DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES		r		12/18/2019
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	MANAGEMENT		MB NO	APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G268	B. WING_		421	47/2040
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	16/	17/2019
MOODE	COUNTY HOME FOR	411710710 4011170	- 1	1112 DEVONSHIRE TRAIL		
	COUNTY HOME FOR			ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	CFR(s): 483.475(d)((2) Testing. The [fac RNHCIs and OPOs] test the emergency [facility, except for R all of the following: *[For LTC Facilities a The LTC facility mus the emergency plan unannounced staff d procedures. The LTC following:] (I) Participate in a full community-based or exercise is not acces facility-based. If the actual natural or man requires activation of [facility] is exempt fro community-based or full-scale exercise for the actual event. (ii) Conduct an addition (A) A second full-sc community-based or its cussion led by a fa clinically-relevant emergency plan. iii) Analyze the [facility naintain documentation in the second full-second full-seco	ility, except for LTC facilities, must conduct exercises to clan at least annually. The NHCIs and OPOs] must do at §483.73(d):] (2) Testing, the conduct exercises to test at least annually, including rills using the emergency of facility must do all of the exercise that is when a community-based sible, an individual, facility] experiences an emergency that the emergency plan, the mengaging in a lindividual, facility-based exercise that may it do to the following: cale exercise that is individual, facility-based, clies that includes a group cilitator, using a narrated, ergency scenario, and a set is, directed messages, or esigned to challenge an exercise to and on of all drills, tabletop ency events, and revise the	E 039		e e enciso sion	1/17/aD
_	/ A	SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE) DATE

Any deficiency statement ending with an asteriak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards grovide 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 regulaite to continued program participation.

PRINTED: 12/18/2019

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES		PRINTE	D: 12/18/201			
		& MEDICAID SERVICES				FORM APPROVE OMB NO. 0938-039		
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTR	UCTION	(03) DATE SUR COMPLETE		
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NAME OF	PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP (/17/2019	
MOORE	COUNTY HOME FOR	AUTISTIC ADULTS			NSHIRE TRAIL N, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(EA	PROVIDER'S PLAN OF COI ICH CORRECTIVE ACTION 3S-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
E 039	Continued From pa	ge 1	E 03	9				
	§486.360] (d)(2) Teamust conduct exercian. The [RNHCI a following: (i) Conduct a paper least annually. A tab discussion led by a following problem statemer prepared questions emergency plan. (ii) Analyze the [RNI to and maintain doct exercises, and emer [RNHCI's and OPO's needed. This STANDARD is Based on record revised to ensure a fact tabletop exercise was emergency plan. The facility's Emerge did not include compificallity/community-base exercise. Review on 12/16/19 collan (dated 2018 - 20 following the community-based exercise est their emergency plans thei	ncy Preparedness (EP) plan letion of sed exercise or tabletop of the facility's current EP 19) did not include a based or individual e or a tabletop exercise to plan.						
i	onfirmed the facility i	Professional (QIDP)			ž			

PRINTED: 12/18/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING_ 34G268 B. WING 12/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONSHIRE TRAIL MOORE COUNTY HOME FOR AUTISTIC ADULTS ABERDEEN, NC 28316 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) E 039 Continued From page 2 E 039 tabletop exercise to test the effectiveness of their current emergency plan. W 186 DIRECT CARE STAFF By \$\frac{1}{31/19} the facility will ensure that sufficient CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff is provided to staff to manage and supervise clients in accordance with their individual program plans. manage and supervise Direct care staff are defined as the present all clients. The staffing on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. pattern will be manitored daily by Home Manager, This STANDARD is not met as evidenced by: Based on observations, record review and bimonthly by Hab Specialist interviews, the facility failed to ensure sufficient staff were provided to supervise clients and and monthly by alop to ensure provision of training provide training in accordance with their individual Program Plan (IPP). This affected 1 of 6 audit clients (#6). The finding is: in accordance with their Sufficient direct care staff were not provided in the home during first shift on 12/16/19. individual program plan. Upon arrival at the home on 12/16/19 at 8:40am, after the surveyor knocked on the door to the home, a client opened the door. Shortly afterwards, Staff A came to the door from a office down the hall. After introducing herself, the staff returned to the office where she was dispensing medications to a client. While the staff remained in the office area, five other clients were observed in the living room area unsupervised. A total of six clients were observed in the home with one staff on duty. At 8:48am, client #6 ran to the bathroom

which was located across the hall from the office.
Once inside the bathroom, the client sat on the

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/18/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 34G268 B. WING 12/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONSHIRE TRAIL MOORE COUNTY HOME FOR AUTISTIC ADULTS ABERDEEN, NC 28316 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 10 (X5) COMPLETION DATE PREFIX PREFIX TAG DEFICIENCY) W 186 Continued From page 3 W 186 toilet and began urinating with the door wide open. At that time, Staff A left the med pass, went out into the hall, closed the door to the bathroom and returned to the office. After less than one minute in the bathroom, the toilet was heard flushing and client #6 immediately exited the bathroom with his pants down halfway pass his buttocks. No water was heard running before the client exited the bathroom and closer observation of the bathroom did not reveal any paper towels inside. Client #6 returned to the living room while Staff A remained in the office. At 9:00am, the staff finished dispensing medications and gathered clients in an activity room. At 9:11am, Staff B arrived at the home. Interview on 12/16/19 with Staff A revealed another staff was scheduled to come in at 7:00am; however, they were late. The staff indicated it has been "hectic" as they had been working alone and trying to make breakfast for clients and complete other tasks. Additional interview revealed two staff usually work on first shift in the home. Additional interview on 12/17/19 with Staff B indicated client #6 has a toileting goal and the goal requires staff to assist and monitor him in the bathroom to ensure completion of all steps. Review on 12/16/19 of client #6's IPP dated 10/10/19 revealed an objective to display appropriate privacy/toileting with 50% independence for 2 review periods (Implemented

10/1/19). Additional review of the objective noted, "When [Client #6] goes to the bathroom on his schedule, staff should have [Client #6] go through the steps each time. Once [Client #6] has made the attempt. Staff can hand over hand with him to

CENTERS FOR MEDICARE & MEDICAID SERVICES						FÖR	D: 12/18/2019 MAPPROVED O. 0938-0391
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		LE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
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NAME C	OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 12	2/17/2019
MOOR	E COUNTY HOME FOR	AUTISTIC ADULTS		1	1112 DEVONSHIRE TRAIL		
(X4) IE		300000000000000000000000000000000000000			BERDEEN, NC 28316		
PREFI) TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBF	COMPLETION DATE
W 18	The second second second second		W 1	86			
	occur each time [Cli- bathroom." Further eleven steps includir Pulls up and adjust of hands and Step #10	review of the objective noted ng the following: Step #7, clothing; Step #9, Washes , Dry hands.			,		
W 189	and Qualified Intellect (QIDP) confirmed two the home on first shift client ratio is 2 to 6, acknowledged suffici- the home from 7:00a with the required ratio	ROGRAM	W 18	9	By 1/24/2020 all sta	ıff	1/24/20
	initial and continuing t	ride each employee with training that enables the his or her duties effectively, etently.			By 1/24/2020 all sta will participate in mi cation training by the egistered nurse or locumentation, process	dure	
	Based on observation	failed to ensure staff were perform their duties		0	ind notification of num To include falls, abro and symptoms. Stal will be monitor ed	se. Gions F	
	Staff were not adeq document on the Medi Record (MAR).	uately trained to correctly ication Administration		1	weekly for appropriating male	tlv	8
	in the home on 12/17/	f medication administration 19 from 8:00am ~ 8:17am, clients to dispense their medication was	ii.	na	nonthly Hab Specialist and monthly by nurs. All staff will be insen	6.	-

DEP/	FOR	D: 12/18/2019 MAPPROVED				
STATEM	ENT OF DEFICIENCIES N OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DA	0. 0938-0391 TE SURVEY MPLETED
		34G268	B. WING		12	/17/2019
	F PROVIDER OR SUPPLIER E COUNTY HOME FOR	AUTISTIC ADULTS		STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONSHIRE TRAIL ABERDEEN, NC 28316	E	7372010
(X4) II PREFI TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFID TAG		OULD BE	(X5) COMPLETION DATE
W 18	dispensed, the staff initials on the MAR. prompted to ingest to Interview on 12/17/1 was observed is how medication technicia. Review on 12/17/19 test revealed staff ar should medication be interview via phone on urse confirmed the clients to ingest their MAR. 2. Staff were not ade nurse and document. During evening obser 12/16/19 at 5:51pm, after a community our from the van to the fin fell onto her left side abody hitting the groun remaining on the pavup and into the home. Interview via phone on nurse revealed she has involving client #1. The should have been call #1 has been experient.	immediately signed their Afterwards, the clients were heir medications. 9 with Staff D revealed what whey had been trained as a in (MT). of a medication technician re asked the question, "When re signed off on the MAR?" on 12/17/19 with the facility's MT should have waited for medicine before signing the requately trained to notify the a significant event. reations in the home on clients returned to the home ting. As client #1 welked ont door of the home, she with the upper portion of her and and the lower portion ement. A staff assisted her in 12/17/19 with the facility's ad not been notified of a fall he nurse indicated she led, especially since client cling ambulation issues. with the Home Manager and not been called and no	W 1	ellent #1. Imp addedu am bulation guidelin loc included.	ddrase m far es will	

			AND HUMAN SERVICES			FOR	D: 12/18/2019 MAPPROVED D: 0938-0391
ST	ATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DA	TE SURVEY
			34G268	B. WING	······································	12	/17/2019
N.	AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		JIIIAU (D
M	OORE	COUNTY HOME FOR	AUTISTIC ADULTS		1112 DEVONSHIRE TRAIL ABERDEEN, NG 28316		l
F	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
V	N 240	Continued From pag	20 6	144.04		A-111-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	
	N 240	A A MILLIAN I LOUIS BOWS		W 24 W 24	00		
		CFR(s): 483.440(c)((6)(i)		194/2020 elier	it	124/20
		The individual progra	am plan must describe		By 1/24/2020 elier #1 IPP will include	an	,
		relevant intervention toward independent	s to support the individual		addedum to address	her	
					impaired ambulation	1144 11 .	
		This STANDARD is	not met as evidenced by:		approved by guardian	<u></u>	
			ons, record review and y failed to ensure client #1's		and Human Rights Com	en i Ma	
		Individual Program P	lan (IPP) included		with number hights com	(T) ITHE	
		affected 1 of 6 audit	rt her Independence. This clients. The finding is:				
		Client #1's IPP did no to address her dropp	at include specific information ing to the floor.				
		During observations is	in the home throughout the 17/19, client #1 frequently				
	- 1	dropped or lowered h	er body to the floor/ground				
	1	Staff consistently verl	and outside of the home.				
		up and provided phys	ical assistance as needed.				
		Interview on 12/16/19 believed the client has as a behavior becaus	with Staff C revealed they s been dropping to the floor e she is "stubborn"				
	1.	Additional interview or	n 12/17/19 with Staff E				
	11	instructions regarding	t been given any specific client #1's dropping to the				
		floor; however, they ju drops on her bottom.	ist help her up when she				
		dated 11/7/19 revealer possible foot drop or r referral for neurology o	evaluation." Additional	-			
		eview of the client's It	PP dated 5/10/19 revealed			1	I

CENTERS FOR MEDIANE AMERICAN							FOR	D: 12/18/20 MAPPROVE	D
STAT	TEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) D/	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
	V-Terring August (and up)		34G268	B. WING	8. WING			12/17/2019	
NA	ME OF	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE			_
MC	OORE	COUNTY HOME FOR	AUTISTIC ADULTS		1	1112 DEVONSHIRE TRAIL ABERDEEN, NC 28316			
PF	(4) ID REFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D SE	COMPLETION DATE	'
		no information regal or how staff should in client when this occul interview on 12/17/1 (HM) and Qualified I Professional (QIDP) dropping down to the October and she has regarding this and is referral. Additional in members have met in trying to determine if behavioral problem. staff have been told in ospecific guidelines included in her IPP to floor. INDIVIDUAL PROGFCFR(s): 483.440(c)(6) The individual program opportunities for clients of clients of the individual program opportunities for clients (#2, #4) included at meals. The finding clients (#2, #4) were food choices at lunch. During lunch observational cut sandwich, fruedd cut sandwich cut	rding her falling to the ground respond and/or assist the urs. 9 with the Home Manager ntellectual Disabilities revealed client #1 began a floor around the end of seen to the doctor awaiting a neurological nterview also indicated team regarding this issue and are this is a medical or Further interview revealed to monitor client #1; however, so instructions have been address her dropping to the tax (AMPLAN S)(vi) Implan must include at choice and falled to ensure the lan (IPP) for 2 of 6 audit ed opportunities for choices is: Inot provided with alternative tions in the home on client #2 served himself a lit cocktail, mixed	W 24	47		t2.	414/20	
W		staff have been told in no specific guidelines included in her IPP to floor. INDIVIDUAL PROGE CFR(s): 483.440(c)(6) The individual progra opportunities for cliens self-management. This STANDARD is a Based on observatio interviews, the facility individual Program Plus clients (#2, #4) includat meals. The finding Clients (#2, #4) were food choices at lunch. During lunch observational curing lunch observational cut sandwich, fruction of the sandwich, fruction of the special cut sandwich in the	to monitor client #1; however, so or instructions have been address her dropping to the care to a choice and to a care	W 24		pecifically for clients to include all clients to pecifically for clients to implementation will monitored by Home. Manager weekly, bimos by Italo Specialist and	t2.	414 20 3	>

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

PRINTED: 12/18/2019 FORMAPPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G268	B, WING		12/17/2019	
	F PROVIDER OR SUPPLIER COUNTY HOME FOR	•		STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONSHIRE TRAIL ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
	Client #1 ate the por and threw out all off client #4 served him mixed vegetables, fr water. Client #4 too drank his liquids and Client #1 and client alternative food choi of their lunch. Interview on 12/17/1 (HM) indicated client Review on 12/16/19 9/27/19 revealed, "Clintake and meal reful Review on 12/16/19 revealed he "makes activities." Interview on 12/16/19 revealed he "makes activities." Interview on 12/17/18 Intellectual Disabilities confirmed client #1 a been offered another refused what was ser PROGRAM IMPLEM CFR(s): 483.440(d)(1) As soon as the interd formulated a client's leach client must rece treatment program cointerventions and sen and frequency to supplications.	tato chips, drank his liquids her food items. At the meal, self a cold cut sandwich, uit cocktail, Kool-aid and k one bite of the sandwich, i threw out other food items. We were not offered ces after refusing the majority with the Home Manager #2 is a picky eater. of client #2's IPP dated ontinue to monitor food sals." of client #4's IPP dated some choices in daily with the Qualified a Professional (QIDP) and client #4 should have lunch choice once they had ved. ENTATION isciplinary team has andividual program plan, ive a continuous active	W 2			

-			AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 12/18/2019 MAPPROVED): 0938-0391	D
	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILL		LE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
-			34G268	B. WING			12	/17/2019	
Miller and a second	NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	A	1172010	1
	MOORE	COUNTY HOME FOR	AUTISTIC ADULTS			I112 DEVONSHIRE TRAIL ABERDEEN, NC 28316			
Marana and a second	(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	W 249	Continued From page This STANDARD is Based on observation interviews, the facility clients (#1, #2, #3, # active treatment program of the interventions and self-help program implements in Clients were not a preparation tasks. During lunch preparation to preparation tasks. During lunch preparation on 12/16/19 at prompted to pour carprepared cold cut sar vegetables in a bowled or came in/out of the not actively involved in the self-help in the self-help in the self-help involved in the self-help in the	not met as evidenced by: ons, record reviews and y failed to ensure 4 of 6 audit 8) received a continuous gram consisting of needed rvices as identified in the vices as identified in the fan (IPP) in the areas of food ofgrooming skills, and tion. The findings are: adequately involved in food tion observations in the 11:58am, client #2 was aned fruit into a bowl. Staff B adwiches and placed mixed while client #2 stood nearby kitchen area. Client #2 was in food preparation tasks. the home from a 12/16/19 at 5:51pm, all food ge, cabbage, carrots and re cooked and on the stove. ade a pitcher of Kool-aid icipation. No clients were ged to assist with any food with Staff B revealed client anything" in the kitchen and		49		piced ited ofing all others while or others with the others with the other other others with the other wit	Y24/20	
		some things without p Review on 12/17/19 o Behavior inventory (Ai he client can prepare	f client #2's Adaptive BI) dated 9/3/19 indicated				The state of the s		

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 12/18/20 MAPPROVE D: 0938-039	ED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) D/	(X3) DATE SURVEY COMPLETED	
		34G268	B. WING			1:	2/17/2019	
NAME OF	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		31772013	ᅥ
MOORE	COUNTY HOME FOR	AUTISTIC ADULTS			1112 DEVONSHIRE TRAIL ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	COMPLETION DATE	N
# # # # # # # # # # # # # # # # # # #	assistance. The AB independently comp Interview on 12/17/1 (HM) and Qualified I Professional (QIDP) involved with food provided across the fractional across the fractional form of the bathroom, and began urinating that time, Staff A left the hall, closed the directurned to the office in the bathroom, the client #6 immediately pants down halfway provided not reveal any particular across a tolleting goal of assist and monitor ensure completion of Review on 12/16/19 of 10/10/19 revealed an appropriate privacy/to	I Indicated the client could not lete meal preparation tasks. 9 with the Home Manager ntellectual Disabilities confirmed clients should be reparation tasks. 19 program was not ten. 19 program was not ten. 10 in the home on 12/16/19 at the to the bathroom which was all from the office. Once the client sat on the toilet with the door wide open. At the med pass, went out into cor to the bathroom and the toilet was heard flushing and exited the bathroom with his pass his buttocks. No water afore the client exited the observation of the bathroom per towels inside. 1 with Staff B Indicated client I and the goal requires staff him in the bathroom to all steps. 1 client #6's IPP dated objective to display	W	248				
" S	When [Client #6] goe chedule, staff should	eview of the objective noted, as to the bathroom on his have [Client #6] go through Once [Client #6] has made						

PRINTED: 12/18/2019 FORM APPROVED OMB NO. 0938-0391

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

NAME OF PROVIDER OR SUPPLIER MOORE COUNTY HOME FOR AUTISTIC ADULTS STREET ADDRESS, CITY, STATE, ZIP 1112 DEVONSHIRE TRAIL ABERDEEN, NC 28315 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 249 Continued From page 11 W 249		
MOORE COUNTY HOME FOR AUTISTIC ADULTS 1112 DEVONSHIRE TRAIL ABERDEEN, NC 28316 (XA) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 249 Continued From page 11 W 249	1	2/17/2019
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 249 Continued From page 11 W 249		A TOTAL OF
44 242	ON SHOULD BE TE APPROPRIATE	COMPLETION DATE
the attempt, Staff can hand over hand with him to do a better job once he has finishedTraining will occur each time [Client #6] goes to the bathroom." Further review of the objective noted eleven steps including the following: Step #7, Pulls up and adjust clothing; Step #9, Washes hands and Step #10. Dry hands. Interview on 12/17/19 with the HM and QIDP confirmed client #6 has a toileting goal which should be implemented as written. 3. All clients were not encouraged to participate with serving themselves or pouring their own drinks. During dinner observations in the home on 12/16/19 at 6:07pm, Staff C placed all food items onto client #1's plate and poured her drinks without prompting her to assist with this task. During snack observations in the home on 12/16/19 at 4:41pm, Staff C poured milk for all of the clients before any clients arrived at the table. During breakfast observations in the home on 12/17/19 at 7:41am, Staff C poured milk for all of the clients before any clients arrived at the table. During breakfast observations in the home on 12/17/19 at 7:41am, Staff C revealed client #2 to pour drinks for all of the clients. Interview on 12/16/19 with Staff C revealed client #1 is "more than capable" of serving herself and pouring her drinks; however, she is "stubborn" at times. Additional interview indicated clients can pour their drinks given assistance. Review on 12/17/19 of client #1's IPP dated 5/10/19 revealed the client "scoops food from serving bow with assistance" and "participates in family style dining with assistance."		

	RS FOR MEDICARE	& MEDICAID SERVICES	Tage		OMB NO	MAPPROV 0. 0938-03
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		34G268	B. WING		12	/17/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORE	COUNTY HOME FOR	AUTISTIC ADULTS		1112 DEVONSHIRE TRAIL ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	DRE	COMPLETIO DATE
W 249	Continued From pag	ge 12	W 24	49		
		of client #3's ABI dated nt can pour from a small ce.				
	Review on 12/17/19 9/5/19 indicated he is pouring from a small	of client #6's ABI dated s totally independent with pitcher.				
	confirmed clients car	9 with the HM and QIDP n pour their drinks with #1 was capable of serving				
	4. Clients (#3, #5) we with grooming their h	ere not prompted to assist air.				
	12/16/19 at 11:35am proceeded to blow dra and client #5's hair wi	rvations in the home on and 12:01pm, Staff A y, brush and style client #3's thout their participation. encouraged to assist with				
1	Interview on 12/16/19 #3 can assist with her #5 usually wants staff	with Staff A revealed client hair care; however, client to do it for her.			-	
4	Review on 12/17/19 o 4/1/19 noted she canr style her hair.	f client #3's ABI dated not independently dry or				
t s	2/15/19 identified need ner hair. The client's A she is partially indeper	f client #5's IPP dated ds to comb and shampoo ABI dated 1/15/19 indicated ndent with ling and shampooing her	٠			

PRINTED: 12/18/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORMAPPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 34G268 A WING 12/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONSHIRE TRAIL MOORE COUNTY HOME FOR AUTISTIC ADULTS ABERDEEN, NC 28315 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY W 249 Continued From page 13 W 249 Interview on 12/17/19 with the HM and QIDP confirmed client #3 and client #5 can assist with grooming their hair. 5. Clients (#3, #6) were not encouraged or assisted to cut their food. During lunch observations in the home on 12/16/19 at 12:10pm, Staff A cut up client #3 and client #6's sandwich without prompting or encouraging them to participate with this task. Interview on 12/16/19 with Staff A indicated client #3 and client #6 can assist with cutting their food given hand-over-hand assistance. Review on 12/17/19 of client #3's ABI dated 4/1/19 Indicated the client cannot independently use a knife for cutting. Review on 12/17/19 of client #6's ABI dated 9/5/19 revealed he requires assistance to use a knife for cutting. During an Interview on 12/17/19, the HM and QIDP acknowledged client #3 and client #6 can assist with cutting their food. W 252 PROGRAM DOCUMENTATION W 252 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:

	ALTH AND HUMAN SERVICES CARE & MEDICAID SERVICES		PRINTED: 12/18/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
MANE OF FOOMERS OF SURV	34G268	8. WING	12/17/2019
MOORE COUNTY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONSHIRE TRAIL ABERDEEN, NC 28315	
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST 8E PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
interviews, the relative to the a Program Plan (in measurable clients (#2, #5). 1. Cilent #5's to documented as During observar 4:20pm, staff pronce outside, or go back inside and banging/kichome. After briother back in staff. Review on 12/16 Intervention Plan objectives to addinappropriate to floor, non-complegging for food disruption. Addinappropriate to floor, non-complegent floor, non-complege	ervations, record reviews and facility failed to ensure data accomplishment of Individual (IPP) objectives was documented terms. This affected 2 of 6 audit. The findings are: arget behaviors were not indicated. Itions in the home on 12/16/19 at rompted clients outside for a walk, then #5 indicated she wanted to and began whining, screaming thing the front and side door of the effy walking around outside, client side with several other clients and for the liance, self wetting, pica, crying, I, loud vocalizations and severe tional review of the BIP noted in Includes, " a variety of ing whining, tearing clothes and ing" The plan also indicated all should be documented. In 12/17/19 of client #5's behavior heet for December 2019 did not aviors observed on 12/16/19 had ed.	W 252 All staff will be inse by y 26/20 on docume to include behavior pl documentation. Imple of appropriate docume will be monitored by Home Managerweekly bimonthly by Hab Sp	ntation lan mentation entation

PRINTED: 12/18/2019

	DEPARTMENT OF HEALTH AND HUMAN SERVICES						PRINTED: 12/18/20		
CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	FORM	APPROVE . 0938-039	
-	STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		X3) DAT	E SURVEY PLETED	
-			34G268	B. WING			401	17/2010	
I	NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	1 24/	17/2019	
	MOORE	E COUNTY HOME FOR	AUTISTIC ADULTS		1112 DEVONSHIRE TRAIL ABERDEEN, NC 28316				
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIA	E NTE	(X6) COMPLETION DATE	
	W 252	Continued From pag	ge 15	W 25	2				
	,	2. Client #2's target documented as indic	behavior was not cated.						
		12/17/19 at 7:01am, assist with setting the While in the kitchen,	ervations in the home on client #2 was prompted to e table and making muffins. client #2 reached out to hit was immediately blocked by arm.						
		2/17/19 revealed objusted behaviors of non-control behavior, inappropriate vocalizations, and phydiditional review of taggression was defining physically harm another instead to hit, kick, puattempt is successful	of client #2's BIP dated ectives to address target inpliance, self-injurious ate touching, loud sysical aggression. The BIP indicated physical ared as "any attempt to mer person, including but not inch, head butting (whether or not)." The plan also is should be documented.						
		Further review of client for December 2019 de behavior had been do	nt #2's behavior data sheet id not indicate the observed ocumented.			e e			
	W 288	Interview on 12/17/19 (HM) confirmed client documented. MGMT OF INAPPRO BEHAVIOR CFR(s): 483.450(b)(3	5 U 5029 (SESSUE) 95 5 900 (SESSE) 938 (SESSUE) 938 (SESSE) 938	W 268					
		Techniques to manage behavior must never to an active treatment pr	be used as a substitute for		:				
	1				1		1		

STATEMENT OF DEPICIENCIES SATEMENT OF DEPICIENCIES (XI) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: 34G288 MAIN OF CORRECTION MAIN OF CORRECTION MAIN OF PROVIDER OR SUPPLIER MOORE COUNTY HOME FOR AUTISTIC ADULTS SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST be PRECEDED BY PULL PREVIOUS AUTISM OF CORRECTION (EACH DEPICIENCY MUST be PRECEDED BY PULL PROVIDERS FLAN OF CORRECTION (EACH DEPICIENCY MUST be PRECEDED BY PULL PROVIDERS FLAN OF CORRECTION (EACH DEPICIENCY MUST be PRECEDED BY PULL PROVIDERS FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) W 288 Continued From page 16 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a technique to manage client #3's behavior was included in a formal active treatment program. Review on 12/1719 of client #3's Behavior Intervention Plan (BIP) dated 21/17/19 revealed objectives to address on-compliance, aggression, disruption, spitting, faces emering, pica, self wetting, falling to the floor and whining, Additional review of the plan identified the use of Valporic acid and off for Trazodone HCL 50mg, take 1 tablet by mouth at badtime. The use of Trazodone was not included in a formal active treatment program. Interview on 12/17/19 with the Home Manager and Qualified Intellectual plassibilities Professional (QIDP) indicated client #3' ingests Trazodone to issues with sleep throughout the night. Additional interview confirmed the use of Trazodone was not included in a formal active treatment program. Interview on 12/17/19 with the Home Manager and Qualified Intellectual plassibilities Professional (QIDP) indicated client #3' ingests Trazodone to issues with sleep throughout the night. Additional interview confirmed the use of Trazodone was not included in a formal active treatment program. DRUG ADMINISTRATION W 369 The system for drug administration must assure			AND HUMAN SERVICES			FOR	M APPROVE
AND PLAN OF CORRECTION A BUILDING S. WING STREET ADDRESS, CITY, STATE, ZIP CODE 12/17/2019 12/17/	CENT	ERS FOR MEDICARE				OMB N	O. 0938-039
MAKE OF PROVIDER OR SUPPLIER MOORE COUNTY HOME FOR AUTISTIC ADULTS STREET ADDRESS, CITY, STATE, ZIP CODE 11/12 DEVONSHIRE TRAIL ABERDEEN, NC 28318 CAH DEFIDIORY MIST BE RECEIVED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) W 288 Continued From page 16	AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) D.	ATE SURVEY
MOORE COUNTY HOME FOR AUTISTIC ADULTS O(4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 288 Continued From page 16 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a technique to manage client #3's behavior was included in a formal active treatment program. Review on 12/1719 of client #3's Behavior Intervention Plan (BIP) dated 2/17/19 revealed objectives to address non-compliance, aggression, disruption, spitting, faces smearing, pica, self wetting, failing to the floor and wininning. Additional review of the plan identified the use of Valporic acid and Onfi to address inappropriate behaviors. Further review physician's orders dated 11/16/19 revealed an order for Trazodone HCL 5.0mg, take I tablet by mouth at bedtime. The use of Trazodone was not included in a formal active treatment program. Interview on 12/1719 with the Home Manager and Qualified Intellectual Disabilities Professional (QIDP) Indicated client #3' ingests Trazodone due to Issues with sleep throughout the night. Additional interview confirmed the use of Trazodone was not included in a formal active treatment program. DRUG ADMINISTRATION CFR(s): 483-480(k)(2) The system for drug administration must assure			34G268	B. WING_		1.	
MOORE COUNTY HOME FOR AUTISTIC ADULTS O(4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRÉCEDED BY FULL TAGE) W 288 Continued From page 18 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a technique to manage client #3's behavior was included in a formal active treatment program. This affected 1 of 6 audit clients. The finding is: Client #3's use of Trazodone was not included in an active treatment program. Behavior such address non-compliance, aggression, disruption, spitting, feces smearing, pica, self wetting, falling to the floor and whinning. Additional review of the plan identified the use of Valporic acid and Offi to address inappropriate behaviors. Further review physician's orders dated 11/16/19 revealed an order for Trazodone HCL 50mg, take 1 tablet by mouth at bedtime. The use of Trazodone was not included in a formal active treatment program. Interview on 12/17/19 with the Home Manager and Qualified Intellectual Disabilities Professional (QIDP) Indicated client #3 ingests Trazodone due to issues with sleep throughout the night. Additional interview confirmed the use of Trazodone was not included in a formal active treatment program. W 369 CFR(s): 483.480(k)(2) The system for drug administration must assure	NAME C	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 1	2/17/2019
PREFIX TAG REGULATORY OR LISC IDENTIFYING INFORMATION) W 288 Continued From page 16 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a technique to manage client #3's behavior was included in a formal active treatment program. This affected 1 of 6 audit clients. The finding is: Client #3's use of Trazodone was not included in an active treatment program. Review on 12/1719 of client #3's Behavior Intervention Plan (BIP) dated 2/17/19 revealed objectives to address non-compliance, aggression, disruption, spitting, faces emening, pica, self wetting, falling to the floor and whinning. Additional review of the plan Identified the use of Valporic acid and Onfi to address inappropriate behaviors. Further review physician's orders dated 11/16/19 revealed an order for Trazodone HCL Somg, take 1 tablet by mouth at bedtime. The use of Trazodone was not included in a formal active treatment program. Interview on 12/17/19 with the Home Manager and Qualified Intellectual Disabilities Professional (CIDP) indicated client #3 ingests Trazodone due to issues with sleep throughout the night. Additional interview confirmed the use of Trazodone was not included in a formal active treatment program. W 369 CROSERETERENCED TO THE APPROPRIATE CONTRACTION (EACH OF THE APPROPRIATE CONTRACTION) and the Contract of the APPROPRIATE CONTRACTION (EACH OF THE APPROPRIATE CONTRACTION) and the Contract of the APPROPRIATE CONTRACTION (EACH OF THE APPROPRIATE CONTRACTION) and the APPROPRIATE CONTRACTION (EACH OF THE APPROPRIATE CONTRACTION (EA	MOOR				1112 DEVONSHIRE TRAIL		
This STANDARD is not met as evidenced by: Based on record review and interview, the facility falled to ensure a technique to manage client #3's behavior was included in a formal active treatment program. This affected 1 of 6 audit clients. The finding is: Client #3's use of Trazodone was not included in an active treatment program. Review on 12/1719 of client #3's Behavior Intervention Plan (BIP) dated 2/17/19 revealed objectives to address non-compliance, aggression, disruption, spitting, faces smearing, pica, self wetting, falling to the floor and whinning. Additional review of the plan identified the use of Valporic acid and Onfi to address inappropriate behaviors. Further review physician's orders dated 11/16/19 revealed an order for Trazodone HCL 50mg, take 1 tablet by mouth at bedtime. The use of Trazodone was not included in a formal active treatment program. Interview on 12/17/19 with the Home Manager and Qualified Intellectual Disabilities Professional (QIDP) Indicated client #3' ingests Trazodone due to issues with sleep throughout the night. Additional interview confirmed the use of Trazodone was not included in a formal active treatment program. W 369 W 369 CFR(s): 483.460(k)(2) The system for drug administration must assure	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY EUL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DSF	COMPLETION DATE
that all drugs, including those that are self-administered, are administered without error.		This STANDARD is Based on record refailed to ensure a technique of the behavior was include treatment program. clients. The finding Client #3's use of Traan active treatment program. Review on 12/17/19 of Intervention Plan (Bill objectives to address aggression, disruption pica, self wetting, fall Additional review of the Valporic acid and Onto behaviors. Further redated 11/16/19 revea HCL 50mg, take 1 tall The use of Trazodone formal active treatment interview on 12/17/19 and Qualified Intellect (QIDP) Indicated client to issues with sleep the Additional interview on Trazodone was not interestment program. DRUG ADMINISTRAT CFR(s): 483.460(k)(2)	not met as evidenced by: view and Interview, the facility chnique to manage client #3's ad in a formal active This affected 1 of 6 audit is: azodone was not included in program. of client #3's Behavior P) dated 2/17/19 revealed is non-compliance, in, spitting, feces smeaning, ing to the floor and whinning, he plan identified the use of fit to address inappropriate eview physician's orders ided an order for Trazodone olet by mouth at bedtime, e was not included in a int program. with the Home Manager that Disabilities Professional at #3 ingests Trazodone due aroughout the night, confirmed the use of cluded in a formal active TION dministration must assure at those that are		By dan 10, 2020 cli #3 IPP will be review and ravised to inclu the use of Trazado	ed de	YIDAO

			AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 12/18/2019 MAPPROVED O: 0938-0391
STATI AND I	EMEN PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
		PROVIDER OR SUPPLIER	34G268	B. WING	2	TREET ADDRESS, CITY, STATE, ZIP CODE	1:	2/17/2019
MÓ	QRE	COUNTY HOME FOR				ABERDEEN, NC 28315		
PRI	4) ID EFIX AG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
W	I (FFt n 2 a a c	This STANDARD is Based on observation interviews, the facility medications were and This affected 2 of 3 or receiving medication. 1. Client #6's medication. 1. Client #6's medication as ordered. During observations in the home on 12/17 assisted client #6 to its Sodlum, Zoloft, Rispewas not observed to it medications at this tirk. Review on 12/17/19 corders dated 11/26/19.5mg, take 1 tablet by and 8pm and Keppramouth twice a day at interview on 12/17/19 client #6 did not received pass. Interview on 12/17/19 HM) and Qualified interview on 12/17/19 client #6 did not received pass. Interview on 12/17/19 client #6 did not received pass. Client #3's medication or dered.	not met as evidenced by: ons, record reviews and y falled to ensure all ministered without error. clients (#3, #6) observed s. The findings are: ations were not administration /19 at 8:00am, Staff D ngest Clonidine, Depakote erdal and Antacid. The client receive any other ne. of client #6's physician's revealed orders for Ativan mouth twice daily at 8am 1000mg, take 1 tablet by 8a and 8pm. with the Staff D confirmed we Ativan and Keppra at the with the Home Manager cellectual Disabilities confirmed client #6 should and Keppra at the 8:00am lions were not administration	W		By dan 24, 2020 all struction be insured on microtion administration to RN to include documer appropriate medication and protocol. Implement will be manitored by Honoger weekly, Hab Somenthly and Nurse monthly.	ntation intation tation	,

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES				F	ITED: 12/18/2019 ORM APPROVED
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4 10 million		PLE CONSTRUCTION	CONTRACTOR DECIMALS	NO. 0938-0391 DATE SURVEY COMPLETED
		34G268	B. WING)			40/47/0040
NAME C	F PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		12/17/2019
MOOR	E COUNTY HOME FOR	AUTISTIC ADULTS			1112 DEVONSHIRE TRAIL ABERDEEN, NC 28316		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	MILDE	COMPLETION DATE
W 454	assisted client #3 to Sodium 250mg, Magacid. The client was other medications at Review on 12/17/19 orders dated 11/26/1 Depakote Sodium 50 twice daily at 8am artablet by mouth in the .025%, apply behind at 8am, 2pm and 8pm tablet by mouth in the afternoon and three fand 8pm. Interview on 12/17/19 client #3 did not rece Onfi and Kenalog. Interview on 12/17/19 confirmed client #3 si Depakote 500mg, Zyr 8:00am med pass. INFECTION CONTROCER(s): 483.470(I)(1) The facility must provito avoid sources and interview, the facility for cross-contamination affected 1 of 6 audit client and sources and interview, the facility far cross-contamination affected 1 of 6 audit client and sources and interview, the facility far cross-contamination affected 1 of 6 audit client and sources and interview, the facility far cross-contamination affected 1 of 6 audit client and sources and interview, the facility far cross-contamination affected 1 of 6 audit client and sources and interview.	Ingest Prenatal, Depakote gnesium Oxide and Folic in not observed to receive any it this time. of client #3's physician's 19 revealed orders for Domg, take 1 tablet by mouth and 8pm; Zyrtec 10mg, take 1 is morning at 8am; Kenalog both ears three times daily m; and Onfi 10mg, take 1 is morning, one tablet in the tablets at night at 8am, 2pm of with Staff D confirmed live Depakote 500mg, Zyrtec, if with the HM and QIDP hould have ingested rec, Onfi and Kenalog at the DL ide a sanitary environment transmission of infections. of met as evidenced by: as, record review and ailed to ensure the potential on was prevented. This lients (#4). The finding is:	W 45	14 A A A A A A A A A A A A A A A A A A A		ons plem clien clien then	entation
	Client #4 consumed a	contaminated drink.			and documented weekly		

CENT	ERS FOR MEDICARE	AND HUMAN SERVICES			FOR	D: 12/18/2019 MAPPROVED D: 0938-0391
STATEME AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) D/	ATE SURVEY OMPLETED
		34G268	B. WING		44	14710040
NAME C	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/17/2019
MOOR	E COUNTY HOME FOR			1112 DEVONSHIRE TRAIL ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE
W 45	Continued From page	ge 19	W 45			
	12/16/19 at 12:14pm drink, put the glass i it over to client #4. (and consumed the n	ations in the home on n, a client took a sip of a pack on the table and pushed Client #4 picked up the drink emaining portion of it, yere in the area during this		Home Manager and monthly by Hab Speciali	st	124/20
	time, client #4 was n another client's drink	ot prevented from consuming				
	regarding Universal I 4/2/19) revealed staff	of the facility's policy Precautions (last revised f should follow "universal es to prevent and control				
	Manager and Qualified Professional (QIDP) to take food and drink	on 12/17/19, the Home and Intellectual Disabilities acknowledged client #4 likes as which do not belong to monitored. The QIDP has the potential for				
W 460	phone on 12/17/19, the know better." FOOD AND NUTRITE		W 460	By 1/14/-0 011 -1 00		
	CFR(s): 483.480(a)(1) Each client must rece well-balanced diet incl specially-prescribed d	lve a nourishing, luding modified and		be inserviced on follow diets as written to inclusion to the though not limited to se	ving	
	Based on observation	ot met as evidenced by: is, record reviews and failed to ensure modified		Portions in bite size Portions. Im plementati Will be documented were by Home manager	Ü	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/18/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING_ 34G268 B. WING 12/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1112 DEVONSHIRE TRAIL MOORE COUNTY HOME FOR AUTISTIC ADULTS ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X8) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 460 Continued From page 20 W 460 diets were followed for 2 of 6 audit clients (#3, #6). The finding is: Clients (#3, #6) modified diets were not followed as written. During breakfast observations in the home on 12/17/19 at 7:35am, client #3 and client #6 served themselves whole muffins and consumed them. The muffins were not cut up. Interview on 12/17/19 with Staff A revealed client #3 and client #6 should have their food cut into bite-size pieces. The staff acknowledged the muffins should have been cut up. Review on 12/16/19 of client #3's Individual Program Plan (IPP) dated 5/17/19 revealed she consumes a regular diet and "cut all food bite size". Review on 12/16/19 of client #6's IPP dated 10/10/19 noted he should receive an 1800 calorie diet and "cut all foods bite size"



GREATER IMAG E HEALTHCARE CORP 401 ROBESON STREET FAYETTEVILLE, NC 28301 (910) 321-0069 Fax: (910) 491-1000

Fax Cover Sheet

Send To:						
	Prom: Jeane Bhone					
Attention:	Jeane Bhone					
Attention: Wilma Diggs RE: Doo						
RE: Da	Office Location: Fau NC Phone Number:					
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