STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G245	A. BUILDING _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINHOOD GROUP HOME	1507 ROBINHOOD RD WILMINGTON, NC 28401

(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 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain a recordkeeping system that accurately reflected 1 of 3 audit clients (#4). The findings are: Client #4's record was not maintained with correct information. a. Review on 10/15/19 of client #4's individual program plan (IPP), dated 7/14/19, revealed a diagnosis of moderate intellectual disability. Review on 10/15/19 of client #4's record revealed a psychological assessment dated 4/14/19. The psychological assessment revealed that client #4 has a previous diagnosis of moderate intellectual disability. At the time of the psychological assessment completed on 4/14/19, she was diagnosed with severe intellectual disability. Interview on 10/16/19, with the qualified intellectual disabilities professional (QIDP), confirmed that client #4's diagnosis was previously moderate, but when she was admitted to her current home she was tested by the facilities psychologist and the diagnosis was changed to severe intellectual disability. The QIDP confirmed that the diagnosis listed on the IPP is incorrect and should have been reflected as severe as the psychological assessment was	W 111	W 111 The QP will ensure that all Program Participant records contain the correct information. This will be monitored quarterly through chart reviews conducted by the QP, GHM and QA/QI Coordinator. The inconsistencies found in Client #4's record will be corrected by 12/14/19.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Edward Ward	Executive Director	10/22/19

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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W 111	Continued From page 1 completed prior to the development of the IPP. b. Review on 10/15/19 of client #4's record revealed a psychological assessment dated 4/14/19. The psychological assessment revealed that client #4 was admitted to a sister facility in April 2019. Interview on 10/16/19, with the QIDP, confirmed that client #4's date of admission to the facility was 3/5/19 and the date in the psychological assessment of April 2019 is incorrect. Further interview with the QIDP revealed that client #4 was admitted to the home she is currently living in and not the sister facility as stated in the psychological assessment.	W 111	Type text here	
W 214	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(iii) The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure one newly admitted client (#4) had a psychological assessment completed within 30 days of admission. The finding is: The facility failed to obtain a psychological assessment for client #4 within 30 days of admission. Review on 10/15/19 of client #4's individual program plan (IPP), dated 7/14/19, revealed she was admitted to the facility on 3/5/19. Further review indicated client #4's psychological	W 214	W 214 A psychological assessment will be completed for new Program Participants within 30 days of admission. This wording will be added to the admissions section of CFGH's policy manual by 12/14/19. The admissions policy will be reviewed by the IDT team prior to the admission of a new Participant. Type text here	

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W 214	Continued From page 2 assessment was completed on 4/14/19. Interview on 10/16/19, with the qualified intellectual disabilities professional (QIDP), confirmed client #4's psychological assessment was not completed within 30 days of admission to the facility.	W 214		
W 217	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure one newly admitted client (#4) had a nutritional assessment completed within 30 days of admission. The finding is: The facility failed to obtain a nutritional assessment for client #4 within 30 days of admission. Review on 10/15/19 of client #4's individual program plan (IPP), dated 7/14/19, revealed she was admitted to the facility on 3/5/19. Further review indicated client #4's nutritional assessment was completed on 4/9/19. Interview on 10/16/19, with the qualified intellectual disabilities professional (QIDP), confirmed client #4's nutritional assessment was not completed within 30 days of admission to the facility.	W 217	W 217 A nutritional assessment will be completed for new Program Participants within 30 days of admission. This wording will be added to the admissions section of CFGH's policy manual by 12/14/19. The admissions policy will be reviewed by the IDT team prior to the admission of a new Participant. Type text here Type text here	
W 221	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v)	W 221		

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W 221	Continued From page 3 The comprehensive functional assessment must include auditory functioning. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure one newly admitted client (#4) had a auditory assessment completed within 30 days of admission. The finding is: The facility failed to obtain a auditory assessment for client #4 within 30 days of admission. Review on 10/15/19 of client #4's individual program plan (IPP), dated 7/14/19, revealed she was admitted to the facility on 3/5/19. Further review indicated client #4's auditory assessment was completed on 4/8/19. Interview on 10/16/19, with the qualified intellectual disabilities professional (QIDP), confirmed client #4's auditory assessment was not completed within 30 days of admission to the facility.	W 221	W 221 An auditory assessment will be completed for new Program Participants within 30 days of admission. This wording will be added to the admissions section of CFGH's policy manual by 12/14/19. The admissions policy will be reviewed by the IDT team prior to the admission of a new Participant.	
W 224	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure one newly admitted client (#4) had a comprehensive functional assessment completed within 30 days of admission. The	W 224	Type text here W 224 A habilitation assessment Type text here will be completed for new Program Participants within 30 days of admission. This wording will be added to the admissions section of CFGH's policy manual by 12/14/19. The admissions policy will be reviewed by the IDT team prior to the admission of a new Participant.	

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W 224	Continued From page 4 finding is: The facility failed to obtain a comprehensive functional assessment for client #4 within 30 days of admission. Review on 10/15/19 of client #4's individual program plan (IPP), dated 7/14/19, revealed she was admitted to the facility on 3/5/19. Further review indicated client #4's habilitation assessment was completed on 4/23/19. Interview on 10/16/19, with the qualified intellectual disabilities professional (QIDP), confirmed client #4's habilitation assessment was not completed within 30 days of admission to the facility.	W 224		
W 226	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure one newly admitted client (#4) received an individual program plan (IPP) within 30 days after admission. The finding is: Client #4 did not receive an IPP within 30 days of admission. Review on 10/15/19 of client #4's IPP, dated 7/14/19, revealed she was admitted to the facility on 3/5/19.	W 226	W 226 An IPP will be completed for new Program Participants within 30 days of admission. This wording will be added to the admissions section of CFGH's policy manual by 12/14/19. The admissions policy will be reviewed by the IDT team prior to the admission of a new Participant.	

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W 226	Continued From page 5 Interview on 10/16/19, with the qualified intellectual disabilities professional (QIDP), confirmed that client #4's IPP was not developed within 30 days after her admission to the facility.	W 226		
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, record reviews and interviews, the facility failed to assure a pattern of interactions supported the individual program plans (IPP) in the areas of dining and program/goal implementation. This affected 2 of 3 audit clients (#1 and #4). The findings are: 1. Client #1's goal for self-medication was not implemented as per the IPP. During observations of the medication administration pass at 8:00am on 10/16/19, client #1 was not asked to initial the medication administration record (MAR). Review on 10/15/19 of client #1's IPP, dated 12-20-18, revealed a current goal for self-medication administration (9/19/3). The goal	W 249	W 249 The QP will in-service staff on the self-medication steps for Client #1. Quarterly observations will be conducted by the QP, GHM and/ or QA/QI Coordinator to ensure correct implementation of the training. This will be completed by 12/14/19. The QP will in-service staff on how to implement Client #4's objectives. Client #4's objectives will be checked quarterly for completion by the QP, GHM and/ or QA/QI Coordinator. This will be completed by 12/14/19. The Nutritionist will in-service staff on appropriate food portion size for Client #4. Quarterly observations will be conducted by the QP, GHM and/ or QA/QI Coordinator to ensure correct implementation of the training. This will be completed by 12/14/19. Regular reviews will be conducted for all Participants to ensure universal compliance in the above listed areas.	

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W 249	Continued From page 6 was listed as total task and the steps which should have been trained on included, "initial the MAR." Interview on 10/16/19, with the qualified intellectual disability professional (QIDP), confirmed staff should have done all steps of client #1's goal for medication administration. 2. Client #4's training was not implemented after the development of the individual program plan (IPP). Review on 10/15/19 of client #4's IPP, dated 7/14/19, revealed multiple objective training goals listed on the IPP. Review on 10/15/19 and further review on 10/16/19 of objective training data revealed that only a few of the training objectives were implemented on 10/14/19 with one data session documented while some objective training had no data collected as of this date 10/15/19. Interview on 10/16/19, with the QIDP, confirmed that the training was not implemented. The QIDP confirmed that some of client #4's training was implemented on 10/14/19 while some of the training has not been implemented. The QIDP stated that the lapse in time to implement the training has been due to staff shortages. 3. Client #4's mealtime procedures were not followed. During observations in the home on 10/15/19 at 6:03pm, client #4 was observed serving herself salad and lasagna at dinner time. The salad had	W 249		

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W 249	Continued From page 7 large pieces of lettuce with slices of cucumbers and tomatoes. The lasagna was served as a whole serving of the scoop with the scoop overflowing. In addition, client #4 retrieved a piece of garlic bread which was 1/3 of a slice of bread. Throughout the dinner observations, client #4 was observed to eat large pieces of lettuce, cucumbers and tomatoes. She was observed to pick up the entire piece of garlic bread to eat off of. Once she had consumed all of her salad, client #4 picked up a large piece of lasagna to eat. The first piece she tried to put in her mouth was approximately the size of a dollar bill. When it was too large for her to get in her mouth, client #4 shook her fork back and forth repeatedly until about half of the amount fell off her fork. Client #4 then ate the amount that was left on her fork. At no time during the dinner observation was client #4 prompted or assisted with cutting her food. During observations in the home on 10/16/19 at 7:05am, client #4 was observed to be eating four french toast sticks. Client #4 was observed to cut the french toast sticks into two pieces, about 1/3 of the stick and 2/3 of the stick. Client #4 proceeded to eat all of her french toast sticks and when she got to the last bite, which was approximately 2/3 of one of the sticks, Staff A was observed to say to her "Now you know that's a big piece of toast you just ate." At no time during the breakfast observation was client #4 prompted or assisted with cutting her food. Review on 10/15/19 of client #4's IPP, dated 7/14/19, revealed that client #4 is able to feed herself independently but requires cues from staff to cut her food into bite size pieces to prevent choking.	W 249	Type text here	

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W 249	Continued From page 8 Review on 10/15/19 of client #4's record revealed a nutritional assessment dated 4/9/19. The nutritional assessment revealed that client #4 requires assistance with cutting her food. Interview on 10/16/19, with Staff A, revealed that client #4 can cut her own food and it is supposed to be cut into bite size pieces. Staff A stated that staff do not have to check the size of client #4's food and do not have to monitor the food to make sure it is bite size "like some of the others." However, Staff A did state "That piece of toast she had this morning was too big." Interview on 10/16/19, with the QIDP, revealed that staff are to assist client #4 with cutting up her food. Further interview revealed that bite size pieces should be "pea" size and that staff should be monitoring client #4 to ensure her food is pea or bite size and if not, assist her with cutting it to the appropriate size.	W 249		
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 reviews and interviews, the facility failed to assure client #1 was furnished with a rocker knife and taught to	W 436	W 436 Client #1 will be furnished with a rocker knife and QP will write a goal to teach her how to use the knife. Staff will be in-serviced by the QP on this goal and the steps involved. Use of the rocker knife will be observed quarterly by the QP, GHM and/or QA/QI Coordinator. This will be completed by 12/14/19. Regular reviews will be conducted for all Participants to ensure universal compliance in the above listed area.	

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W 436	Continued From page 9 use it independently. This affected 1 of 3 audit clients (#1). The finding is: Client #1 was not provided with her own rocker knife and taught to use it. During dinner on 10/15/19 and breakfast on 10/16/19, client #1 was not provided with her own rocker knife. During dinner, at approximately 6:00pm, staff C asked another staff for a peer's rocker knife and then used it to cut client #1's food. She did not prompt client #1 to use the rocker knife herself. Additionally the rocker knife had the peer's name on it and was handed back to the peer. At breakfast on 10/16/19, staff B obtained the same peer's rocker knife, took it to the kitchen, rinsed it, and came back to hand-over-hand assist client #1 in cutting her french toast. On the morning of 10/16/19 after the breakfast observation, staff B was interviewed and asked if client #1 had a rocker knife. She stated that she thinks one has been ordered but that client #1 does not currently have a rocker knife. She also revealed the current medication administration record which is a copy of the current physician's orders (at the doctor's office for signature.) Review of the MAR dated October 2019, revealed client #1 should "use a rocker knife for all meals to increase her fine motor ability." Review of client #1's record on 10/15/19 and 10/16/19 revealed a nutritional evaluation dated 12/4/18 which indicated client #1 needs assistance with cutting. Interview on 10/16/19, with the qualified	W 436		

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W 436	Continued From page 10 intellectual disabilites professional (QIDP), revealed the staff should not share a peer's adaptive rocker knife with client #1 and that client #1 should have her own rocker knife. The QIDP also confirmed that staff should not use it for her but that client #1 should be taught to use it herself.	W 436	Type text here	

CAPE FEAR GROUP HOMES, INC.
CFGH

P.O. Box 4203 Wilmington, NC 28406 Phone (910) 251-2555 FAX (910)-251-0590

October 22, 2019

Ms. Joy Alford

Facility Survey Consultant 1

Mental Health Licensure and Certification Section

NC Division of Health Service Regulation

2718 Mail Service Center

Raleigh NC 27699-2718

Dear Ms. Alford,

Thank you for the time and courtesy in completing the annual survey for our group home at 1509 Robin Hood Rd on October 16th and 17th 2019. We are working to correct the issue that was identified in your time with us and these will be completed before 12/14/19. We look forward to you returning for a follow up review after this date.

Sincerely,

Ed Walsh

Executive Director

Cape Fear Group Homes Inc.