STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G136	A. BUILDING _____ B. WING _____	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE FOREST HOME	1209 PELLHAM DR LAURINBURG, NC 28352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on 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 area adaptive equipment. This affected 1 of 3 audit clients (#5). The finding is: Client #5 was not prompted to use his adaptive spoon during medication administration. During morning medication administration in the home on 11/13/19 at 9:37am, client #5 used a plastic spoon to consume his pills. During an interview on 11/13/19, Staff C confirmed client #5 should have used his adaptive spoon. Review on 11/13/19 of client #5's physician orders dated 10/1/19 stated, "maroon spoon at...med pass." During an interview on 11/13/19, the facility's nurse confirmed client #5 should have used his	W 249	**W249** **DSA's will be in-serviced by Occupational Therapist//Nurse on adaptive equipment of client #5 and all other clients in the home. Nursing will conduct at a minimum 3 medication assessments within 30 days to ensure all adaptive equipment is being utilized per physician order. QP will assign assessments utilizing an 30 day schedule.** **Target Date: December 15, 2019** DHSR-Mental Health NOV 25 2019 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 11/18/19

* deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 249	Continued From page 1 maroon spoon during medication administration.	W 249		
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, 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 third shift were not conducted at varied times. Review of fire drill reports on 11/12/19 revealed the following: Four fire drills were conducted on third shift: 12:40am, 12:30am, 12:15am and 1:39am. During an interview on 11/12/19, the qualified intellectual disabilities professional (QIDP) confirmed the fire drills conducted on third shift were not varied. Further interview revealed the hours for third shift are 10:30pm until 7am and 11pm until 8am.	W 441	**W441** **DSA's will be in-serviced by the Home Manager/Safety Chairperson/QP on the variation of drills. A Safety Assessment Tracking form will be maintained documenting dates and times for all fire drills. The QP/ Home Manager/Safety Chairperson will review the Safety Assessment Form on a monthly basis to ensure drill times are varied.** **Target Date: December 15, 2019**	
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:	W 460	**W460** **DSA's will be in-serviced by Nurse/Dietician on the proper food consistency and diet of client #5 and all other clients in the home. Dietician will also in-service all DSA's on the proper amount of THICKEN for liquids for client#5 as well as all other clients in the home. The clinical team is to conduct at a minimum, 5 mealtime assessments within 30 days to ensure all diets are adequately per physician order. QP will assign assessments utilizing a 30 day schedule.** **Target Date: December 15, 2019**	

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W 460	Continued From page 2 Based on observations, document/record reviews and interviews, the facility failed to ensure 1 of 3 audit clients (#5) received his specially-prescribed diet as indicated. The finding is: Client #5's diet was not followed. 1. During dinner observations in the home on 11/12/19 at 6:15pm, client #5 consumed his dinner which consisted of a boneless pork chop, black bean vegetable mixture and 1 slice of whole wheat bread. Further observations revealed the boneless pork chop cut into penny sized pieces, the bean mixture was served regular; without any modifications and the bread was cut into bite size pieces. During an interview on 11/12/19, Staff A confirmed client #5's food should be in a ground consistency. Further interview revealed client #5 had a previous choking episode. Review on 11/12/19 of the home's Prevent Choking Hazards located on the refrigerator in the kitchen stated, "Ground food should be about the size of a grain of rice." Review on 11/12/19 of client #5's individual program plan (IPP) dated 7/23/19 revealed, "...Ground Consistency...." Review on 11/13/19 of client #5's physician orders dated 10/1/19 indicated his diet is a ground consistency. Review on 11/13/19 of client #5's choking risk assessment dated 5/14/19 revealed, "coughing while eating, talking with found in mouth, previous	W 460		

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W 460	Continued From page 3 choking incident and modified diet; Ground consistency." Review on 11/13/19 of client #5's medical evaluation dated 7/5/19 revealed, "...Ground Consistency." Review on 11/13/19 of client #5's nutritional evaluation dated 4/5/19 stated, "...ground...." During an interview on 11/13/19, the facility's nurse confirmed client #5's diet consistency is ground. 2. Client #5's liquids were not nectar thick consistency. a. During afternoon observations at the day program on 11/12/19 at 12:14pm, Staff B poured an undetermined amount from a eight ounce bottle of Gatorade into a glass and then added one scoop of Thick It. Further observations revealed client #5 drinking the mixture. Staff B then at 12:16pm poured the remainder of the Gatorade into the glass and added in one scoop of Thick It and client #5 drinking it. Additional observations revealed the two glasses of the mixture was a watery consistency. During an interview on 11/13/19, Staff B asked the surveyor was it the correct amount, when asked about how many scoops of Thick It should be added to client #5's liquids. b. During morning medication administration in the home on 11/13/19 at 9:08am, Staff C poured client #5's Lactulose into a cup, then poured in a undetermined amount of water to mixture, then added two scoops of Thick It. Further	W 460		

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W 460	Continued From page 4 observations revealed at 9:21am, Staff C adding more water of an undetermined amount. At 9:37am, client #5 drank the mixture. Additional observations revealed the mixture was a "honey" like consistency. During an interview on 11/13/19, Staff C denied not using a measuring cup to measure the water for client #5's water. Review of a document on the medication administration door states, "Thick It Use 2 Large Scoops for 8 ounces of liquids." Review on 11/12/19 of client #5's individual program plan (IPP) dated 7/23/19 revealed, "...Nectar Thick Liquids...." Review on 11/13/19 of client #5's physician orders dated 10/1/19 indicated his liquids are Nectar Thick. During an interview on 11/13/19, the facility's nurse confirmed client #5's liquids should be nectar thick.	W 460		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

November 15, 2019

Johnathan Bostic, Administrator
RHA Health Services, NC, LLC
15235 Airport Road
Maxton, NC 28364

Re: Recertification Survey November 12 - 13, 2019
Lee Forest Home, 1209 Pelham Drive, Laurinburg, NC 28352
Provider Number 34G 136
MHL# 054-141 and 083-007
E-mail Address: Johnathan.bostic@rhanet.org

Dear Ms. Herring:

Thank you for the cooperation and courtesy extended during the recertification survey completed on November 13, 2019.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is **January 12, 2020**.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and***

please remember never to send confidential information (protected health information) via email.

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Eugina Barnes at 919-819-8182.

Sincerely,

Eugina Barnes

Eugina Barnes, BSW, QIDP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: qmemail@cardinalinnovations.org
DHSRreports@eastpointe.net
QM@partnersbhm.org
File