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VOCA-MEADOWOOD DRIVE GROUP HOME	401 MEADOWOOD STREET GREENSBORO, NC 27409

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W 000	INITIAL COMMENTS NC00153753 Immediate Jeopardy cited in Health Care Services. W148 recited as part of follow-up survey.	W 000		
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: The facility failed to show evidence guardians were promptly notified of an investigation involving 3 of 3 sampled clients (#2, #3, #4) and 2 of 2 non-sampled clients (#1, #5) for 1 of 1 investigation reviewed as evidenced by interview and review of records. The finding is: Review on 5/30/19 of the facility investigation reports for abuse/neglect revealed an investigation that began on 3/16/19 where it was reported staff P left the facility at the end of night shift (11pm-7am) before staff arrived for day shift (7am-3pm) leaving clients alone and unattended. The investigation was substantiated, and the staff P was terminated. Additional review of the investigation report revealed no evidence the Department of Social Services (DSS) for Guilford County or the guardians for all 5 clients residing in the home were notified of the abuse/neglect incident/investigation. Review of the facility policy and procedure	W 148		

RECEIVED
AUG 28 2019
DHSR NH L & C
Black Mountain / WRO

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

8/22/19

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 148	Continued From page 1 manual revealed "The investigator will be responsible for ...follow up reports and calls to the DFS". "The family/guardian and advocate should be informed within 24 hours of the investigation's initiation." Interview on 5/30/19 with the investigator that conducted the internal investigation revealed he did not contact DSS. Interview on 5/30/19 with the qualified intellectual disabilities professional (QIDP) revealed the guardians for all 5 clients that reside in the home were not notified. Further interview with the QIDP revealed the guardians for all 5 clients should have been notified. During the follow-up and complaint investigation conducted on 7/29/19 review of medical records for client #3 revealed a fall occurred on 6/28/19 that resulted in hospital emergency room treatment. Continued review of facility documentation revealed no evidence the facility notified client #3's legal guardian of the 6/28/19 fall resulting in hospital treatment. Further review revealed the facility failed to ensure body checks for client #3 regarding the 6/28/19 fall incident were documented in client #3's clinical documentation. In addition, the facility could produce no evidence DSS was notified. Continued review of documentation revealed the facility failed to complete the required North Carolina Incident Response Improvement System (IRIS) report of client #3's 6/28/19 fall incident. Interview conducted on 7/29/19 with the facility QIDP revealed he informed client #3's guardian of the 6/28/19 incident although he did not remember when and had no documentation of when the contact occurred. Therefore, as the facility failed to show documented efforts to	W 148		

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W 148	Continued From page 2 promptly notify a guardian regarding the change in health status of client #3 and failed to follow facility policy as documented in the plan of correction (POC) for the initial citation cited 5/30/19, this citation was not brought back into compliance. Additional interview with the QIDP on 7/29/19 verified the POC developed for the cited W148 deficiency during the facility refortification survey on 5/30/19 had not been completed although the identified completion date was 7/28/19. The QIDP confirmed the facility had not conducted guardian notification, clinical documentation or contact with DSS relative to client #3's 6/28/19 fall incident.	W 148		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on review of facility records and interviews, the facility failed to ensure an unwitnessed injury resulting in a head laceration for 1 of 5 clients (#3) was reported immediately to the administrator. The finding is: Review of internal facility reports on 7/29/19 during a complaint investigation for the period of 5/2019 through 7/2019 revealed no report for an alleged incident that occurred on 6/28/19 for client #3. Review of client #3's record revealed a hospital discharge summary for a visit to the	W 153		

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W 153	Continued From page 3 emergency department (ED) on 6/28/19 for a laceration to his right brow. Further review of the hospital discharge summary revealed client #3 sustained the injury during a fall and was admitted into the hospital and discharged on 7/1/19 with a discharge diagnosis of "sepsis secondary to a urinary tract infection (UTI) and laceration to the right brow treated in the ER". Subsequent review of the 7/1/19 hospital discharge summary revealed on 6/28/19 when client #3 was brought to the ED, staff reported the client was not wearing a prescribed helmet at the time of the fall and the fall was not observed by staff. Continued review of client #3's record revealed no further medical documentation concerning the incident on 6/28/19 and no documentation showing the guardian had been contacted. In addition, the facility could produce no evidence the Department of Social Services (DSS) for Guilford County was notified. Continued review of documentation revealed the facility failed to complete the required North Carolina Incident Response Improvement System (IRIS) report of client #3's 6/28/19 fall incident. Interview with the qualified intellectual disabilities professional (QIDP) revealed two incident reports for the period of 5/2019-7/2019, neither of which were related to the 6/28/19 fall of client #3. Further interview with the QIDP revealed he was contacted by staff on 6/28/19 due to a fall of client #3 that resulted in a head laceration. The QIDP reported nursing was immediately contacted on 6/28/19 and client #3 was taken by staff to the local ED as a directive from nursing. Additional interview with the QIDP verified the facility administrator had no knowledge of client #3's 6/28/19 incident until he notified her on	W 153		

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W 153	Continued From page 4 7/29/19 during the complaint investigation. Interview with the facility administrator on 7/29/19 revealed she was contacted that morning by the QIDP reporting the incident. Further interview with the QIDP and the facility administrator revealed an incident report should have been completed by staff during the incident and an internal investigation should have been conducted as a result of a report by staff to the hospital that the client was not wearing a prescribed helmet at the time of the fall and that the fall was unwitnessed by staff.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of facility records and interview, the facility failed to provide evidence an allegation of abuse was thoroughly investigated for 1 of 5 clients (#3). The finding is: Review of internal facility reports on 7/29/19 during a complaint investigation, revealed no internal investigation for a recent (unknown date) alleged injury/head laceration to client #3. Review of facility incident reports since 6/1/19 revealed no documentation of any falls or injuries to client #3 resulting in a head laceration. Review of medical reports for client #3 revealed a hospital discharge summary dated 7/1/19. Review of the 7/1/19 hospital report revealed client #3 was seen in the hospital emergency department on 6/28/19 for a fall and admitted to the hospital for sepsis related to a urinary tract infection (UTI). Further	W 154		

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W 154	Continued From page 5 review of the 7/1/19 hospital discharge summary revealed on 6/28/19 when client #3 was brought to the emergency room, staff reported the client was not wearing a prescribed helmet at the time of the fall and the fall was not observed by staff. Interview with the qualified intellectual disabilities professional (QIDP) on 7/29/19 verified client #3 had recently been to the emergency room for a head laceration due to a fall on 6/28/19 and an investigation had not been conducted for the incident as staff were present. Further interview with the QIDP revealed he was contacted by staff on 6/28/19 due to a fall client #3 had sustained from the living room couch that resulted in a head laceration. The QIDP reported nursing was immediately contacted on 6/28/19 and client #3 was taken by staff to the local emergency room as a directive from nursing. Additional interview with the QIDP verified he had reviewed the hospital discharge record and did not realize staff had reported to the hospital client #3 was not wearing a prescribed helmet during the fall or that the fall was unwitnessed. The QIDP verified a facility investigation should have occurred as a result of a report by staff to the hospital that the client was not wearing a prescribed helmet at the time of the fall and that the fall was unwitnessed by staff.	W 154		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	W 189		

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W 189	Continued From page 6 This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff were sufficiently trained relative to required documentation. The finding is: During a complaint investigation conducted on 7/29/19 review of medical records for client #3 revealed a fall occurring on 6/28/19 that resulted in treatment at the hospital emergency department (ED). Continued review of facility internal reports revealed no evidence of an incident report of the 6/28/19 fall resulting in ED treatment. Further review revealed no nursing documentation regarding client #3's 6/28/19 fall incident. Subsequent review of internal documentation revealed no evidence of proper notifications relative to the incident to include client #3's guardian, Department of Social Services or a North Carolina Incident Response Improvement System (IRIS) report. A review of facility internal reports of staff training relative to incident reporting revealed a recent training titled "Incident Reporting and Protocols" dated 6/15/19. Continued review revealed 8 staff signatures and the training facilitator identified as the qualified intellectual disabilities professional (QIDP). Further review of the 6/15/19 staff training revealed "All incidents shall be documented and reported to the appropriate persons stated in the policy and procedures." Interview on 7/29/19 with staff B revealed staff are trained to complete incident reports. Continued interview with staff B revealed staff are to notify "the QP and the Home Manager" of the incident, complete an incident report, and place	W 189		

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W 189	Continued From page 7 the completed incident report in a stacking letter tray system located in the group home's television room area. Interview conducted on 7/29/19 with the facility QIDP confirmed an incident report should have been completed for client #3's 6/28/19 fall incident. Further interview with the QIDP verified staff are trained on incident reports and he reviews all submitted incident reports daily. Continued interview with the QIDP confirmed more staff training on incident reports is continually needed to ensure client health and safety.	W 189		
W 253	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to document an interdisciplinary team (IDT) meeting or team collaboration relative to a change in client health status for 1 of 5 clients (#3). The finding is: During a complaint investigation on 7/29/19 review of medical records for client #3 revealed a fall occurred on 6/28/19 that resulted in medical treatment by the hospital emergency department (ED). Review of records for client #3 on 7/29/19 revealed no documentation of an IDT meeting to document status or frequency of falls, injuries	W 253		

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W 253	Continued From page 8 related to falling events or behaviors, or prevention measures to address fall incidents. In addition, review of client #3's behavioral support plan (BSP), revised 12/12/18, revealed client #3 to wear a protective helmet during waking hours except for meal time or bathing to protect his head from falls or bangs. Further BSP review revealed a target goal that client #3 will exhibit 0 or less episodes of dropping to the floor or banging his head while exhibiting a behavior for 12 consecutive months. Continued review of client #3's BSP revealed, "Dropping to the floor as well as AWOL attempts have decreased but continue to be significant". Subsequent BSP review revealed client #3's doctor ordered a helmet due to the client's behaviors of dropping to the floor or moving away. The 12/12/18 BSP further indicated during times when client #3 exhibits this behavior he has "bumped" his head and has had to be taken to the emergency room numerous times. Interview with staff B on 7/29/19 revealed staff to report about client #3 that "falling is occurring a lot now". Further interview with staff B revealed client #3 is not on a 1 to 1 level of supervision. Interview with the facility qualified intellectual disabilities professional (QIDP) on 7/29/19 confirmed client #3 has recently experienced multiple falls. Continued interview with the QIDP confirmed client #3's current level of supervision is 3 clients to 1 staff. Further QIDP interview revealed client #3 is currently on 1 to 1 level of supervision upon a second walk off attempt from either a community outing or group home premises. Additional interview with the QIDP revealed there were no recent team meeting discussions pertaining to fall prevention strategies	W 253		

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W 253	Continued From page 9 to address client #3's increasing falls. The QIDP further revealed team meeting discussions for client #3 pertained to the behavioral data findings of the behaviorist. The QIDP additionally confirmed, the facility's interdisciplinary team should have had team meeting discussions to address fall prevention strategies and to ensure appropriate safeguards for client #3's increasing falls.	W 253		
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: The facility failed to provide clients with nursing services in accordance with their needs (W322, W331). The facility failed to provide or obtain preventable and general care (W322) and failed to provide clients with nursing services in accordance with their needs (W331). The cumulative effect of these systematic practices resulted in the facility's failure to provide statutorily mandated health care services for it's clients.	W 318		
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by:	W 322		

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W 322	Continued From page 10 Based on record review and interview, the facility failed to assure 1 of 5 clients (#3) received general and preventive medical care relative to scheduling initial and follow up appointments after emergency care and hospitalization. The finding is: Review of medical consults for client #3 on 7/29/19 revealed multiple emergency room (ER) hospital visits relative to falls and urinary tract infections (UTI) with recommended follow-up appointments with the preferred/primary care physician (PCP). These ER hospital visits were: 2/16/19 with a recommended 1 week follow-up, 3/26/19, 4/1/19, 4/29/19, 5/2/19, 5/7/19 and 7/1/19. Additional medical consult review on 7/29/19 of client #3's record revealed a hospital report for a visit to the ER on 6/28/19 where the client had sustained a laceration to the right brow during an unwitnessed fall in the home. Further review of the hospital report revealed client #3 was admitted for sepsis secondary to a urinary tract infection and was discharged on 7/1/19. Continued review of the discharge orders revealed the client was to follow up with his PCP within 1 week. An additional 7/1/19 discharge recommendation revealed client 3#'s medication of Clonidine be decreased due to low blood pressure. Client #3's internal medical record revealed no nursing documentation concerning the laceration, sepsis or a follow up consultation with client #3's PCP. Interview with the qualified intellectual disabilities professional (QIDP) on 7/29/19 revealed client #3 had not followed up with his PCP since he was	W 322		

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W 322	Continued From page 11 discharged from the hospital 7/1/19. Interview on 7/29/19 via telephone with the facility nurse verified client #3 had not been to see his PCP since the 7/1/19 hospital discharge, as getting an appointment with the client's PCP was difficult. Further interview with the facility nurse verified follow up appointments for client #3 after ER visits on 2/16/19, 3/26/19, 4/1/19, 4/29/19, 5/2/19 and 5/7/19 had not occurred as recommended by the ER physician. Interview with the facility nurse further revealed client #3's Clonidine medication was not reduced until 7/6/19, 5 days after the hospital physician's recommendation on 7/1/19. Subsequent interview with the facility nurse verified she had not provided any nursing services, with the exception of a general assessment on 7/3/19, to client #3 since hospital discharge on 7/1/19. Interview with the QIDP and facility nurse revealed client #3 should have had a follow up appointment with his PCP. Immediate Jeopardy (IJ) was cited as the facility failed to provide needed general care after frequent hospitalizations and a system to provide needed health care services was functional. The facility provided a plan of correction (POC) on 7/29/19 stating the nurse will follow-up with physician orders and recommendations within 24 hours for any changes or recommendations to individual's orders. All documented conversations (progress notes) will be documented and kept on file in the individual's red clinical book. The nurse will document an individual's progress when resulting from an injury or illness within 24 hours. All assessments and documentations will be kept in the individual's red clinical book in the home setting. The QIDP will	W 322		

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W 322	Continued From page 12 follow-up with the parent/guardians on all injuries or illness and document the outcome on all incident reports and individual's progress notes. The QIDP will notify the Operations Manager/Behaviorist on all illness or injuries and bring all documented reports to Safety and Management for review. The IJ was able to removed but the Health Care Services condition remains out of complaince.	W 322		
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 review of records and interviews, nursing services failed to assess, document and follow recommendations for 1 of 5 clients (#3). The findings are: A. Nursing services failed to provide nursing services after a hospitalization for client #3. For example: Review on 7/29/19 of client #3's record revealed a hospital discharge summary with physician orders documenting an emergency department (ED) and hospital admission 6/28/19 to 7/1/19 for a laceration with sutures to his right brow and admission for dehydration and sepsis secondary to a UTI. Further review revealed a facility consultation sheet that had been completed by the hospital 7/1/19 and was signed by the facility nurse on 7/3/19. Continued review of the discharge summary revealed orders from the	W 331		

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(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 331	Continued From page 13 hospital physician to decrease client #3's clonidine and to follow up with his primary care physician (PCP) in one week. Subsequent review did not reveal nursing documentation for any nursing services provided to client #3 since the hospital discharge, 28 days prior. Interview on 7/29/19 via telephone with the facility nurse revealed she should have performed an assessment of client #3, contacted the clients PCP and documented nursing services since hospital discharge of 7/1/19. Additional interview with the facility nurse verified she had provided no nursing services to client #3 since the hospital discharge date 7/1/19 and failed to get him to the PCP after any other hospitalizations. B. Nursing services failed to ensure a timely medication adjustment after a physician recommendation. For example: Record review on 7/29/19 of the hospital discharge summary revealed an order to "Change Clonidine 0.1 mg to bedtime only due to low blood pressure during day" from client #3's facility orders of "Clonidine 0.1 mg 2 tablets twice daily and Clonidine 0.1 mg 1 tablet at bedtime". Interview on 7/29/19 with the qualified intellectual disabilities professional (QIDP) revealed the electronic medication administration record (MAR) to have current orders, dated 7/1/19 to 7/31/19, for client #3, to identify on 7/1/19 to 7/5/19 client #3 was given Clonidine 0.1 mg 2 tablets twice daily and Clonidine 0.1 mg at bedtime, and on 7/6/19 to 7/29/19 client #3 was given Clonidine 0.1 mg 1 tablet twice daily and Clonidine 0.1 mg at bedtime. Interview via phone with the facility nurse on 7/29/19 revealed she	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G181	A. BUILDING _____ B. WING _____	R-C 07/29/2019

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W 331	Continued From page 14 had not contacted the PCP for clarification of the discharge orders and could not produce nursing notes to corroborate the orders on the electronic MAR. Interviews with the QIDP and facility nurse revealed there should have been documentation of the physician orders in client #3's record.	W 331		

W148---Communication with Clients, Parents, & CFR

Correction:

In an event of serious illness, accident, death, abuse, or unauthorized absence the Group Home Manager and Qualified Professional will notified the parents or guardians of all individuals involved in the situation. All body checks will be documented in the clinical book to make sure all individuals have current health assessments. The investigator will make sure to notify DSS and make a note on his report for contact information. The Home Manager and Qualified Professional will be **Re-In-Services** on all protocols notifying all parties involved and completing incidents reports. The Operation Manager, QP, & Home Manager will complete 1 home observation weekly to monitor both practice and systems of corrections.

Responsible Parties: **Qualified Professional, Group Home Manager, Operation Manager**
Completion Date: **August 29, 2019**

W153 – The facility must assure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

Correction:

The facility will have evidence that all allegations of mistreatment, neglect, abuse or injuries of unknown source are reported immediately to the supervisor/administrator (Operation Manager) to make sure all allegations/violations are thoroughly investigated. All allegations will be reported to management staff on the date of alleged incident occurs. Accurate documentary evidence will be available to indicate that proper timelines on Investigation are followed, as outlined in CANC Investigation Policy. The Executive Director, Operation Manager and Qualified Professional will assure all investigations/unknown inquiries are initiated within 24 hours and reported to the healthcare personnel registry (HCPR) within 24 hours. All staffs and ID Team members will receive additional In-Service training regarding this procedure.

Responsible Parties: **Qualified Professional, Operations Manager, Executive Director**

Completion Date: **September 29, 2019**

W154 – The facility must have evidence that all alleged violations are thoroughly investigated.

Correction:

The facility will have evidence that all alleged violations are thoroughly investigated and reported to the healthcare personnel registry (HCPR) within five working days. All allegations will be reported to management staff on the date of alleged incident occurs. Accurate documentary evidence will be available to indicate that proper timelines on Investigation are followed, as outlined in CANC Investigation Policy. The Executive Director, Operation Manager and Qualified Professional will assure all investigations/unknown inquiries are initiated within 24 hours and reported to the healthcare personnel registry (HCPR) within 24 hours. After the investigation is complete, a five day working report of the investigation and summary will be reported to the healthcare personnel registry (HCPR) within five days. The Investigator will make sure all forms/reports are completed before filing. All staff, and ID Team members will receive additional In-Service training regarding this procedure.

Responsible Parties: Qualified Professional, Operations Manager, Executive Director
Completion Date: September 29, 2019

W189 – The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

Correction:

The facility will assure all employees are trained on incident reports protocol. The staff training along with QP and Group Home Manager will consist of how to complete an incident report, who to notify & contact after the incident report is complete, and where to file it. The QP will be responsible for assuring all employees knows the correct interventions, services in sufficient number and frequency of supports therefore to achieve the best outcome of active treatment for each individual served within the company to decrease accidents. The QP/Group Home Manager will In-Service all employees to make sure they understand and can effectively implement the ISP and BSP plan. The Qualified Professional will complete 1 home observation a week to monitor both practice and systems of corrections. The Nurse will complete 1 home observation a month to monitor both practice and systems of corrections regarding to incidents reports. The Operation Manager will meet weekly to make sure all parties involved all following all plans, protocols and interventions correctly.

Projected Completion Date: September 29, 2019
Responsible Parties: Qualified Professional, Nurse, Group Home Manager, Operation Manager

W253 – The facility must document significant events that are related to the client's individual program plan and assessments.

Correction:

The facility will assure all individuals significant events will be documented and updated as needed according to the individuals progress and assessments. The ISP will be updated as needed or changed when the individual health or behavioral needs decrease in order to support the achievement of the objectives identified in the individual program plan. The QP & Behaviorist will be responsible for assuring all staff knows the correct interventions, services in sufficient number and frequency of supports therefore to achieve the best outcomes of active treatment. After a consumer has a change in health status or behavioral increase , the QP will make changes to the ISP to addressed or revise goals and the Behaviorist will revised the BSP after Core Team meetings to discuss prioritize needs such as safeguards and strategies. The Qualified Professional & Behaviorist will be In-serve on making addendum to ISP plans, BSP and goals. The Operation Manager will monitor weekly for accuracy.

Projected Completion Date: September 29, 2019
Responsible Parties: Qualified Professional, Group Home Manager, Behaviorist, Operation Manager

W318---Healthcare Services Nursing Services: Additional to 322 & 331

1. CANC Nurse will follow up with physician orders and recommendations within 24 hours for any changes or recommendations to individual's orders. All document conversations (progress notes) will be documented and kept on file in the individual's red clinical book.

2. CANC Nurse will document all individual's progress when resulting from an injury or illness within 24 hours. All assessments and documentations will be kept in the individual's red clinical book in the home setting.

3. QP will follow up with parent/guardians on all injuries or illness and document the outcome on all incident reports & individuals progress notes. The QP will notify the Operation Manager/Behaviorist on all illness or injuries and bring all documented reports to Safety & Management for review.

Projected Completion Date: September 12, 2019
Responsible Parties: Nurse, QP, Behaviorist, Operation Manager

W322 – The facility must provide or obtain preventive and general care.

Correction:

The facility will assure all clients' doctors recommendations are following up in a timely manner. The Nurse will be In-service to make sure all doctors recommendations are followed up immediately. The Nurse will review all physicians' recommendation and will record all follow up recommendation on nurse's progress notes in each client record on a monthly basis or as needed. The Operation Manager will complete 1 home observation weekly to monitor both practice and systems of corrections.

Projected Completion Date: September 12, 2019
Responsible Parties: Nurse, Operation Manager

W331 – The facility must provide clients with nursing services in accordance with their needs.

Correction:

The facility will assure all clients' doctors recommendations are following up in a timely manner. The Nurse will be In-service to make sure all doctors recommendations are followed up immediately. The Nurse will review all physicians' recommendation and will record all follow up recommendation on nurse's progress notes in each client record on a monthly basis or as needed. Group Home Manager/Staff will report the medical finding to the nurse and scan the medical consultant form for review. The Nurse will review the medical consultant form and physician orders and make changes according to orders. The Nurse will complete an assessment or document progress note when any individual has been seen by the emergency room or additional appointments that are not the individual routine wellness check- up. All medications review, or changes will occur within 24 hours of all physician orders. The Operation Manager will complete 1 home observation weekly to monitor both practice and systems of corrections.

Projected Completion Date: September 12, 2019
Responsible Parties: Nurse, Operation Manager