm. Continued review revealed staff notified facility management and management instructed staff to immediately take client #1 to Wake Forest Baptist Health for emergency medical attention, which occurred at 8:30 PM. Further review revealed client #1 immediately received an x-ray at the hospital, and was seen by a hospital physician; however, no injury/medical problem was found or noted. Subsequent review revealed client #1 was released from the hospital on 7/9/19 and arrived back to the group home at 11:44 PM with written discharge instructions to follow up with the primary care physician (PCP).

Ongoing interviews on 9/12/19 with the QIDP revealed, to ensure client #1's care, they had taken client #1 back to the hospital on 7/14/19, then to his PCP on 7/19/19, and to an ultrasound on 7/31/19. Further interview with the QIDP revealed client #1 falls on his knees or to the ground as a gesture of refusal or noncompliance at various times such as when requested to participate in his daily living activities, doing chores, walking to the mailbox, or going on

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outings or at other times, especially outside of the group home. In addition, the QIDP revealed other than client #1's 7/9/19 fall, she is unaware of any prior falls for client #1 and staff have not provided her any written documentation of client #1's falls. Interview with Staff C on 9/12/19 at 1:30 PM revealed client #1 falls approximately 1 time monthly onto his knees or to the floor when he does not want to do chores, go on outings or attend to his daily living tasks and goals.

Interviews on 9/12/19 with the facility nurse revealed staff have verbally informed her of client #1's intermittent unsteady gait and falls instead of completing written documentation, as staff did document for client #1's 7/9/19 fall. Subsequent interview with the facility nurse confirmed she did not provide staff training relative to written documentation to report client #1's falls. Further interview also revealed the facility nurse has deferred client #1's unsteady gait and balance issues to the PCP and the QIDP to address.

Interview with the QIDP confirmed nursing services should have conducted staff training on the need to complete written documentation to ensure client care needs are met.