STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G030	A. BUILDING ______ B. WING ______	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	126 ROBINHOOD LANE ABERDEEN, NC 28315

(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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that client #12 had a legal guardian. This affected 1 of 11 clients. The finding is: Client #12 had no documentation of legal guardianship. Review of client #12's chart on 11/18/19 revealed that guardianship was not established. A further review of the chart indicated that client #2 had been hospitalized from 1/8/19-1/15/19 for an "untreatable urinary tract infection (UTI)" and again from 8/16/19-8/20/19 for an UTI. On 10/30/19 the team agreed to increase client #12's dosage of Thorazine to 150 mg via tube three times a day, for explosive behaviors and agitations. During interview with the qualified intellectual disabilities professional (QIDP) on 11/18/19 she shared that client #12's mother was deceased for more than a year. The client's sister had expressed an interest in becoming the guardian but had not filed the required paperwork, although assistance had been offered. The QIDP indicated the last time she had discussed guardianship with client #12's sister was when he was in the hospital in August.	W 125		
W 130	PROTECTION OF CLIENTS RIGHTS	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
	34G030	A. BUILDING ______ B. WING ______	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	**126 ROBINHOOD LANE ABERDEEN, NC 28315**

(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 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 observations, record review and interviews, the facility failed to ensure privacy for 2 of 11 audit clients (#8 and #9) residing in the home. The findings are: 1. Client #8 was not afforded privacy while in the home. During evening observations in the home on 11/18/19 at 4:57pm, client #8 entered a bathroom, pulled down his pants and sat on the toilet. Further observations revealed the bathroom door remained open. During in interview on 11/19/19, Staff A revealed client #8 will close a bathroom door independently, for privacy. Review on 11/19/19 of client #8's adaptive behavior inventory (ABI) dated 3/7/19 revealed he will close a bathroom door interdependently for privacy. During an interview on 11/19/19, the qualified intellectual disabilities professional (QIDP) stated client #8 needs to verbally prompted to close a bathroom door to ensure his privacy. 2. Privacy was not afforded for client #9 while he rested in bed.	W 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G030	A. BUILDING ______ B. WING ______	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	126 ROBINHOOD LANE ABERDEEN, NC 28315

(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 During observations at the facility on 11/18/19 at 6:04 pm, client #2 had been sitting in lobby area, when she got up from her chair and walked down the hall, pass the visitor bathroom and opened the first bedroom door on her left, without knocking. Staff E who was in the den with the other clients, observed client #2's in the hall and hurriedly left the den and called out to client #2, "let's use the bathroom someplace else." Client #2 was not redirected from the room and entered to use the bathroom, although the room was occupied by client #9, a male client. Review of client #2's adaptive behavior inventory (ABI) dated on 3/15/19 indicated that client #2 had no independence for finding the correct bathroom. During an interview with Staff A on 11/19/19, it was revealed that client #2 typically went to her bathroom or to the bathroom of clients #9 and #11. During an interview with the QIDP on 11/19/19, it was revealed that client #2 usually did a good job going to bathroom independently. QIDP commented that client #2 had been known to use the bathroom in clients #9 and #11 room, without knocking before entering their room. QIDP stated staff were expected to intervene and redirect client #2 from using other client's bathrooms, if there was no urgent need to toilet.	W 130		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual	W 240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G030	A. BUILDING ______ B. WING ______	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	126 ROBINHOOD LANE ABERDEEN, NC 28315

(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 240	Continued From page 3 toward independence.	W 240		

This STANDARD is not met as evidenced by:
Based on observations, record review and staff interviews, the facility failed to ensure that client #2's individual program plan (IPP) included information to support her independence. This affected 1 of 11 clients. The finding is:

Client #2's IPP did not include information to support independent toileting.

During observations in the home on 11/18/19 at 12:50 pm, the door to client 2's room was ajar and she was laying in bed, with a blanket partially covering her body. Next to her hip was a large brown stain on the sheets. The bathroom door was open and the light was still on. On the floor was an used incontinence brief, full of stool, soiled pants on the floor and some stool on the toilet seat. Minutes later, client #2 exited her room, wearing the soiled knit pants from the bathroom floor that had a noticeable brown stain across the buttocks. The qualified intellectual disabilities professional (QIDP) found client #2 in the lobby, and brought client #2 back to her room, where she cleaned her up with the assistance of Staff F.

An additional observation on 11/19/19 at 8:25 am, allowed an opportunity to watch the house manager (HM) approaching client #2 in the lobby and asking to take her to her room to change. Afterwards, HM could be seen leaving client #2's room carrying an incontinence brief.

Record review on 11/19/19 of client #2's adaptive behavior inventory (ABI) dated on 3/15/19 shared

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G030	A. BUILDING ______ B. WING ______	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	126 ROBINHOOD LANE ABERDEEN, NC 28315

(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 240	Continued From page 4 that client #2 was totally independent with daytime and nighttime bowel and bladder control and partially independent with wiping with tissue after a bowel movement and urination and with washing her hands after toileting. In addition, the nursing evaluation on 6/1/19 indicated that client #2 was continent of bowel and bladder. During an interview with the HM on 11/19/19, she revealed that client #2 had intermittent incontinence, but was able to recognize when she needed to use the bathroom. She could walk to the bathroom, sit on the toilet independently, but should be accompanied by staff. Staff needed to assist client #2 with wiping and should check on client #2 while resting for toileting assistance. HM stated that client #2 wore incontinence briefs because she had toileting accidents. During an interview with Staff A on 11/19/19, she revealed that she worked with client #2 most evenings and stated for the past month, client #2 has been having on average, 2 toilet accidents a night. Staff A acknowledged that client #2 was capable of going to the bathroom by herself, sitting on the toilet but would forget to wipe. Client #2 did not wait for staff to accompany her to the bathroom and was wearing "pull ups." Staff A mentioned that she could tell that client #2 had an accident due to odor or visible stain to her clothing. During an interview with QIDP on 11/19/19, she revealed that client #2 did not have a physician's order to wear incontinence briefs and that she did not have accidents often.	W 240		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G030	A. BUILDING ______ B. WING ______	**11/19/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	**126 ROBINHOOD LANE ABERDEEN, NC 28315**

(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 5 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 observation, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of self-help skills, self administration of medications, clothing, dining guidelines and adaptive equipment. This affected 5 of 11 audit clients (#5, #8, #11, #14 and #15). The findings are: 1. Client #5's adaptive equipment guidelines were not followed. During afternoon observations in the home on 11/18/19, at 12:26pm client #5 was wheeled into the dining room using her Rifton Chair. Review on 11/19/19 of client #5's Rifton chair guidelines dated May 2017 stated, "...7. Please do not push her in the Rifton chair because she could fall out of the chair or the chair could tip forward...." During an interview on 11/19/19, the qualified intellectual disabilities professional stated client	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G030	A. BUILDING ______ B. WING ______	**11/19/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	**126 ROBINHOOD LANE ABERDEEN, NC 28315**

(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 6 #5 is not suppose to be pushed while sitting in the Rifton chair. 2. Client #5's dining guidelines were not followed. During breakfast observations in the home on 11/19/19 at 8:45am, client #5 was observed eating her cereal with her fingers. Further observations revealed Staff A telling client #5 "slow down". Additional observations revealed Staff A assisting another client at a different table while she ate. Further observations revealed a spoon at client #5's place setting. During an interview on 11/19/19, Staff A revealed client #5 does not know how to use a spoon. Additional interview revealed client #5 prefers to eat with her fingers and she will not use a spoon when it is presented to her. Review on 11/19/19 of client #5's dining guidelines dated 11/3/16 revealed, "...[Client #5] eats with her L hand using a built-up spoon. She is resistive to hand over hand for scooping therefore staff scoops the foods for her...Note: Her plate is placed away from her reach unless finger foods are used. Adaptive items used...built up spoon." Review on 11/19/19 of client #5's IPP dated 12/13/19 stated, "[Client #5] eats with her left hand using a built-up spoon. She is resistive to hand over hand for scooping therefore staff scoops the foods for her." Further review revealed, "When eating [Client #5] has her plate placed away from her unless finger foods are consumed. She uses a...built up spoon." Review on 11/19/19 of client #5's adaptive	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G030	A. BUILDING ______ B. WING ______	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	126 ROBINHOOD LANE ABERDEEN, NC 28315

(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 7 behavior inventory (ABI) dated 8/15/19 stated she has partial independence with using a spoon with minimal spillage. During an interview on 11/19/19, the QIDP revealed client #5 is now trying to use a regular spoon without any adaptive features. The QIDP stated client #5's plate is suppose to be pushed away from her unless she is eating finger foods. 3. Client #11 was not prompted to change his clothing. During observations during the survey on 11/18-19/19, client #11 was observed wearing jeans, a striped button down shirt under a brown pull over shirt. At no time was client #11 prompted to change is clothing. Review on 11/19/19 of client #11's IPP dated 6/27/19 revealed, "[Client 11] will wear the same outfit for several days. He fears that his clothes will be lost in the washer and not returned to him. People working with him should assure [Client #11] that his clothing will be returned to him. If he is not informed of this, he will become upset and refuse to change." Additional review revealed, "Sometimes he will wear the same outfit every day. He does this because he thinks he will not get his clothe back after they have been washed. Staff can support [Client #11] by assisting me with washing my clothes." Review on 11/19/19 of client #11's ABI dated 5/3/19 revealed, "[Client #11] dress independently but he will wear the same clothes without washing then several days in a row. Staff need to prompt him to change clothes continuously."	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G030	A. BUILDING ______ B. WING ______	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	126 ROBINHOOD LANE ABERDEEN, NC 28315

(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 8	W 249		

During an interview on 11/19/19, Staff B stated client #11 will wear the same clothes every day without changing them. Further interview revealed staff need to ensure client #11 he will get his clothes back after they are washed. Additional interview revealed client #11 will use inapropriate language if staff are trying to redirect him to change his clothing after he is already dressed.

During an interview on 11/19/19, the QIDP stated client #11 is very particular about his clothes and it can be very hard for him to change his clothes after he is dressed.

4. Client #8 was not prompted to flush the toilet.

During evening observations in the home on 11/18/19 at 4:57pm, client #8 entered a bathroom, pulled down his pants and sat on the toilet. Further observations revealed client #8 exiting the bathroom at 4:58pm without flushing the toilet.

Review on 11/19/19 of client #8's ABI dated 3/7/19 revealed he is totally independent with flushing the toilet.

During an interview on 11/19/19, Staff A stated client #8 will flush the toilet on his own.

During an interview on 11/19/19, the QIDP revealed client #8 needs to be verbally prompted to flush the toilet.

5. Clients #8 and #11 did not wash their hands after toileting.

a. During evening observations in the home on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G030	A. BUILDING ______ B. WING ______	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	**126 ROBINHOOD LANE ABERDEEN, NC 28315**

(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 9 11/18/19 at 4:57pm, client #8 entered a bathroom, pulled down his pants and sat on the toilet. Further observations revealed client #8 exiting the bathroom at 4:58pm without washing his hands. Review on 11/19/19 of client #8's ABI dated 3/7/19 revealed he is totally independent with washing his hands after using the toilet. During an interview on 11/19/19, Staff A revealed client #8 needs to be verbally prompted to wash his hands after toileting. During an interview on 11/19/19, the QIDP stated client #8 needs to be verbally prompted to wash his hands. b. During evening observations in the home on 11/18/19 at 5:05 pm, client #11 indicated to Staff C that he needed to use the bathroom, went into bathroom, flushed toilet, and then exited the bathroom without washing his hands. Review on 11/19/19 of client #11's ABI dated 6/27/19 revealed that totally independent with washing hands after using the toilet. During an interview on 11/19/19, the QIDP had previously observed client #11 to exit the bathroom with a paper towel, when he remembered to wash hands. The QIDP indicated that client #11 at times needed reminders to wash his hands and would need to be redirected to use hand sanitizer. 6. The med techs did not consistently involve clients #14 and #15 in self-administration of their medications.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G030	A. BUILDING ______ B. WING ______	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	126 ROBINHOOD LANE ABERDEEN, NC 28315

(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 10 a. During observations on 11/18/19 from 4:47-4:53 pm of medication administration, Staff C popped the pill (Divalproex Tab 500 mg) from blister pack and placed pill in plastic sleeve, then crushed the pill without any assistance from client #15. Staff C also removed applesauce container from the refrigerator and scooped contents into a small med cup, adding crushed pill and stirred medicine for client #15. In addition, Staff C took a water pitcher and poured a cup of water for client #15 without her assistance and took the spoon and placed it in client #15's mouth so that she could ingest the medication. Then Staff C provided hand over hand assistance to hold the cup so that client #15 could drink. Review on 11/19/19 of client #15's annual nursing evaluation dated on 8/2/19 that client #15 could use hand over hand assistance to punch out meds. A further review of the IPP dated 8/22/19, revealed that she can hold cup and drink from a straw. Staff working with her on self administration of meds should assist with hand over hand when scooping her meds from a bowl cup. During an interview with Staff C on 11/18/19, revealed that he held her cup because she had hand tremors. b. During observations on 11/19/19 from 7:23-7:43 am of medication administration, Staff D did not allow opportunity for client #14 to pour cranberry juice or dispose trash afterwards. Review on 11/19/19 of client #14's IPP dated 8/20/19, revealed that client #14 was capable of pouring her water and disposing the trash.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G030	A. BUILDING ______ B. WING ______	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	**126 ROBINHOOD LANE ABERDEEN, NC 28315**

(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 11 During an interview with the director of nursing (DON) on 11/19/19, she explained that all med techs have received computer based training on administering medications with clients.	W 249		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to adequately train staff on hygiene practices when performing medication administration. This affected 1 of 5 audit clients (#6). The finding is: Staff failed to use gloves when touching pill. During observations of medication administration on 11/19/19 at 7:05 am, Staff D opened two capsule medications (Cranberry Capsule 400 mg and Docusate Sod Capsule 100 mg) with her bare hands and sprinkled the contents into a medication cup. Interview with Staff D on 11/19/19 revealed that she understood that she was only required to wear gloves when administering eye and ear drops and for medications that had a warning, to not touch with bare skin. Interview with the director of nursing (DON) on	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G030	A. BUILDING ______ B. WING ______	**11/19/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	**126 ROBINHOOD LANE ABERDEEN, NC 28315**

(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 340	Continued From page 12 11/19/19 revealed that staff had been trained to wear gloves whenever touching pills.	W 340		
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: Based on observations, record review and interviews, the facility failed to follow physician orders when administering medications to 2 of 5 clients (#7 and #6). The findings are: 1. The medication technicians did not measure fluids when mixing with medications. During observation of the 4 pm medication administration by Staff C on 11/18/19 at 5:14 pm, Staff C measured 17 gram of Miralax powder and poured in a clear drinking cup. Staff C then poured an undetermined and unmeasured amount of nectar thick cranberry juice, over the powder in the cup and stopped at the top line of the cup. The mixture was partially stirred and offered to client #7 to drink, independently. An additional observation of the 8 am medication administration by Staff D on 11/19/19 at 7:18 am, revealed that Staff D measured 30 cc of Lactulose and Miralax powder, then poured into a clear plastic cup. Staff D then poured an unmeasured amount of nectar thick cranberry juice over the mixture, stirred it and offered to client #7.	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G030	A. BUILDING ______ B. WING ______	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	**126 ROBINHOOD LANE ABERDEEN, NC 28315**

(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 13	W 368		

Review of client #7's November 2019 Physician's Orders revealed that client #7 should have received 17 grams of Miralax mixed with 4 ounces of beverage.

During an interview with Staff C on 11/18/19 revealed that he poured 8 ounces of juice and mixed with the Miralax powder. When asked what the physician's order read, he reviewed it and stated that the order was for 4 ounces.

During an interview with Staff D on 11/19/19 revealed that she was told when pouring fluids in the cup, to try to get it up to 8 ounces.

During an interview with the Director of Nursing (DON) on 11/19/19 was that the medication room had a measuring cup and staff should use the cup when measuring fluids that needed to be poured. The DON also went to the refrigerator and pulled out a 4 ounce container of thickened water that was intended for client #7 to use during med pass to mix with orders.

2. The medication technician did not offer Acetaminophen at the prescribed time listed on the physician's orders.

During observation of the 4 pm medication administration by Staff C on 11/18/19 at 5:40 pm, client #6 was given a single dose of Acetaminophen 325 mg, mixed in applesauce.

Review of the Physician's Orders, dated November 2019 revealed that client #6 was ordered to receive Acetaminophen 325 mg at 8 am, 2 pm, 8 pm and 2 am, that was written on 7/22/19.

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	34G030	A. BUILDING ______ B. WING ______	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERWOOD PARK HOME	126 ROBINHOOD LANE ABERDEEN, NC 28315

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W 368	Continued From page 14 During an interview with the DON on 11/19/19 revealed that a former nurse transcribed the 7/22/19 new order for Acetaminophen 325 mg on the medication administration order (MAR) that suggested that the medication be given every 6 hours. The DON speculated that the nurse might have been trying to offset Motrin was given to client #6 at 8 am, 2 pm, 8 pm and 2 am and wrote to administer at 6 am, 12 pm, 6 pm and 12 am instead. When reviewing the actual physician's orders, the DON conceded that given the medication yesterday at 5:40 pm, would be a medication error.	W 368		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed 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 observations, record review and interviews, the facility failed to ensure client #9's wheelchair was repaired and client #3 received a recommended wheelchair, this affected 2 of 11 audit clients. The findings are: 1. Client #9's wheelchair is in need of repair. During observations throughout the survey on 11/18-19/19 client # 9's right foot rest on his wheelchair was torn. Further observations revealed the cushion inside of the foot rest was	W 436		

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	34G030	A. BUILDING ______ B. WING ______	11/19/2019

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W 436	Continued From page 15 visible and hanging out. During an interview on 11/19/19, Staff B revealed whenever he transfer client #9 into the wheelchair his right leg looked very uncomfortable. Further interview revealed Staff B stating the "medical personnel" from the facility stated having client #9 use the Geri chair which was more comfortable. Further interview revealed client #9's foot rest was torn when he transferred from another facility in September 2019. During an interview on 11/19/19, the qualified intellectual disabilities professional (QIDP) revealed she had not noticed the torn foot rest on client #9's wheelchair. 2. Staff did not follow up on ordering recommended wheelchair for client #3 During observations in the home on 11/18/19 at 4:30 pm, client #3 was up in his wheelchair for medications, then at 4:45 pm, client #3 was transported to the den to watch television. The wheelchair was tilted backwards. Review of client #3's chart revealed a QIDP note dated on 3/15/19 stated that client #3 had a stage 3 ulcer on sacrum and was referred to the wound clinic for treatment. An additional review of the record's individual program plan (IPP) dated on 3/26/19, revealed that he was on a positioning program since his ability to position was impaired and placed him high risk for pressure ulcers. In a further review of the chart, revealed the occupational therapy (OT) notes on 6/19/19 indicated that client #3 was assessed for new	W 436		

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	34G030	A. BUILDING ______ B. WING ______	**11/19/2019**

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W 436	Continued From page 16 wheelchair and that OT was waiting for documentation from named staff to start the process for insurance authorization. On 6/21/19, the team agreed to get new wheelchair. During an interview with the director of nursing (DON) on 11/19/19, she indicated that the previous nurse had coordinated replacing client #3's wheelchair at the wheelchair clinic and she thought they were waiting to see what was going to be reimbursed (by insurance) so that they could pay the difference. She indicated that she would need to review the record to get specific information, then later acknowledged that she could not find any follow up notes in the file concerning client #3's wheelchair replacement. During an interview with the QIDP on 11/19/19, she recalled that over the summer it was determined that client #3 did not qualify for a new wheelchair because his Medicaid was not correct, but could not recall the details. She further stated that the physical therapist provided a measurement for the chair to submit to insurance but it was put on hold when client #3 was discharged in September and placed in Hospice, but was later able to return to the facility. QIDP could not find documentation that client #3 was seen in the wheelchair clinic to get new chair.	W 436		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on review of fire drill reports and interview,	W 441		

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SHERWOOD PARK HOME	126 ROBINHOOD LANE ABERDEEN, NC 28315

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W 441	Continued From page 17 the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients residing in the home. The finding is: Fire drills on first, second and third shifts were not conducted at varied times. Review of fire drill reports on 11/18/19 revealed the following: Four fire drills were conducted on first shift: 11:28am, 11:52am, 12:34pm and 12:30pm. Five fire drills were conducted on second shift: 5:45pm, 6:10pm, 6:30pm, 6:12pm and 5:53pm. Four fire drills were conducted on third shift: 1:01am, 12:02am, 12:29am and 12:07am. During an interview on 11/18/19, the qualified intellectual disabilities professional (QIDP) confirmed the fire drills conducted on first, second and third shifts were not varied. Further interview revealed first shirt hours are 7am/7:30 until 3pm/3:30pm, second shift hours are 3pm until 11pm and third shift hours are 11pm until 7am/8am.	W 441		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to contain soiled linens and disposable briefs, during transport to prevent the potential for	W 454		

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W 454	Continued From page 18 leakage or contamination of other surfaces. This potentially affected all clients in the home. The findings are: During observations at the facility on 11/18/19 at 12:50 pm, client #2 was observed in bed, on top of soiled sheet that contained feces. The qualified intellectual disabilities professional as well as Staff F entered client #2's room to change her and clean up soiled areas. Staff F was seen leaving the room, carrying balled up linens, with visible stool, across the hall to the bathroom. Further observations at the facility on 11/18/19 at 5:12 pm, Staff E left an unknown client's room and was seen walking up the hallway, to the laundry room carrying a soiled garment that contained stool. During observation at the facility on 11/19/19 at 6:50 am, Staff G was observed coming out of unknown client's room, with a soiled item and placed it in the open plastic bag, that was on the hall floor. Staff G then re-entered the room. The area where the bag was placed had a noticeable odor of stool. Continued observation at the facility on 11/19/19 at 8:30 am, the house manager (HM) was observed leaving a client #2's room carrying an used open incontinence brief on the hall to the bathroom to discard. During an interview with the director of nursing (DON) on 11/19/19 revealed that staff were trained to contain soiled items before transporting in order to maintain infection control. When items were being transported, they should be placed in a hamper. The DON acknowledged that the	W 454		

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W 454 Continued From page 19 W 454

facility needed to order additional hampers for staff to use.

W 455 INFECTION CONTROL W 455

CFR(s): 483.470(l)(1)

There must be an active program for the prevention, control, and investigation of infection and communicable diseases.

This STANDARD is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure that the infections control prevention procedures were carried out. This potentially affected all clients residing in the home. The findings are:

Precautions were not taken to promote client health and prevent possible cross-contamination.

1. During evening observations in the home on 11/18/19 at 4:58pm, client #8 exited the bathroom after using the toilet and did not wash his hands. Further observations revealed client #8 sitting down at a table in the activity room and at 5pm, he touched one of the cards from a matching game. Additional observations revealed another client then touching the cards. Client #8 then stood up walked to a couch sat down and at 6:13pm he picked his nose 5 times. Further observations revealed client #8 sitting at the dining room table at 6:20pm and touching the napkin holder. At no time was client #8 prompted to wash his hands.

During an interview on 11/19/19, Staff A revealed client #8 needs to be verbally prompted to wash his hands.

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W 455	Continued From page 20 Review on 11/19/19 of client #8's adaptive behavior inventory (ABI) dated 3/7/19 stated he is independent when it comes to washing his hands. During an interview on qualified intellectual disabilities professional (QIDP) revealed client #8 needs to be verbally prompted to wash his hands. 2. During observations at the facility on 11/18/19 at 5:05 pm, client #11 entered his room and told Staff C that he needed to use the bathroom. Client #11 independently used the toilet, flushed it, then exited the bathroom. He touched the door knobs to the bathroom, then the bedroom door and returned to the hall. Staff C who was giving client #9 a nutritional supplement, left the room touching the same door knob. Review of client #11's ABI dated 5/31/19 stated that client #11 was totally independent of washing his hands after toileting. During an interview with the QIDP on 11/19/19 revealed that there were times when client #11 forgot to wash his hands after toileting, although he was mostly independent. The QIDP commented that client #11 would often be seen rubbing hands on paper towel, after washing hands and exiting the bathroom.	W 455		