STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G251	A. BUILDING ______ B. WING ______	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAREN LANE HOME	3224 KAREN LANE MONROE, NC 28112

(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, review of records and interviews, the facility failed to ensure objectives listed in the person centered plans (PCP's) were implemented as prescribed for 3 of 4 sampled clients (#1, #2 and #3). The findings are: A. The facility failed to ensure a medication administration objective was implemented as prescribed for client #1. Observation in the group home on 11/19/19 at 7:10 AM revealed client #1 to participate in his morning medication administration. Client #1 was observed to enter the medication room, sit in a chair with verbal prompts by staff D, to hand over hand punch medications accessed by staff D and to take medications mixed with cool whip, followed by water with staff D assistance. Continued observation revealed staff D to return client #1's medication box to a shelf in the medication room and support client #1 with ambulation in returning to the dining room for leisure activity. It was observed for staff D to sanitize her hands before the medication pass although client #1 was not prompted to sanitize	W 249		

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.

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his hands. Staff D was also observed to access client #1's medication box from a shelf with no assistance from client #1.

Review of records for client #1 on 11/19/19 revealed a PCP dated 4/1/19. Review of the PCP revealed a medication administration program implemented 4/1/19. Review of the 4/2019 medication program revealed client #1 will obtain his medication basket with 100% accuracy over three consecutive months by 3/31/20. Continued review of client #1's medication objective revealed a two step program for client #1 to obtain medication basket and place basket on the table. Subsequent review of the medication program for client #1 revealed the program should be run daily at the group home.

Interview with the facility qualified intellectual disabilities professional (QIDP) on 11/19/19 revealed client #1's medication program remains current. The QIDP further verified client #1's medication program should have been implemented with the morning medication pass as the client should have accessed his medications with verbal prompts from staff.

B. The facility failed to ensure a medication administration objective was implemented as prescribed for client #2.

Observation in the group home on 11/19/19 at 7:17 AM revealed client #2 to enter the medication room for morning medication administration. Client #2 was observed to enter the medication room, sit in a chair with verbal prompts by staff D, to independently punch a vitamin from a bubble pack accessed by staff D, place vitamin in a medication cup and to take the

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vitamin independently. Continued observation revealed staff D to return client #2's medication box to a shelf in the medication room and to independently exit the medication room. It was observed for staff D to sanitize her hands before the medication pass although client #2 was not prompted to sanitize her hands. Staff D was also observed to access client #2's medication box from a shelf with no assistance of client #2.

Review of records for client #2 on 11/19/19 revealed a PCP dated 10/18/19. Review of the PCP revealed a medication administration program implemented 10/18/19. Review of the 10/2019 medication program revealed client #2 will participate in medication administration with 85% accuracy over three consecutive months, by 10/17/20. Continued review of client #2's medication objective revealed a five step program for client #2 to wash her hands with sanitizer or soap, locate her picture on a medication basket, access her vitamin in a cup, consume her medication with water and place used cup in the trash.

Interview with staff on 11/19/19 revealed she forgot to offer the client the opportunity to sanitize her hands before the medication administration process started. Interview with the facility QIDP on 11/19/19 revealed client #2's medication administration program remains current. The QIDP further verified client #2's medication program should have been implemented with the morning medication pass as the client should have washed her hands and accessed her medications with verbal prompts from staff.

C. The facility failed to ensure a medication

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administration objective was implemented as prescribed for client #3.

Observation in the group home on 11/19/19 at 7:22 AM revealed client #3 to enter the medication room for morning medication administration. Client #3 was observed to enter the medication room, sit in a chair with verbal prompts by staff D, to hand over hand punch medications from a bubble pack accessed by staff D, and to take medications mixed with pudding with staff D assistance . Continued observation revealed staff D to return client #3's medication box to a shelf in the medication room and to exit the medication room with staff assistance. It was observed for staff D to sanitize her hands before the medication pass although client #3 was not prompted to sanitize his hands. Staff D was also observed to access client #3's medication box from a shelf with no assistance of client #3 and to provide no medication identification training with client #3 during the medication pass.

Review of records for client #3 on 11/19/19 revealed a PCP dated 10/15/19. Review of the PCP revealed a medication administration program implemented 10/15/19. Review of the 10/2019 medication program revealed a three step program for client #3 to wash his hands with sanitizer or soap, locate his picture on a medication basket and name medication "Colace". Further review of the medication program for client #3 revealed the program to be implemented Monday through Friday on first shift.

Interview with staff on 11/19/19 revealed she forgot to offer client #3 the opportunity to sanitize his hands before the medication administration

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W 249	Continued From page 4 process started. Interview with the facility QIDP on 11/19/19 revealed client #3's medication administration program remains current. The QIDP further verified client #3's medication program should have been implemented with the morning medication pass as the client should have washed his hands, located his picture on the medication basket, and named medication "Colace" with verbal prompts from staff.	W 249		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure techniques used to manage inappropriate behavior for 1 of 5 sampled clients (#5), were not used as a substitute for an active treatment program. The finding is: Observation in the group home on 11/19/19 at 8:15 AM revealed staff E to enter the kitchen of the group home and to be handed a key from staff D. Continued observation revealed staff E to walk with client #5 down the hallway of the group home with laundry items and to enter the bedroom of client #5 and unlock the client's closet. Further observation revealed staff to exit client #5's bedroom with the client and to unlock a closet in the hallway of the group home with excess toiletry items. Subsequent observation revealed staff to lock the closet and return to the	W 288		

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living room with client #5.

Review of records on 11/19/19 for client #5 revealed a person centered plan dated 2/15/19. Review of the 2/2019 PCP revealed a behavior support plan (BSP) dated 10/17/19 for client #5 for target behaviors of property destruction and inappropriate sexual behavior. A review of intervention strategies of the BSP to address target behaviors revealed no restriction of locking client #5's closet or the hygiene closet of the hallway in the group home as an intervention strategy to support client #5 with inappropriate behavior.

Interview with staff E on 11/19/19 revealed client #5's bedroom closet is kept locked due to behaviors of client #5 relative to clothing destruction. Continued interview with staff E revealed the closet in the hallway of the group home containing extra supplies and hygiene items is also kept locked due to client #5's behaviors as she tears things up. Interview with the facility home manager (HM) and qualified intellectual disabilities professional (QIDP) on 11/19/19 revealed client #5's bedroom closet is kept locked due to behaviors. Further interview with the HM and QIDP revealed the hallway closet of the group home should not be locked. Subsequent interview with the QIDP revealed client #5's restriction to her bedroom closet should be in the clients BSP and it was an oversight the intervention was not added.

W 436 — SPACE AND EQUIPMENT — W 436

CFR(s): 483.470(g)(2)

The facility must furnish, maintain in good repair, and teach clients to use and to make informed

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choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

This STANDARD is not met as evidenced by:
Based on observation, record review, and interviews, the facility failed to provide training relative to the use and storage of hearing aids for 1 of 3 sampled clients (#4). The finding is:

Observations in the group home on 11/18/19 at 5:00 PM revealed client #4 to request assistance from staff A to remove his hearing aids so he could use his headphones to listen to music. Continued observations revealed client #4 to hand his hearing aids to staff A, and the staff escorted the client to the medication administration room. Further observation revealed client #4 to store his hearing aids in the medication administration room with staff assistance. Subsequent observation revealed client #4 to return to the dining table and use headphones to listen to music while completing an art activity.

Observation at 5:16 PM revealed client #4 to request his hearing aids from staff A. Continued observation revealed staff to escort the client to the medication administration room. Client #4 was observed to retrieve and place his hearing aids in his ears and return to the dining room to assist staff and other clients to set the table for the dinner meal.

Review of records for client #4 on 11/19/19 revealed a person centered plan (PCP) dated

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W 436	Continued From page 7 7/1/19. Further review of the PCP revealed behavior guidelines dated 6/2019. Further review of the behavior guidelines revealed target behaviors to include stealing food, stuffing his mouth, bossy behaviors, and hoarding food in his room. Continued review of the PCP revealed no intervention strategy relative to the need of client #4's hearing aids to be stored or locked in the medication administration room when not in use. Additional review of the PCP revealed no training objectives relative to the use or storage of client #4's hearing aids. Interview with staff A and the facility home manager (HM) on 11/18/19 revealed client #4 requests to store his hearing aids in the medication administration room so that he doesn't misplace them. Interview with the facility HM on 11/19/19 verified that client #4 has misplaced his hearing aids in the past. Continued interview with the HM revealed she was unsure if client #4 had received past training relative to the storage and handling of his hearing aids. Interview with the qualified intellectual disabilities professional (QIDP) verified that client #4 stores his hearing aids in the medication administration room. Interview with the QIDP further revealed client #4 had a history of losing his hearing aids although the client has not lost the adaptive devices in a long time. Additional interview with the QIDP confirmed that client #4 had not recieved training to support independence in maintaining his hearing aids in his bedroom.	W 436		