STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G278	A. BUILDING _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENT FERRY HOME	904 AVENT FERRY ROAD HOLLY SPRINGS, NC 27 540

(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
E 037	**EP Training Program** **CFR(s): 483.475(d)(1)** **(1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:** **(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.** **(ii) Provide emergency preparedness training at least annually.** **(iii) Maintain documentation of the training.** **(iv) Demonstrate staff knowledge of emergency procedures.** ***[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:** **(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.** **(ii) Provide emergency preparedness training at least annually.** **(iii) Maintain documentation of the training.** **(iv) Demonstrate staff knowledge of emergency procedures.** ***[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:** **(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.** **(ii) Demonstrate staff knowledge of emergency procedures.**	E 037	RECEIVED NOV 0 6 2019 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	QIDP	11.1.19

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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E 037	Continued From page 1 (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.	E 037		

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E 037	Continued From page 2 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The	E 037		

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E 037	Continued From page 3 **CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.** **This STANDARD is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to ensure direct care staff were adequately trained in the facility's emergency plan (EP). The finding is:** **Facility conducted EP training to only minimum staff.** **Review on 10/15/19 of the facility documents dated 10/12/19 revealed an in-service class was held with 8 employees in attendance. Three of the seven staff (Staff D, E and G) were listed as attendees.** **During an interview on 10/15/19 with Staff B, revealed that she did not participate in the recent training for EP. Staff B could not state where to transport clients offsite in the event of an emergency evacuation and was not familiar with the emergency communication equipment selected for use.** **During an interview on 10/16/19 with Staff E, it was revealed that he had not attended any emergency training this year.** **During an interview with the qualified intellectual**	E 037	The facility will ensure that all staff receive training on the Emergency Preparedness Plan (EPP). The QP and/or Program Manager will provide training to all staff (D, E and G, etc.) on the facility's EPP. in addition, the program manager will provide EPP training to any new employees thereafter. The QP will maintain and update in-service training records monthly to ensure documentation of EPP training for all applicable staff. The ICF Director and/or QA will monitor the EPP in-service records monthly to ensure continued compliance.	12/15/19 12/15/19

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E 037	Continued From page 4 disabilities professional (QIDP) on 10/16/19 she initially offered that only two direct care staff who had not received the EP training. When questioned about the other employees working during the survey, who were not on the attendance sheet, the QIDP acknowledged that several more had not received the EP training.	E 037		12/15/19
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii)Conduct an additional exercise that may include, but is not limited to the following: (A)A second full-scale exercise that is community-based or individual, facility-based. (B)A tabletop exercise that includes a group	E 039	The program manager will implement the EPP to include a tabletop exercise and document a summary of the event. The program manager will provide summary documentation of the EPP exercise and address any areas of concern with the activation. The ICF Director and/or QA will monitor the EPP activation quarterly to ensure continued compliance.	12/15/19

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E 039	Continued From page 5 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. '[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure facility/community-based or table top exercises to test their emergency preparedness (EP) plan were conducted. The finding is: The facility's EP plan did not include completion of facility/community-based exercises or table top exercise. Review on 10/15/19 of the facility's EP dated	E 039		

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E 039	Continued From page 6 9/16/19 did not include a table top exercise. During an interview with Staff E on 10/16/19 revealed that he had previously been involved in a full scale emergency preparation exercise, but the facility had not conducted a full scale or table top EP plan exercise this year with staff. During an interview with the QIDP on 10/16/19, she acknowledged that the facility had not conducted a full scale or table top EP plan exercise this year with staff.	E 039		
W 123	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(1) The facility must ensure the rights of all clients. Therefore, the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's rights and the rules of the facility. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 3 audit clients (#5) was fully aware of this rights. The finding is: Client #5 did not receive all the information he needed to be aware of his rights. Review on 10/15/19 revealed client #5 serves as his own guardian. Further review revealed client #5 was admitted to the facility on 4/27/18. Additional review revealed client #5 did not have any documentation in his record explaining his rights. During an interview on 10/16/19, the facility's quality assurance consultant confirmed client #5	W 123	The facility will ensure that all clients and/or or legal guardians are informed of their rights upon admission and updates annually. For Client #5 the QP will gather forms relative to client rights and secure consent from client/guardian. The QP will review all client files to ensure documentation to support awareness of their rights. The ICF Director and/or QA will monitor quarterly to ensure continued compliance.	12/15/19 12/15/19

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W 123	Continued From page 7 did not have any information in his chart explaining his rights. Further interview revealed all clients newly admitted to the facility are to receive a packet of information, which includes the explanation of their rights.	W 123	The facility will ensure written consent for clients with behavior support plans incorporating the use of psychoactive medications and clients' right to privacy during medication administration. For Client #1 the QP will secure written consent from the guardian on the behavior support plan (BSP) dated 9/4/19. The QP will review all clients' BSPs as applicable to ensure written consent to the plan to include use of psychoactive medications. QA and/or ICF Director will monitor monthly to ensure compliance. For Client #3, privacy will be afforded him during medication administration. The QP will provide in-service training to all staff to ensure privacy is afforded to all clients during medication administration. The program manager and/or QP will conduct observations of the medication pass in the home weekly to ensure privacy for clients during medication administration.	12/15/19 12/15/19 12/15/19
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 observations, record reviews and interviews, the facility failed to ensure 1 of 3 audit clients (#1, #3) had the right to have a consent obtained by their legal guardians and client #3 was afforded the right to privacy during his medication administration. The findings are: 1. Consents were not signed by the legal guardians for clients #1 and #3. a. Review on 10/15/19 of client #1's record revealed a behavior support plan (BSP) dated 9/4/19. Further review revealed client #1's behavior medications are: Tegretol, Risperdal, Mitazapine and Cogentin. Additional review of client #1's record revealed he does not have a current behavior consent signed by his legal guardian. During an interview on 10/15/19, the qualified intellectual disabilities professional (QIDP) confirmed client #1 does not have a behavior consent for his medications signed by his	W 125		

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W 125	Continued From page 8 guardian. b. Review on 10/15/19 of client's 3's record revealed a BSP dated 8/1/19. Further review revealed client #3's behavior medications are: Impramine, Lithium, Gedon and Lamictal. Additional review of client #3's record revealed the last behavior consent signed by the legal guardian was on 9/20/17. During an interview on 10/15/19, the QIDP commented that the legal guardian was given the packet for consents at the individual program plan (IPP) meeting held on 9/12/19. She further revealed that th legal guardian took the unsigned consents with him, due to his hurried schedule and the forms were not returned. 2. Client #3 was not afforded the right to his privacy during medication administration. During morning medication observations in the home on 10/16/19 at 7:11am, client #3 came into the medication room, sat down and reached over to shut the door. Immediately, Staff D said, "No, let it stay open it's hot in here." At 7:18am, another client came to the open door and asked Staff D for a medication cup. Further observations revealed the other client came to the open door three more times asking for a medication cup, while Staff D was administering client #3 his medications. During an interview on 10/16/19, Staff D revealed she wanted the door to remain open because she was getting hot. During an interview on 10/16/19, the QIDP confirmed client #3 should have been afforded	W 125		

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W 125	Continued From page 9 the right to close the door during his medication administration.	W 125	The facility will ensure privacy for all cleints during the care of personal needs to include but not limited to dressing and toileting.	12/15/19
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 observations, record review and interviews, the facility failed to ensure privacy for 1 of 3 audit clients (#5) residing in the home. The findings are: Client #5 was not afforded privacy while in the home. a. During evening observations in the home on 10/15/19 at 5:51pm, client #5 was observed sitting on the toilet. Further observations revealed the bathroom door remained opened. At no time was client #5 prompted to close the bathroom door. Review on 10/16/19 of client #5's adaptive behavior inventory (ABI) dated 9/1/19 revealed he is not independent with closing the bathroom door for privacy. During an interview on 10/16/19, Staff F revealed client #5 relies on staff to ensure the bathroom door is closed for privacy. b. During morning observations in the home on 10/16/19 at 6:03am, Staff F entered client #5's bedroom and began assisting him out of the bed.	W 130 to client #5	The QP will provide in-service training to all staff on importance of privacy for clients during dressing and toileting. The staff will be instructed to have client close the bathroom door or bedroom door and staff are to assist the client as necessary to ensure privacy. Client #5 will be prompted to close the bedroom and bathroom doors; staff will provide assistance as needed to ensure privacy during care of personal needs for client #5. The home manager will conduct morning and evening observations in the group home twice weekly to ensure privacy for all cleints during care of their personal needs. The QP will monitor in the home weekly and QA will monitor monthly to ensure continued compliance.	12/15/19 12/15/19

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W 130	Continued From page 10 Further observations revealed client #5 was only wearing depends. At 6:05am, other clients and staff were observed walking pass client # 5's bedroom. At 6:07am, client #5's depends fell completely off, where as he was completely naked. During the observations in client #5's bedroom, the door remained wide open. Further observations revealed client #5 and Staff F exiting his bedroom, walking down the hallway and entering the far bathroom. Additional observations revealed client #5 was not wearing any clothing when he exited his bedroom to walk down to the bathroom. At 6:21am, client #5 and Staff F exited the bathroom to return to his bedroom. Additional observations revealed client #5's robe was open and his depends was visible. Client #5's bedroom door remained open while Staff F assisted him with getting dressed. Review on 10/16/19 of client #5's adaptive behavior inventory (ABI) dated 9/1/19 revealed he is not independent with closing the bathroom door for privacy. During an interview on 10/16/19, Staff F revealed he should have closed client #5's bedroom door for privacy. Further interview revealed he was "trying to get [Client #5] into the bathroom in a hurry" so that is the reason he had him walk out of his bedroom into the bathroom without any clothes on. During an interview on 10/16/19, the qualified intellectual disabilities professional (QIDP) revealed client #5 should have been given verbal prompts to close the doors for privacy.	W 130		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2)	W 192		

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W 192	Continued From page 11 **For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.** **This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained on competencies directed towards client's health needs. This affected 1 of 3 audit clients (#3). The finding is:** **Staff documented client #3 received 17 grams of his Miralax, even though he did not.** **During morning medication observations in the home on 10/16/19 at 7:25am, Staff D poured client #3's Miralax into the purple cap all the way to the top, which comes with the bottle of Miralax. Further observations revealed Staff D then pouring some of the Miralax back into the bottle. Additional review revealed Staff D then leaving the medication room, going into the kitchen looking for a measuring cup to measure for 17 grams; when the surveyor asked was that 17 grams of Miralax in the cap. Staff then came back from the kitchen without any measuring devices and just poured the undetermined amount of Miralax into 8 ounces of juice.** **During an interview on 10/16/19, Staff D revealed she was unaware there was a line inside of the purple cap which indicated where to pour the Miralax to 17 grams.** **During an interview on 10/16/19, the facility's nurse confirmed all staff are trained by one of the other nurses to ensure they are aware on how to**	W 192	The facility will ensure that staff receive training and demonstrate competencies to administer medications in accordance with the physician's orders to include but not limited to appropriate amount of mixtures such as Miralax. For Client #3, the home manager will provide in-service training to all staff on the accurate measurement of Miralax to 17 grams. The home manager will conduct weekly morning medication pass observations in the home to determine accurate measurement of Miralax and other such mixtures to clients as applicable. The QP and/or QA will monitor medication pass observations in the home twice monthly to ensure continued compliance.	12/15/19 12/15/19

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W 192	Continued From page 12 measure out medications. Further interview revealed management will do observations on staff during medication administration and all have have to go though a recertification process once a year.	W 192	For all clients, the facility will ensure implementation of individual program plan (IPP) interventions to address dining and self-help skills.	
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 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 dining skills and self-help skills. This affected 3 of 3 audit clients (#1, #3, #5). The findings are: 1. Clients #1 and #5 were not prompted to wipe their mouths during breakfast. a. During breakfast observations in the home on 10/16/19 at 6:47am, client #1 stood up from the table after consuming his breakfast. Further observations revealed he had food particles on the corner of his mouth. Additional observations revealed there were no napkins at client #1's	W 249	1.For clients' #1 and #5 the program manager will provide in-service training to all staff to include instructions to provide assistance and allow client participation in wiping mouth with a napkin during meals to address food spillage. The program manager and/or QP will provide weekly observations of meals in the home to ensure continued compliance. 2.For client #5 the program manager will provide in-service training to all staff on the need to prompt client to flush the toilet and wash hands after toileting. The program manager and/or QP will provide weekly observations of morning routine in the home to ensure continued compliance.	

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W 249	Continued From page 13 place setting or on the table. Review on 10/16/19 of client #1's adaptive behavior inventory (ABI) dated 9/1/19 revealed he does not have any independence when it comes to wiping his mouth with a napkin. b. During breakfast observations in the home on 10/16/19 at 6:50 am, client #5 had food particles on the corner of his mouth. Additional observations revealed there were no napkins at client #5's place setting or on the table. Review on 10/16/19 of client #5's adaptive behavior inventory (ABI) dated 9/1/19 revealed he does not have any independence when it comes to wiping his mouth with a napkin. During an interview on 10/16/19, the qualified intellectual disabilities professional (QIDP) revealed there should have been napkins on the table to ensure both clients #1 and #5 were given the opportunity to wipe their mouths. 2. Client #5 was not prompted to flush the toilet or wash his hands after toileting. During evening observations in the home on 10/15/19 at 5:51pm, client #5 was observed sitting on the toilet, with his right hand down between his legs. Further observations revealed client #5 did not flush the toilet or wash his hands before exiting the bathroom. Review on 10/16/19 of client #5's ABI dated 9/1/19 revealed he does not have independence is either flushing the toilet or washing his hands. During an interview on 10/16/19, the QIDP	W 249	For clients #1 and #5 the program manager will provide in service training on the availability of napkins during all melas and snacks. Staff will be instructed to have clients participate in setting place setting to include the napkins. Staff will prompt the use of napkins during meals or snacks for all clients in the home. The program manager and/or QP will monitor in the home during meals weekly to ensure compliance. 2.For client #5 the program manager will provide in-service training to all staff on the need to prompt client to flush the toilet and wash hands after toileting. The program manager and/or QP will conduct weekly observations of evening routine in the home to ensure continued compliance.	12/15/19 12/15/19 12/15/19

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W 249	Continued From page 14 **revealed staff should have verbally prompted client #5 to flush the toilet and to wash his hands prior to him exiting the bathroom.** **3. Clients #3 and #5 dining guidelines were not followed.** **a. During breakfast observations in the home on 10/16/19 at 6:42am, client #5 was served all of his meal at one time on a single plate. His breakfast consisted of two waffles and two scoops of scambled eggs.** **Review on 10/15/19 of client #5's IPP dated 5/26/19 stated, "...staff should prepare 1/2 portion of meal on one plate and then another 1/2 portion of meal on a separate plate."** **During an interview on 10/16/19, the QIDP confirmed client #5's food should be served in one 1/2 portions at a time. Further interview revealed he should not be served his entire meal at one.** **b. During dinner observations on 10/15/19 at 6:30 pm, client #3 was observed to pick up a piece of baked pork chop with right hand, lift to his mouth and bite into it. Client #3 intermittently used his fork to eat the pieces of fork on plate, but used his fingers to pick up cooked black beans and chopped red and green peppers. Staff A and B remained at the table, while the clients ate and at no time were observed to verbally prompt client #3 to get a knife and to use his utensils to eat. Further observations at breakfast on 10/16/19 at 6:35 am, client #3 used a fork and spoon to cut his waffles. At no time did Staff D and F, who were present at the table, encourage client #3 to use a knife.**	W 249	3. For clients #3 and #5 the program manager will provide in-service training to all staff on their dining guidelines. Staff will follow ½ portions protocol for client #5 during all meals. For client #3 staff will prompt client to retrieve all utensils before the meal. Staff will redirect client from the use of his fingers and to use appropriate utensils to include but not limited to a knife and fork when applicable. The program manager and/or QP will monitor in the home during meals weekly to ensure compliance.	12/15/19 12/15/19

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W 249	Continued From page 15 Review of client #3's IPP dated 9/12/19 revealed that he ate independently. Further review of the ABI dated 9/1/19 indicated that client #3 finger feeds some food and was independent with using a knife for cutting. He was also independent with using appropriate eating utensils for different foods. Interview with the QIDP on 1016/19 revealed that sometimes client #3 would not use his utensils and will use his fingers. She stated that staff should verbally prompt client #3 to ensure that he has the proper utensils and encourage him as well to use all 3 utensils.	W 249	The facility will ensure that staff complete documentation on the flow sheet accordingly.	12/15/19
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on documentation review and interviews, the facility failed to ensure data was documented correctly. This affected 1 of 3 audit clients (#5). The finding is: 1. Client #5's data was not collected on a consistent basis. During observations throughout the survey on 10/15 - 16/19, client #5's fingernails were observed to be very long and over the top of his fingers.	W 252	For Client #5, the program manager will in service all staff on the need to cut client's fingernails every two weeks and document on flow sheet. The program manager will monitor in the home weekly to review status of client #5's fingernails and documentation on the flow sheet for all clients for continued compliance.	12/15/19

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W 252	Continued From page 16 Review on 10/15/19 of client #'s daily flow sheet for the month of October 2019 his fingernails were only cut once on 10/6/19; the other days were either blank or had a minus symbol. For the month of September 2019 his fingernails were only cut on 9/24/19; the other days were either blank or had a minus symbol. Further review revealed for the month of August 2019 his fingernails were only cut on 9/24/19; the other days were either blank or had a minus symbol. Review on 10/16/19 of client #5's guidelines for cutting nails dated 5/2018 stated, "This guideline is devised for [Client #5] to receive total assistance with cutting his finger...nails every two weeks after bath time...finger...nails will be checked on both hands...prior to cutting his nails and to make sure nails are neatly trimmed." Review on 10/16/19 of a incident report dated 9/12/19 revealed client #5 had scratches on his right arm. Further review revealed the following comments: "Staff will be inserviced on cutting [Client #5's] nails on a weekly basis." During an interview on 10/15/19, Staff C revealed the minus on the data sheet means the cutting of client #5"s fingernails was not accomplished. Further interview revealed client #5's fingernails grow very fast. When asked about the length of client #5's fingernails Staff C said that is "about a weeks worth of growth." During an interview on 10/15/19, the qualified intellectual disabilities professional (QIDP) revealed there was a in-service two weeks ago about ensuring documentation is complete.	W 252		

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W 287	Continued From page 17	W 287		12/15/19
W 287	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 1 of 3 audit clients (#5) received a technique to manage inappropriate behavior was not used for the convenience of staff. The finding is: The facility failed to ensure a technique to manage the inappropriate behavior of client #5 was not used for the convenience of staff. During morning medication observations in the home on 10/16/19 at 7:55am, Staff F locked the door of the medication room. Further observations revealed client #5 standing at the door, turning the door knob and pushing on the door. At 8:01am, Staff F unlocked the door, exited the medication room to obtain some applesauce. At 8:02am, Staff F reentered the medication room and locked the door again. During an interview on 10/16/19, Staff F said, "Locking the door makes it easy for me, because [Client #5] will leave the medication room." During an interview on 10/16/19, the qualified intellectual disabilities professional (QIDP) revealed there is no time the medication room door should be locked while a client is in the medication room receiving their medications.	W 287	The facility will ensure that any techniques to manage client behaviors are not used for the convenience of staff. The QP will in-service all staff on Client #5's individual support plan. Staff will be instructed to not lock the door to the medication room since this is not allowable under the existing plan. The program manager and/or QP will monitor the morning medication pass to ensure continued compliance.	12/15/19

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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 observations, record review and interviews, the facility failed to ensure a technique to address the inappropriate behaviors of 1 of 3 audit clients (#5) was included in an active treatment program. The finding is:** **A technique to manage client #5's eating at a rapid rate was not part of an active treatment plan.** **During breakfast observations in the home on 10/16/19, Staff F was physically using their open hand/palm to hold down client #5's wrist while he was attempting to consume his breakfast. Further observations revealed Staff F utilized this technique on two separate occasions. Additional observations revealed client #5 was still holding his spoon and attempting to scoop more food.** **During an interview on 10/16/19, Staff F revealed the holding down of client #5's wrist is not part of his plan. Further interview revealed Staff F held client #5's wrist due to the fact his was eating fast.** **Review on 10/16/19 of client #5's informal eating guidelines dated 5/2018 does not indicate staff are to hold down his wrist if he is eating at a rapid pace.**	W 288	The facility will ensure that any techniques to manage client behaviors are not used outside of an active treatment program. The QP will in-service all staff on Client #5's individual support plan (ISP). The ISP does not address any physical holds to the wrist to slow the rate of eating. The dining guidelines will be reviewed to address staff competencies in slowing the client's rate of eating. The program manager and/or QP will monitor breakfast meals weekly in the home to ensure continued compliance.	12/15/19 12/15/19

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W 288	Continued From page 19 During an interview on 10/16/19, the qualified intellectual disabilities professional confirmed client #5's wrist should not have been held down while he was eating.	W 288		
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 observation, record review and interview, the facility failed to ensure the system of administrating medications as ordered was implemented. This affected 1 of 3 audit clients (#3) The findings are: 1. Client #3 did not receive his Miralax as ordered. a. During an medication administration observation in the home on 10/15/19 at 4:50pm, client #3 bought a cup of water into the medication room. Further observations revealed it was an undetermined amount of water in the glass. During an interview on 10/15/19, Staff B stated, "[Client #3] usually gets the water when he comes from the kitchen." Further interview revealed Staff B stated she "didn't know if it was eight ounces of water" in the glass. Review on 10/16/19 of client #3's physician's orders signed 8/30/19 stated, "Mix One Cap (17 grams) with 8 oz of water...."	W 368	The facility will ensure medications are administered to all clients in accordance with the physician's orders to include but not limited to medication mixtures. For Client # 3 the QP will provide in-service training to all staff on administration of medications. Staff will be instructed to secure 8 ounces of water for the Miralax. In addition, staff will administer 17 grams of the Miralax mixture. QA, Home Manager and /or QP will monitor the medication pass weekly in the home to ensure continued compliance.	12/15/19 12/15/19

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W 368	Continued From page 20 b. During morning medication observations in the home on 10/16/19 at 7:25am, Staff D poured client #3's Miralax into the purple cap all the way to the top, which comes with the bottle of Miralax. Further observations revealed Staff D then pouring an some of the Miralax back into the bottle. Staff then poured the undetermined amount of Miralax into 8 ounces of juice. During an interview on 10/16/19, Staff D revealed she was unaware there was a line inside of the purple cap which indicated where to pour the Miralax to 17 grams. Review on 10/16/19 of client #3's physician's orders signed 8/30/19 stated, "Mix One Cap (17 grams)...." During an interview on 10/16/19, the facility's nurse confirmed all staff are trained by one of the other nurses to ensure they are aware on how to measure out medications. Further interview revealed management will do observations on staff during medication administration and all have have to go though a recertification process once a year.	W 368		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications remained locked.	W 382		

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W 382	Continued From page 21 The findings are: The medications were left unsecured and unsupervised. 1. During afternoon medication observations in the home on 10/15/19 at 4:54pm, Staff B closed the medication cabinet. Further observations revealed Staff B did not lock the medication cabinet. Additional observations revealed Staff B closing the door to the medication room. The door to the medication room was not locked and the surveyor was able to open it. During an interview on 10/15/19, Staff B revealed she had misplaced the key to the medication cabinet and was unable to ensure it was locked. Further interview revealed she had been trained to ensure all medications are kept locked unless they are being administered. 2. During morning medication observations in the home on 10/16/19 at 7:03am, Staff D exited the medication room. Further observations revealed the medication cabinet was left open. During an interview on 10/16/19, Staff D revealed she had been trained to ensure all medications are kept locked unless they are being administered. During an interview on 10/15/19, the qualified intellectual disabilities professional (QIDP) revealed staff have been trained to ensure all medications are kept locked unless they are being administered. During an interview on 10/16/19, the facility's nurse confirmed all staff have been trained to	W 382	The facility will ensure that medications are always secured unless when preparing for administration. The QP will in-service all staff on the importance of securing the medication room. Staff will be advised to lock the medication room upon exiting and maintain the key on their person. The program manager and/or QP will monitor during the morning and evening routines in the home to ensure continued compliance.	12/15/19 12/15/19

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W 382	Continued From page 22 ensure all medications are kept locked unless they are being administered.	W 382	The facility will ensure that the medication keys are with personnel authorized to administer medications and not left out and accessible to others. The QP will in-service all staff on the importance of limited access to the medication key for only authorized staff. Such access is only for staff who have completed medication administration training. The key will not be left on the medication cart, instead will be maintain on the person of the medication certified staff. The program manager and/or QP will monitor during the morning and evening routines in the home to ensure continued compliance.	12/15/19 12/15/19 12/15/19
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure only authorized persons have access to keys to the drug storage area. The finding is: A key to the facility's drug storage area were accessible to anyone in the home. During afternoon medication observations in the home on 10/15/19 at 4:22pm, the key to the medication cabinet was left on a cart in the medication room, while Staff B exited the room to obtain a towel. Further observations revealed the surveyor and the client were left in the room with the key. During an interview on 10/15/19, Staff B revealed she had been trained to ensure the key is not left unattended. During an interview on 10/15/19, the qualified intellectual disabilities professional (QIDP) confirmed staff have been trained not to leave the key to the medication cabinet unattended. During an interview on 10/16/19, the facility's nurse revealed all staff have been trained to ensure they do not leave the key to the	W 383		

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W 383	Continued From page 23 medication cabinet unattended.	W 383		12/15/19
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 staff interview, the facility failed to ensure 1 of 3 audit clients (#3) had access to a pair of eyeglasses in good condition. The finding is: Client #3's eyeglasses were not repaired. During the survey, from 10/15/19 to 10/16/19, client #3 was not observed wearing his eyeglasses, during vocational, meal preparation, dining and household chores activities. Review on 10/16/19 of client #3's Ophthalmology Report dated for 11/15/18 revealed that new eyeglasses were needed and worn full time. During an interview on 10/16/19, the qualified intellectual disabilities professional (QIDP) revealed that client #3 broke his eyeglasses a few weeks ago, while upset. She had intended to make a referral to the ophthalmologist to have them replaced.	W 436	The facility will ensure that clients have access to assistive devices to include but not limited to eyeglasses. The QP will make a referral for new eyeglasses for client #3. The QP will schedule a team meeting to address Client #3's personal property destruction of eyeglasses. The QP will document results of the team meeting. QA and QP will review the ISPs on quarterly basis for all clients to ensure availability of assistive devices to include but not limited to eyeglasses.	12/15/19
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1)	W 440		

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W 440	Continued From page 24 The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on fire drill reports and interviews, the facility failed to ensure fire drills were conducted one per shift per quarter. This potentially affected all the clients residing in the home. The finding is: The facility did not consistently conduct a fire drill every quarter for first, second and third shifts. Review on 10/16/19 of the fire drill revealed the following five drills were held for a twelve month time frame: 1/14/19 (first shift); 2/6/19 (second shift); 3/4/19 (third shift); 4/12/19 (first shift) and 5/5/19 (second shift). During an interview on 10/16/19, Staff E, who works on third shift, revealed he was not sure when a fire drill was held on third shift. During an on 10/16/19, the qualified intellectual disabilities professional (QIDP) confirmed there was only documentation for five drills for a twelve month time frame.	W 440	The facility will implement a system to ensure that evacuation drills are conducted quarterly for all shifts. The home manager will review and/or develop a schedule for staff in the home to implement evacuation drills quarterly for all 3 shifts (1st, 2nd and 3rd) The QP will in-service all staff on the update evacuation schedule with a specific emphasis on conducting quarterly drills on all 3 shifts. The QA and QP will monitor the evacuation drills on a monthly basis to ensure continuous compliance.	12/15/19 12/15/19
W 455	INFECTION CONTROL 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:	W 455		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G278	A. BLDG. _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 455	Continued From page 25 **Based on observations and interviews, the facility failed to ensure that the infections control prevention procedures were carried out. This potentially affected all clients audit 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 10/15/19 at 5:51pm, client #5 was observed sitting on the toilet, with his right hand down between his legs. Further observations revealed client #5 did not wash his hands before exiting the bathroom. Further observations at 5:52pm, client #5 began touching the end of the dining room table and a chair. At 5:57pm, he took his cup and began to drink from it. Staff B then took the cup from client #5 and placed it on the kitchen counter. Additional observations at 5:58pm, Staff B then took client #5's right hand and walked him out of the kitchen. Staff B then picked up a pen which was laying on the kitchen counter and began writing in one of the clients' data books. Further observations at 6:29pm, revealed another client picking up client #5's cup and placing it on the table. At no time was client #5 prompted to wash his hands. Staff B was not observed to wash her hands.** **Review on 10/16/19 of the facility sanitation and infection control procedures dated 3/15/11 revealed, "each staff is to wash their hands thoroughly, using warm water and soap, or use hand sanitizer."** **During an interview on 10/16/19, the qualified intellectual disabilities professional (QIDP) revealed staff should have washed their hands**	W 455	The facility will implement an active infection control system in the home to prevent cross contamination and reduce the spread of infections. The home manager will in-service all staff on infection control practices. Such practices will include but not limited to thorough hand washing after toileting, for Client #5. In addition, handwashing for Client #5 before consuming foods or liquids. In addition, staff will be instructed to change gloves when moving from a sterile location. Staff are encouraged to wash hands frequently and use cooking gloves when handling meat for meal preparation. Staff should change gloves frequently to avoid any possibility of cross contamination. The home manager and QP will monitor in the home weekly to ensure continued compliance.	12/15/19 12/15/19 12/15/19

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W 455	Continued From page 26 after coming in contact with client #5. 2. During observations of the afternoon snack on 10/15/19 at 4:10 pm, Staff A peeled a banana for client #5. After Staff A peeled the banana, she removed it with her bare hands and placed it in a bowl. Staff A then took a knife and sliced the bananas into 1/2 inch pieces. Staff A assisted client #5 with loading his spoon, placing her index finger on the plate, and pushing the banana onto the spoon, each time client #5 needed to raise the spoon to his mouth. During observations of the dinner meal preparation on 10/15/19 at 4:50 pm, Staff A washed her hands, then placed gloves on her hands and encouraged client #3 place gloves on clean hands. On the dinner menu was Southwest Foil Packs with pork chops, black beans and fajita vegetables. Staff A instructed client #3 how to clean the pork chops underneath the running water. There were two packs of pork chops with approximately 10 pork chops in each container. While preparing the pork chops, client #5 entered the kitchen and attempted to give Staff A his cup, but it fell on the floor. Staff A picked he cup off of the floor with the gloves and did not change the gloves before resuming cleaning the meat. Then Staff A had to step out of the kitchen, returned a few minutes later, and went to the trash can to throw something away, using her gloved hand to open the lid of the can. On four separate occasions, Staff A went to the trash can, still wearing the gloves, to toss out empty containers, once seen pushing the trash down inside the can with her hands. Staff A did not change the gloves as she continued seasoning the meat and handling the vegetables on top of the pork chops.	W 455		

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W 455	Continued From page 27 The food was placed in individual foil packs, while Staff A wore the same gloves and placed in the oven to bake. Review on 10/16/19 of the facility sanitation and infection control procedures dated 3/15/11 revealed, that " Even if gloves are worn, each staff is to wash their hands thoroughly, using water and soap, or use hand sanitizer: prior to and frequently during the preparation of food- especially after handling raw meat. Any time hands are soiled." During an interview with Staff A on 10/15/19, she acknowledged that she touched client #5's banana with her hands but was unaware of the facility's infection control policy. Staff A explained that she had only considered cross contamination risks to involve meat juices running together. During an interview with the facility's quality assurance coordinator on 10/16/19, she commented that that staff should wash hands and/or change gloves in between washing fruits, prepping meats or after leaving the kitchen.	W 455		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, document/record reviews and interviews, the facility failed to ensure 3 of 3 audit clients (#1, #3, #5) received their specially-prescribed diets as indicated. The	W 460		

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W 460	**Continued From page 28 findings are:** **1. Clients #1, #3 and #5 diets were not followed.** **a. During mealtime observations throughout the survey on 10/15 - 16/19, client #1 did not receive double portions. For lunch on 10/15/19 he had 1 bologna and cheese sandwich, 1 jello cup, 1 fruit bar and 1 baggie of an undetermined amount of butter cookies. For snack on 10/15/19 he had 1 banana, 2 wafer cookies and 1 whole apple. For dinner he had 1 serving of Southwestern Foil Pack, consisting of pork chop, black beans on a fajita and vegetables. For breakfast he had 2 waffles and 1 scoop of scrambled eggs. At no time was client #1 offered seconds during any of his meals.** **Review on 10/16/19 of client #1's nutritional evaluation dated 5/30/18 stated, "...encourage/offer seconds."** **Review on 10/16/19 of client #1's nursing evaluation dated 9/10/19 indicated, "...double portions available due to high energy levels."** **During an interview on 10/16/19, the qualified intellectual disabilities professional (QIDP) revealed client #1 should have been given double portions during all his meals.** **b. During lunch observations at the day program on 10/15/19 at 12:04pm, client #1 consumed a sandwich which was not completely cut all the way through. Further observations revealed client #1 consuming 1/2 each pieces of bread and bologna. Further observations revealed client #1 eating 1 fruit bar in two bites. On 10/15/19 at 4:14pm, client #1 was observed taking 5 to 6**	W 460	The facility will ensure that all clients receive their specially prescribed diets as indicated by the ISP and physician's orders. For Clients #1, #3 and #5 all staff in the home and day program will be in-service on their diets as prescribed to include but not limited to portions, food consistency and caloric intake per diets, mealtime protocols, and Menu guidelines. The QP and/or the Nutritionist will provide in-service training to day program and group home staff on all clients' prescribed diets. The QP, QA and program manager will monitor meals in the group home and day program weekly to ensure continued compliance.	12/15/19 12/15/19 12/15/19

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W 460	Continued From page 29 bites out of a whole apple and consuming 1 banana which was sliced into half dollar size. At 5:16pm, client #1 was observed eating a whole apple. Client #1 was observed at 6:22pm, eating a whole apple. Additional observations on 10/16/19 at 6:59am, client #1 was observed eating 1 whole apple. At no time were any of the apples chopped for client #1. During an interview on 10/15/19, Staff B revealed client #1's food is to be chopped to prevent choking. During an interview on 10/16/19, Staff E revealed the apple client #1 had consumed was not finely chopped as his diet indicated. Review on 10/15/19 of client #1's nutritional evaluation dated 5/30/18 stated "Regular finely chopped diet...." Review on 10/16/19 of client #1's nursing evaluation dated 9/10/19 revealed, "...finely chopped diet...." Review on 10/15/19 of diet orders dated 8/19/19 for client #1 stated, "...finely chopped...." During an interview on 10/16/19, the QIDP confirmed client #1's diet is finely chopped. Further interview revealed staff should have ensured client #1's diet was followed. c. During afternoon snack observations in the home on 10/15/19 at 4:14pm, client #1 consumed 2 chocolate wafers. Additional observations during dinner on 10/15/19 at 6:45pm, client #1 consumed 1 chocolate brownie.	W 460		

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W 460	Continued From page 30 Review on 10/16/19 of client #1's national evaluation dated 5/30/18 stated, "No...chocolate per MD d/t dx of gout." Review on 10/15/19 of diet orders dated 8/18/19 for client #1 stated, "...No chocolate." During an interview on 10/16/19, the QIDP stated client #1 should have been given an alternative for the chocolate. d. During snack observations on 10/15/19 at 4:05pm, client #5 consumed 15 pieces of a banana which was sliced into half dollar sizes and two chocolate wafers that were cut in half. At no time was client #5's banana or wafers coarsely chopped. Further observation on 10/16/19 at 6:40 am during breakfast meal, revealed that Staff D cut 2 waffles into 1/2 inch bite sized pieces for client #5 with the exception of one piece that was larger than 1/2 inch. Staff C monitored client #5 during breakfast. Client #5 ate at a rapid pace at times and had stuffed a large piece of waffle into his mouth, then began coughing. Staff C was observed patting client #5 on his back, and then client #5 took a sip of water. Review on 10/15/19 of diet orders dated 8/19/19 for client #5 stated, "...Coarsely Chopped, 1/4/ - 1/2 inch pieces maximum, all foods." During an interview on 10/16/19, the QIDP confirmed client #5's diet is coarsely chopped. Further interview revealed staff should have ensured client #5's diet was followed. e. During a lunch observation on 10/15/19 at 11:05 am, the following contents were pulled from	W 460		

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W 460	Continued From page 31 client #3's lunch bag: flatbread sandwich with bologna and cheese, 3-4 butter cookies, that were partially broken, a fruit cereal bar and a small container of fruit punch. After client #3 ate all his lunch, he was later observed eating chips from a small vending machine bag. During an observation of client #3's afternoon snack on 10/15/19 at 3:40 pm, he was offered vanilla and chocolate wafers by Staff G and took 6 wafers from the pack and later consumed all of them. An additional observation of client #3 at breakfast on 10/16/19 at 6:35 am, revealed that he had one serving of scrambled eggs and three waffles with sugar free syrup. For his beverages, he drunk orange juice, 2 % white milk and water. Record review on 10/15/19 of client #3's nutritional assessment and health goals dated 9/10/19, revealed that client #3 received a 1800 calorie diet. Further review of the individual program plan (IPP) dated 9/12/19, indicated that client #3 was above the desired weight range for his height, was on a 1800 calories diet with an exercise program. An additional review of the facility's undated menu cycle 1 indicated that a regular diet consisted of 1800 calories; portion size for waffles were 2 and cookies were 3. During an interview on 10/15/19 with the QIDP at the day program, he commented that client #3 overpacked food for his lunch. During an interview on 10/16/19 with the facility's QIDP, she indicated that client #3 should not have eaten chips, cookies and a cereal bar for lunch, instead he should have been asked to choose one snack since all the snacks were carbohydrates. Initially, the QIDP stated that the	W 460		

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W 460	Continued From page 32 serving size for cookies were 4-6 but upon further review of their menu, she corrected herself and stated that client #3 should have only been allowed to eat 3 cookies on a 1800 calories diet. She further stated that client #3 should have only received 2 waffles for breakfast. QIDP shared that if a client's diet orders do not specifically list 2nd portions, "then typically we encourage 2nds of fruits and vegetables." She also added that client #3 should be supervised when packing his lunch.	W 460	The facility will ensure that staff document food substitutions when there is any deviation from the Menu. The QP and/or the Nutritionist will provide in-service training to all staff in the home to address documentation on the food substitution list.	12/15/19
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food substitutions were documented. The finding is: Food substitutions were not documented. During lunch observations at the day program on 10/15/19 at 12 noon, client #1 was observed consuming 1 bologna/cheese sandwich, 1 fruit bar, jello and butter cookies. Review on 10/16/19 of the facility's menu for the date 10/15/19 the lunch was: "Tuna Melt on W. W. Bread Toast, Baked Beans, Mandarin Oranges and Vanilla Pudding." Further review of the menu book revealed the last time a menu substitution was recorded was on 5/11/19. During an interview on 10/16/19, the qualified intellectual disabilities professional (QIDP) confirmed the food substitutions for lunch on	W 481	The QP, QA and program manager will monitor meals and the substitution list in the group home and day program weekly to ensure continued compliance.	12/15/19

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W 481	Continued From page 33 10/15/19 was not recorded.	W 481		

October 28, 2019

Ms. Eugina Barnes, BSW, QIDP
Facility Compliance Consultant I
Mental Health Licensure and Certification Section
N.C. Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Annual Recertification Survey completed October 16, 2019
Avent Ferry Home
Holly Springs, NC
MHL#092-126, Provider # 34G278

Dear Ms. Barnes:

See attached hard copy of the plan of correction (POC) for the Avent Ferry Home survey. We hope that you will find the attached POC acceptable. If you have questions, feel free to contact me directly or Julia Johnson. Otherwise, we very much look forward to your follow-up visit.

Kindest regards,

Tonya Beckwith, QP - Community Innovations