STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G013	A. BUILDING _____ B. WING _____	09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE ICF/MR GROUP HOME	5509 DORSEY ROAD OXFORD, NC 27565

(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 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. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the individual program plan (IPP) was consistently implemented specifically around mealtime guidelines for 1 of 3 audit clients (#5). The finding is: Client #5's mealtime specifics were not consistently followed. During observations on 9/5/19 at breakfast, client #5's food was not the correct consistency and staff attempted to feed him with a left hand curved spoon from the right. His food was finely chopped but only his cereal was moistened. Review on 9/5/19 of client #5's IPP dated 7/31/19 revealed he should be allowed to feed himself with a curved spoon and should received a pureed diet. Interview on 9/5/19 with the nurse revealed client #5 had a history of aspiration and his food should therefore be pureed.	W 249	The Qp will inservice staff on each person's supported adaptive equipment and diet consistency per physician orders. The clinical team will monitor to ensure adaptive equipment and diet consistencies are implemented as prescribed though Mealtime Assessments completed at least 2 times per week for the next 30 days and then on a routine basis. In the future the QP will ensure staff consistently implement each person supported PCP including their mealtime guidelines. RECEIVED SEP 12 2019 DHSR-MH Licensure Sect	11/03/19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G013	A. BUILDING _____ B. WING _____	09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE ICF/MR GROUP HOME	5508 DORSEY ROAD OXFORD, NC 27565

(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 249	Continued From page 1 Interview on 9/5/19 with the qualified intellectual disabilities professional (QIDP) confirmed his food should have been pureed in consistency.	W 249		

RHA Health Services, LLC
2527 E. Lyon Station Rd
Creedmoor, NC 27522
Phone: 919-528-2558
Fax: 919-528-2971

FAX TRANSMISSION

CONFIDENTIAL HEALTH INFORMATION ENCLOSED

To:	Joy Alfred	**Fax:**	919-715-8078
From:	Morris Thomas	**Date:**	09/11/19
Re:		**Pages:**	6 (Including Cover)
CC:			

Urgent	**For Review**	**As Requested**	**Please Reply**	**Please Recycle**

Additional Comments: _____

Confidentiality Note: **The enclosed facsimile transmission contains confidential medical record information. This information has been disclosed to the recipient identified above and is protected by State and Federal law. Those laws limit your ability to further disclose this confidential medical information without the prior written consent of the patient/client and his/her legal guardian or unless otherwise permitted by State and Federal law. If you are not the intended recipient, you are hereby notified that any USE, disclosure, copying , distribution, or OTHER action taken WITHOUT RESPECT TO the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.**

RHA
HEALTH SERVICES, LLC

September 11, 2019

Mrs. Joy Alford, QIDP/SW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

RE: Recertification Survey Completed on September 5, 2019
Granville ICF/MR Group Home, 5509 Dorsey Road Oxford, NC 27564
Provider Number: 34G013
MHL Number: MHL039-041

Dear Mrs. Alford

Thank you for your recent survey of Granville ICF/MR. It was a pleasure working with you and we look forward to your follow up and return to ensure all deficiencies have been corrected.

Enclosed you will find the plan of correction for all deficiencies cited. If anything was missed please let me know and I will make the proper corrections.

Sincerely

Morris Thomas
Administrator

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

September 9, 2019

Mr. Morris Thomas, Administrator
RHA Health Services NC LLC
2527 East Lyons Station Road
Creedmoor, NC 27522

Re: Recertification Survey Completed September 5, 2019
Granville ICF/MR Group Home, 5509 Dorsey Road, Oxford, NC 27564
Provider Number: 34G013
MHL#039-041
E-mail Address: mthomas@rhanet.org

Dear Mr. Thomas:

Thank you for the cooperation and courtesy extended during the recertification survey completed 9/5/19. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, The time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is November 3, 2019

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Joy Alford at 919-605-4336

Sincerely,

W. Joy Alford

Joy Alford, QIDP/SW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: qmemail@cardinalinnovations.org
DHSR@Alliancebhc.org
QM@partnersbhm.org
dhhs@vayahealth.com
DHSRreports@eastpointe.net