STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G118	A. BUILDING ______ B. WING ______	10/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANNONBROOK HOME	**914 WEST FIRST STREET NEWTON, NC 28658**

(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 interview, the facility failed to assure privacy was maintained for 1 of 3 sampled clients (#1) and 1 non-sampled client (#6). The findings are: A. The facility failed to assure privacy was maintained while completing personal hygiene activities for client #1. For example: Observation in the group home on 10/15/19 at 6:50 AM revealed an audio monitor in the living room of the group home and conversation between client #1 and the group home manager (HM) could be overheard from the monitor. Continued observation revealed client #1 to be in her bedroom with the HM. Further observation revealed client #3 to sit in the living room during the audio conversation of client #1 and the HM. Subsequent observation revealed conversation between client #1 and the HM to continue until 7:05 AM when client #1 exited the bedroom area. Review of the record for client #1 on 10/15/19 revealed a current guardian consent for an audio monitor to be used while the client is in the bedroom to notify staff when the client gets out of bed. Interview with the HM on 10/15/19 revealed client #1's monitor is used for seizure monitoring of client #1 and should be turned off when the client is not in her room.	W 130		

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
	34G118	A. BUILDING ______ B. WING ______	10/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANNONBROOK HOME	914 WEST FIRST STREET NEWTON, NC 28658

(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	Continued From page 1 Interview with the QIDP (qualified intellectual disabilities professional) further confirmed client #1's audio monitor should not be on while staff is in the client's bedroom assisting with personal care. B. The facility failed to assure privacy was maintained while assisting with toileting and personal care for client #6. For example: Observation in the group home on 10/15/19 at 7:05 AM revealed staff B to assist client #6 from the bedroom area to the hallway bathroom. Continued observation revealed staff B to assist client #6 to sit on the toilet with the bathroom door open, to exit the bathroom closing the door, and return to the bathroom after gathering personal items of client #6 from the clients bedroom. Further observation at 7:15 AM revealed client #6 to sit on the toilet of the bathroom, undressed with the bathroom door partially open until staff was observed to return to the bathroom and close the door. Review of records for client #6 on 10/15/19 revealed a diagnosis that included osteoporosis. Continued record review revealed fall guidelines implemented 4/27/2009. Review of a physical therapy evaluation for client #6 dated 5/24/19 revealed client #6 has a high risk of falls. Further record review revealed an annual medical evaluation dated 7/25/19 that reflected staff are to utilize a gait belt to assist with ambulation. Interview with the QIDP and home manager (HM) on 10/15/19 verified client #6 has a fall history. Interview with the HM further revealed client #6 can stay in the bathroom unsupervised for short periods of time while staff leave the door open to listen for the client. Interview with the QIDP	W 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G118	A. BUILDING ______ B. WING ______	10/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANNONBROOK HOME	914 WEST FIRST STREET NEWTON, NC 28658

(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	Continued From page 2 revealed when client #6 is in the bathroom staff should protect the client's privacy with closing the bathroom door.	W 130		
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. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure staff were sufficiently trained relative to the adaptive equipment needs for 1 of 3 sampled clients (#4) . The finding is: Observation in the group home on 10/15/19 throughout morning observations revealed client #4 to participate in morning activities of hygiene, meal participation, chores, and leisure activity that included working on a puzzle. Observation of client #4 during activity transitions revealed staff to verbally prompt the client, and physically gesture the client when the client did not respond to a verbal prompt. Client #4 was observed at times to stare at staff after receiving a verbal prompt until the verbal prompt was repeated or a physical gesture was provided to which the client complied. At no time during morning observations was it observed for client #4 to wear a hearing aid. Review of records for client #4 on 10/15/19 revealed a communication evaluation dated 4/7/19 that indicated sensorineural hearing loss.	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G118	A. BUILDING ______ B. WING ______	10/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANNONBROOK HOME	**914 WEST FIRST STREET** **NEWTON, NC 28658**

(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 189	Continued From page 3 Further record review revealed an ear, nose, and throat (ENT) consult dated 8/19/19. Review of the 8/19/19 consult revealed: hearing aid cleaned, mic covers replaced, and ear tubing replaced. Continued review of the 8/19/19 consult revealed: data logging function shows 2.6 hours of daily use. If battery door is not fully closed, hearing aid may be worn but not turned on. Subsequent record review revealed an ENT consult dated 9/12/19 that further documented client #4's use of a hearing aid. Interview with the group home manager (HM) on 10/15/19 at the vocational site verified client #4 wears a hearing aid daily. Further interview with the HM revealed client #4 requires reminders by staff to wear her hearing aid while the client is compliant with wearing the adaptive device, has no history of misuse relative to her hearing aid, and keeps the hearing aid in her bedroom. Subsequent interview with the HM verified client #4 was not wearing her hearing aid on the current day (10/15/19). Interview with nursing staff and the qualified intellectual disabilities professional (QIDP) revealed an in-service training to address the need for staff to support client #4 with wearing a hearing aid or to ensure the device was correctly turned on/working since the 8/19/19 consult had not been conducted.	W 189		
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication	W 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G118	A. BUILDING ______ B. WING ______	10/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANNONBROOK HOME	914 WEST FIRST STREET NEWTON, NC 28658

(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 242	Continued From page 4 of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, review of records and interview, the team failed to ensure the person centered plan (PCP) for 1 of 3 sampled clients (#4) included objective training to address observed needs relative to privacy. The finding is: Observation in the group home on 10/15/19 at 6:57 AM revealed client #4 to exit her bedroom and enter the hallway bathroom across from her bedroom. Continued observation revealed client #4 to use the bathroom without turning on the light, without closing the door, and to exit the bathroom without washing her hands. Subsequent observation revealed client #4 to return to her bedroom and close the door. Observation at 7:35 AM revealed client #4 to exit her bedroom and enter the hallway bathroom across from her bedroom. Continued observation revealed client #4 to again use the bathroom without turning on the light, without closing the door and, to exit the bathroom without washing her hands. Subsequent observation revealed client #4 to return to her bedroom and close the door. Review of records on 10/15/19 for client #4 revealed a PCP dated 5/10/19. Review of the 5/10/2019 PCP revealed training objectives to address choosing the correct cleaning supplies, laundry, hygiene, meal prep, and number identification. Further record review revealed an	W 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G118	A. BUILDING ______ B. WING ______	10/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANNONBROOK HOME	**914 WEST FIRST STREET NEWTON, NC 28658**

(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 242	Continued From page 5 adaptive behavior inventory (ABI) assessment dated 4/28/19. Review of the 4/28/2019 ABI revealed client #4 to be assessed at total independence with skills to close the bathroom door for privacy, flush the toilet, and washes hands after toileting. Continued review of the 4/2019 ABI revealed a documented note that due the hyperactivity of client #4, the client will always need someone to monitor her to ensure she takes the time to wipe thoroughly and close the door. Interview with the facility qualified intellectual disabilities professional on 10/15/19 revealed client #4 did not have current programming to address toileting or privacy related to toileting. Further interview with the QIDP revealed she was unsure when client #4 had past programming related to toileting/privacy. The QIDP further verified current training relative to toileting and privacy could benefit client #4 with increasing independence in personal skills.	W 242		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: The facility's system for ensuring drugs were administered in compliance with physician's orders failed for 2 non-sampled clients(#2 and #5) observed as evidenced by observations, interview and review of records. The finding is: Observation in the group home on 10/15/19 at	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G118	A. BUILDING ______ B. WING ______	10/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANNONBROOK HOME	914 WEST FIRST STREET NEWTON, NC 28658

(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 368	Continued From page 6 9:00 AM revealed the group home manager (HM) to verbally prompt client #5 to the medication room for morning medications. Continued observation revealed client #5 to enter the medication room and exit the medication room at 9:08 AM. Subsequent observation at 9:10 AM revealed the HM to verbally prompt client #2 to the medication room. Client #2 was observed to enter the medication room with the HM and exit at 9:16 AM. Review of records for client #5 on 10/15/19 revealed a person centered plan (PCP) dated 4/30/19. Continued record review revealed physician orders dated 8/12/19. Review of the 8/2019 physician orders revealed all morning medications to be ordered at 8 AM to include: Keppra 250mg, Pantoprazole 40mg, Tizanidine HCL 4 mg, Vitamin B-12 1000mcg, Vitamin C 500mg, Vitamin D3 2000i.u. Review of records for client #2 on 10/15/19 revealed a PCP dated 5/21/19. Continued record review revealed physician orders dated 8/12/19. Review of the 8/2019 physician orders for client #2 revealed all morning medications to be ordered at 8 AM to include: Ducosate Sodium 100mg, Calcium 600mg D3 400IU, Glucerna shake, Linzess 290mcg, Lorazepam 0.5mg, Magnesium Citrate 30ML, and Pantoprazole 40mg. Interview with the HM on 10/15/19 revealed she had administered all morning medications to clients #2 and #5 during the medication pass. Further interview with the HM revealed she did not realize she had administered medications to clients #2 and #5 after 9 AM, outside of the medication window and out of compliance with	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G118	A. BUILDING ______ B. WING ______	10/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHANNONBROOK HOME	**914 WEST FIRST STREET** **NEWTON, NC 28658**

(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 368	Continued From page 7 physician orders. Subsequent interview with the HM and nursing revealed medications ordered at 8 AM should be administered by 9 AM. The HM further verified she did not call nursing regarding the administration of medications for client #2 or #5 as she did not realize the time of the medication pass for either client.	W 368		