STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G303	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE ROAD	7621 MONROE ROAD CHARLOTTE, NC 28212

(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 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on review of records and interview, the team failed to ensure the individual habilitation plan (IHP) for 1 of 3 sampled clients (#5) included objective training to address needs relative to behavior management. The finding is: Observations in the group home on 1/8/20 revealed client #5 to be verbally prompted at various times throughout the morning to complete morning tasks and hygiene activities. Continued observations revealed client #5 to refuse initial verbal prompts by staff multiple times and then to follow through with staff requests (make bed, choose/participate in leisure activity, shower and pack lunch). Observation at 8:05 AM revealed client #5 to be verbally prompted by staff A to put on her coat in preparation of leaving the group home. Client #5 was observed to take the coat of client #4 and put it on. Continued observation revealed staff A to redirect client #5 to put on her own coat to which the client refused. After multiple efforts to redirect client #5, staff A provided client #5's coat to client #4 and all clients left the group home. Observation on the facility van at 8:20 AM revealed client #5 to sit on the van with the lap belt of her seatbelt on and the shoulder strap behind her back. Staff B was observed to prompt client #5 to put her shoulder strap on correctly to which the client refused.	W 227		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 227	Continued From page 1 Review of records for client #5 on 1/8/20 revealed an IHP dated 10/4/19 with current objectives relative to exercise, laundry, set table and community integration. Further review of records for client #5 revealed no behavior support plan or guidelines to address refusal or non-compliance behavior. Additional review of the 10/2019 IHP revealed client #5 is able to sit in a seat on the van and buckle/unbuckle the seat belt. Interview with staff B on 1/8/20 revealed client #5 will at times wear other client's clothing especially if it has a hood. Staff B further indicated sometimes client #5 can be redirected to wear her own clothing if she is presented with something that she likes or prefers. Additional interview with staff B revealed it has been an ongoing, everyday issue for client #5 to refuse to wear her seat belt correctly, placing the shoulder strap behind her back. Interview with the Habilitation specialist and facility qualified intellectual disabilities professional (QIDP) verified client #5 has recently had an increase in refusal behavior. Further interview with the habilitation specialist and QIDP verified client #5 should have formal training to address the increase in non-compliance behavior.	W 227		
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 observation and interview, the facility	W 382		

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W 382	Continued From page 2 failed to assure all drugs and biologicals were kept locked except when being prepared for administration. The finding is: Observation in the group home on 1/8/20 at 6:15 AM revealed the facility home manager (HM) to knock and enter the bedroom of client #2 with the group home medication cart. The HM was observed to unlock the medication cart and take out medications. After reviewing medications the HM indicated she needed to call the facility nurse as she had a question about client #2's medications. Continued observation revealed the HM to leave client #2's medications on top of the medication cart and to exit client #2's room to get the phone for the group home. It should be noted the surveyor at this time exited the clients room with the HM and observed client #2's door to remain partially open while the HM went up the hallway of the group home, entered another clients room looking for the group home phone and then returned to client #2's room. Interview with the HM on 1/8/20 revealed medications should never be left unlocked or left out unattended. Further interview with the HM revealed she should never have left medications out in client #2's room while going to get the phone. The HM further reported she forgot and lost focus while trying to ensure she was giving client #2 the proper medications. Interview with the facility nurse and qualified intellectual disabilities professional further verified medications should not have been left unlocked or unattended at anytime.	W 382		