STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G164	A. BUILDING _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A JACK WALL GROUP HOME	1213 MOSS SPRINGS ROAD ALBEMARLE, NC 28001

(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 observations, review of records and interview, the team failed to ensure the individual support plan (ISP) for 2 of 3 sampled clients (#1 and #3) and 1 non-sampled client (#4) included objective training to address needs relative to non-compliance. The findings are: A. The ISP failed to include objective training to address non-compliance relative to seat belt use for clients #1 and #4. Morning observations at 9:00 AM on 1/16/2020 of van loading at the group home revealed client #4 seated in the van with his seat belt shoulder strap properly applied across his torso. Further observation, at 9:01 AM revealed client #4 to swiftly remove his seat belt shoulder strap from around his torso and to lower his seat belt shoulder strap to a position around his waist. Continued observation of van loading, at 9:05 AM, revealed client #1 loaded the van with staff assistance and sat alongside client #4. Client #1 was observed to then recieve staff assistance with his seat belt. Subsequent observation at 9:06 AM revealed client #1 became visibly agitated and swiftly removed his seat belt shoulder strap from around his torso to a lower position around his waist.	W 227		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 227	Continued From page 1 Interview with the home manager (HM) on 1/16/2020 at 9:06 AM regarding the observations of improper usage of the seat belt shoulder straps by client #1 and #4 revealed the clients often refuse to properly wear their seat belt shoulder straps during van trips. Further interview revealed both client's #1 and #4 will remove their seat belt shoulder straps, and a staff member is positioned between both client's on van trips to monitor their seat belt shoulder straps. Continued interview with the HM prompted the HM to direct staff A to sit between clients #1 and #4 to monitor their seat belt use during the van trip. Ongoing interview with the HM confirmed clients #1 and #4 are in need of training to address proper seat belt use. Interview with the qualified intellectual disabilities professional (QIDP) on 1/16/20 revealed she was unaware of client #1 and #4's refusal behavior to properly wear their seat belt shoulder straps. Further interview with the QIDP verified client #1 and #4 should have formal training objectives to address the non-compliance behavior with van seat belts. B. The ISP failed to include objective training to address personal space for client #3. Observation in the group home on 1/15/2020 at 3:20 PM revealed client #3 to sit at the dining table and engage in an activity with staff. Further observation revealed client #3 to get up from the table, walk up to staff A while hovering over her and attempt to place his head on the staff's chest. Further observation revealed staff A to put her hands up and state "hands down" while blocking client #3 from getting into her personal space. Client #3 was observed to continue pushing his	W 227		

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W 227	Continued From page 2	W 227		

body weight aggressively against staff A and to disregard staff A's verbal prompts to refrain from the pushing behavior. Staff A was further observed losing balance and holding up her hands while simultaneously blocking client #3 from placing his hands on her face. Subsequent observation revealed the House Manager (HM) to intervene and guide client #3 back to the dining table to engage in another activity.

Continued observation on 1/15/2020 at 5:05 PM revealed client #3 to approach staff A seated in a chair in the living room and attempt to place his head on her chest. Staff A was observed to attempt to redirect client #3 two additional times while simultaneously holding up her hands to block the client and verbally repeat "hands down." Additional observation revealed the HM intervened and walked with client #3 to the dining table to engage the client in an activity.

Review of the client record for client #3 on 1/16/2020 revealed an ISP dated 3/5/2019. Further review of the ISP revealed a behavioral support plan (BSP) dated 11/2019. Review of the 11/2019 BSP revealed client #3's target behaviors to include: disruptive verbalization, self-injurious behaviors, social aggression, property aggression, taking food from others, self-stimulation rumination, and inappropriate toileting. Further review of the BSP did not indicate a target behavior of respecting the personal space of others.

Interview with staff A on 1/15/2020 confirmed that client #3 can be quite aggressive at times; however, he has not targeted her in the past. Interview with the HM on 1/16/2020 revealed she believes that client #3 is allowed to display this

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W 227	Continued From page 3 type of behavior while he is on home visits. The HM confirmed that client #3 could benefit from training objectives to address respecting the personal space of others. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 1/16/2020 confirmed client #3 to have no current program goals relative to personal space. The QIDP additionally confirmed client #3 could benefit from training objectives relative to respecting the personal space of others.	W 227		
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 observations, record review, and interviews, the facility failed to ensure objectives listed in the individual support plan (ISP) were implemented as prescribed relative to a communication device for 1 of 3 sampled clients (#4). The finding is: Observations in the group home on 1/15/2020 at 5:45 PM revealed client #4 to sit at the dinner table and to participate in the dinner meal. Further observations revealed three communication switches to sit on the kitchen counter. Further observations of the dinner meal	W 249		

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at 6:00 PM revealed staff to place the three communication switches in the center of the dining table beside the serving dishes and not within reach of client #4. Further observation of the dinner meal revealed staff to turn on the communication switches and one communication device to not work properly. The house manager (HM) was observed to return the faulty communication switch to the kitchen counter. Throughout the dinner meal, three clients were observed using the communication switches on the dining table. Continued observation revealed client #4 to complete the dinner meal and be instructed by staff to take his plate and utensils to the kitchen. At no point during the dinner meal was client #4 instructed by staff to use the communication switch and it was uncertain who the communicatiion devices belonged to.

Observations on the morning of 1/16/2020 at 7:30 AM revealed client #4 to sit at the dining table and to participate in the breakfast meal. Further observation revealed two out of three communications switches were placed in front of client #4. Continued observation revealed the third communication switch remained on the kitchen counter. At no point during the breakfast meal was client #4 prompted by staff to use the communication switch. At the completion of the breakfast meal, this surveyor tested all three communication switches and all three had batteries; however, one of the devices was not in working order.

Record review for client #4 on 1/16/2020 revealed an Individual Support Plan (ISP) dated 1/24/2019 which revealed client #4 should use a Big Mack simple voice output device throughout the daily routine. Further review of the ISP revealed a

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W 249	Continued From page 5 communication assessment dated 11/2018 which revealed that client #4 is able to use a Big Mack simple voice output device throughout the day, using the communication switch to ask for things he may see, make comments and engage in social interactions. The communication assessment also revealed client #4 cannot use the device to express yes and no. Further review of the record revealed a communication assessment dated 1/3/2019 that revealed client #4's communication objectives have remained as prescribed in his last assessment with no significant changes. Interview with the HM on 1/16/2020 verified one of the three communication switches had a shortage in it and has not been working properly for quite some time. Further interview with the HM verified that client #4 no longer has a communication program relative to using a Big Mack voice output switch. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 1/16/2020 confirmed the communication objective for client #4 remains current. The QIDP also confirmed the communication switch for client #4 is not in working order and will be replaced to allow client #4 to run the communication program as prescribed.	W 249		