STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084056	A. BUILDING: _____ B. WING _____	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWDER REUNION GROUP HOME	33973 LOWDER REUNION ROAD ALBEMARLE, NC 28001

(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) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on 10/23/19. One of the two complaints was substantiated (Intakes #NC156472, #NC156683). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

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V 111	Continued From page 1	V 111		

This Rule is not met as evidenced by:
Based on records review and interviews, the facility failed to ensure assessments were completed to identify the needs of the client affecting 1 of 3 clients (#1). The findings are:

Review on 10/7/19 of client #1's record revealed:
-admission on 10/21/10;
-diagnoses of Profound Intellectual Developmental Disabilities, Autistic Disorder, Cerebral Palsy and Unspecified Urinary Incontinence;
-Risks/Support Needs Assessment dated 2/15/19 with last update on 9/18/19 documented client #1 picks at his skin around his finger nails, scratches bumps, hits himself, hits objects with his hands and bruises easily;
-behavior support plan dated 10/1/18 documented self injurious behaviors.

Interview on 10/7/19 with the Qualified Professional(QP) revealed:
-staff were supposed to check client #1 for bruises/marks once a day prior to safety plan;
-now staff must check three times a day at shift change per safety plan;
-client #1 bruises easily;
-client #1 also has self injurious behaviors.

Review on 10/10/19 of client #1's body checks

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V 111	Continued From page 2 documentation for the month of August 2019 revealed the following dates no body check was documented: 8/10, 8/11, 8/12, 8/14-8/21, 8/25, 8/27. Review on 10/7/19 of a form titled "Safety Plan Protocol" dated 9/6/19 completed by the Qualified Professional (QP) documented the following: -body checks will be completed on client #1 during each shift (8am, 4pm, 8pm); -any marks will be documented. Review on 10/10/19 of documentation of client #1's body checks revealed the following dates body checks were not completed three times daily on each shift: 9/8, 9/10, 9/11, 9/12, 10/5, 10/6, 10/8, 10/9 10/10. Further interview on 10/124/19 with the QP revealed: -will ensure body checks are completed as needed for the safety plan for client #1; -will train staff on how to document properly on body check documentation.	V 111		