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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G268 | A. BUILDING ______ 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 |

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| E 039 | EP Testing Requirements<br>CFR(s): 483.475(d)(2)<br><br>(2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:<br><br>*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]<br><br>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.<br>(ii) Conduct an additional exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, facility-based.<br>(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. | E 039 | By January 17, 2020 the facility will participate in a facity based exercise and/or a table top exercise to include group discussion, prepared questions and a facilitator to challenge emergency plan.<br><br>RECEIVED<br>JAN 02 2020<br>DHSR-MH Licensure Sect | 1/17/20 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] QIDP, MA, LCAS
TITLE
(X6) DATE: 12/31/19

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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| E 039 | Continued From page 1<br><br>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:<br>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is:<br><br>The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise.<br><br>Review on 12/16/19 of the facility's current EP plan (dated 2018 - 2019) did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan.<br><br>Interview on 12/17/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility has not conducted a full-scale facility/community-based exercise or a | E 039 | | |

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| E 039 | Continued From page 2<br>tabletop exercise to test the effectiveness of their current emergency plan. | E 039 | | |
| W 186 | DIRECT CARE STAFF<br>CFR(s): 483.430(d)(1-2)<br><br>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.<br><br>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to ensure sufficient staff were provided to supervise clients and provide training in accordance with their individual Program Plan (IPP). This affected 1 of 6 audit clients (#6). The finding is:<br><br>Sufficient direct care staff were not provided in the home during first shift on 12/16/19.<br><br>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 | W 186 | By 12/31/19 the facility will ensure that sufficient staff is provided to manage and supervise all clients. The staffing pattern will be monitored daily by Home Manager, bimonthly by Hab Specialist and monthly by QIDP to ensure provision of training in accordance with their individual program plan. | |

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| W 186 | Continued From page 3<br>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.<br><br>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.<br><br>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.<br><br>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 | W 186 | | |

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| W 186 | Continued From page 4<br>do a better job once he has finished...Training 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.<br><br>Interview on 12/17/19 with the Home Manager and Qualified Intellectual Disabilities Professional (QIDP) confirmed two staff should be working in the home on first shift and the facility's staff to client ratio is 2 to 6. The management staff acknowledged sufficient staff were not provided in the home from 7:00am - 9:11am in accordance with the required ratio. | W 186 | | |
| W 189 | STAFF TRAINING PROGRAM<br>CFR(s): 483.430(e)(1)<br><br>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained to perform their duties effectively. The findings are:<br><br>1. Staff were not adequately trained to correctly document on the Medication Administration Record (MAR).<br><br>During observations of medication administration in the home on 12/17/19 from 8:00am - 8:17am, Staff D assisted three clients to dispense their medications. As each medication was | W 189 | By 1/24/2020 all staff will participate in medication training by the registered nurse on documentation, procedure and notification of nurse. To include falls, abrasions and symptoms. Staff will be monitored weekly for appropiate implementation, weekly by Home Manager, bi-monthly Hab Specialist and monthly by nurse. All staff will be inserviced | 1/24/20 |

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| W 189 | Continued From page 5<br>dispensed, the staff immediately signed their initials on the MAR. Afterwards, the clients were prompted to ingest their medications.<br><br>Interview on 12/17/19 with Staff D revealed what was observed is how they had been trained as a medication technician (MT).<br><br>Review on 12/17/19 of a medication technician test revealed staff are asked the question, "When should medication be signed off on the MAR?"<br><br>Interview via phone on 12/17/19 with the facility's nurse confirmed the MT should have waited for clients to ingest their medicine before signing the MAR.<br><br>2. Staff were not adequately trained to notify the nurse and document a significant event.<br><br>During evening observations in the home on 12/16/19 at 5:51pm, clients returned to the home after a community outing. As client #1 walked from the van to the front door of the home, she fell onto her left side with the upper portion of her body hitting the ground and the lower portion remaining on the pavement. A staff assisted her up and into the home.<br><br>Interview via phone on 12/17/19 with the facility's nurse revealed she had not been notified of a fall involving client #1. The nurse indicated she should have been called, especially since client #1 has been experiencing ambulation issues.<br><br>Interview on 12/17/19 with the Home Manager confirmed the nurse had not been called and no paper work was completed. | W 189 | on guidelines to address client #1 IPP addedum for ambulation guidelines will be included. | |

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| W 240 | Continued From page 6 | W 240 | | |
| W 240 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(6)(i)<br><br>The individual program plan must describe relevant interventions to support the individual toward independence.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to ensure client #1's Individual Program Plan (IPP) included information to support her independence. This affected 1 of 6 audit clients. The finding is:<br><br>Client #1's IPP did not include specific information to address her dropping to the floor.<br><br>During observations in the home throughout the survey on 12/16 - 12/17/19, client #1 frequently dropped or lowered her body to the floor/ground while walking inside and outside of the home. Staff consistently verbally prompted her to stand up and provided physical assistance as needed.<br><br>Interview on 12/16/19 with Staff C revealed they believed the client has been dropping to the floor as a behavior because she is "stubborn". Additional interview on 12/17/19 with Staff E indicated they had not been given any specific instructions regarding client #1's dropping to the floor; however, they just help her up when she drops on her bottom.<br><br>Review on 12/16/19 of client #1's physician's note dated 11/7/19 revealed, "Falls may be related to possible foot drop or redirection. Will send referral for neurology evaluation." Additional review of the client's IPP dated 5/10/19 revealed | W 240 | By 1/24/2020 client #1 IPP will include an addedum to address her impaired ambulation. approved by guardian and Human Rights Committee. | 1/24/20 |

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| W 240 | Continued From page 7<br>no information regarding her falling to the ground or how staff should respond and/or assist the client when this occurs.<br><br>Interview on 12/17/19 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) revealed client #1 began dropping down to the floor around the end of October and she has been to the doctor regarding this and is awaiting a neurological referral. Additional interview also indicated team members have met regarding this issue and are trying to determine if this is a medical or behavioral problem. Further interview revealed staff have been told to monitor client #1; however, no specific guidelines or instructions have been included in her IPP to address her dropping to the floor. | W 240 | | |
| W 247 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(6)(vi)<br><br>The individual program plan must include opportunities for client choice and self-management.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure the Individual Program Plan (IPP) for 2 of 6 audit clients (#2, #4) included opportunities for choices at meals. The finding is:<br><br>Clients (#2, #4) were not provided with alternative food choices at lunch.<br><br>During lunch observations in the home on 12/16/19 at 12:10pm, client #2 served himself a cold cut sandwich, fruit cocktail, mixed vegetables, potato chips, Kool-aid and water. | W 247 | By January 10, 2020 staff will be inserviced on providing alternative food choices to include all clients but specifically for client #2. Implementation will be monitored by Home Manager weekly, bimonthly by Hab Specialist and monthly by QIDP. | 1/10/20 |

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| W 247 | Continued From page 8<br>Client #1 ate the potato chips, drank his liquids and threw out all other food items. At the meal, client #4 served himself a cold cut sandwich, mixed vegetables, fruit cocktail, Kool-aid and water. Client #4 took one bite of the sandwich, drank his liquids and threw out other food items. Client #1 and client #4 were not offered alternative food choices after refusing the majority of their lunch.<br><br>Interview on 12/17/19 with the Home Manager (HM) indicated client #2 is a picky eater.<br><br>Review on 12/16/19 of client #2's IPP dated 9/27/19 revealed, "Continue to monitor food intake and meal refusals."<br><br>Review on 12/16/19 of client #4's IPP dated revealed he "makes some choices in daily activities."<br><br>Interview on 12/17/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 and client #4 should have been offered another lunch choice once they had refused what was served. | W 247 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>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. | W 249 | | |

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| W 249 | Continued From page 9<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure 4 of 6 audit clients (#1, #2, #3, #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of food preparation, self-help/grooming skills, and program implementation. The findings are:<br><br>1. Clients were not adequately involved in food preparation tasks.<br><br>During lunch preparation observations in the home on 12/16/19 at 11:58am, client #2 was prompted to pour canned fruit into a bowl. Staff B prepared cold cut sandwiches and placed mixed vegetables in a bowl while client #2 stood nearby or came in/out of the kitchen area. Client #2 was not actively involved in food preparation tasks.<br><br>As clients returned to the home from a community outing on 12/16/19 at 5:51pm, all food items (smoked sausage, cabbage, carrots and mashed potatoes) were cooked and on the stove. At 6:00pm, Staff C made a pitcher of Kool-aid without any client participation. No clients were prompted or encouraged to assist with any food preparation tasks.<br><br>Interview on 12/16/19 with Staff B revealed client #2 can so just about "anything" in the kitchen and some things without prompting.<br><br>Review on 12/17/19 of client #2's Adaptive Behavior Inventory (ABI) dated 9/3/19 indicated the client can prepare sandwiches with | W 249 | All staff will be inserviced by 1/24/20 on the active treatment process to include though not limited to food preparation, toileting personal hygiene, privacy and use of utensils.<br>Program implementation will be monitored weekly by Home Manager, bimonthly by Hab Specialist and monthly by QIDP. | 1/24/20 |

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| W 249 | Continued From page 10<br>assistance. The ABI indicated the client could not independently complete meal preparation tasks.<br><br>Interview on 12/17/19 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) confirmed clients should be involved with food preparation tasks.<br><br>2. Client #6's toileting program was not implemented as written.<br><br>During observations in the home on 12/16/19 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 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.<br><br>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.<br><br>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 | W 249 | | |

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|---|---|---|---|
| | 34G268 | A. BUILDING ______ 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 |

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| W 249 | Continued From page 11<br>the attempt, Staff can hand over hand with him to do a better job once he has finished...Training 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.<br><br>Interview on 12/17/19 with the HM and QIDP confirmed client #6 has a toileting goal which should be implemented as written.<br><br>3. All clients were not encouraged to participate with serving themselves or pouring their own drinks.<br><br>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.<br><br>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.<br><br>During breakfast observations in the home on 12/17/19 at 7:41am, Staff A asked client #2 to pour drinks for all of the clients.<br><br>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.<br><br>Review on 12/17/19 of client #1's IPP dated 5/10/19 revealed the client "scoops food from serving bowl with assistance" and "participates in family style dining with assistance." | W 249 | | |

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| W 249 | Continued From page 12<br><br>Review on 12/17/19 of client #3's ABI dated 4/1/19 noted the client can pour from a small pitcher with assistance.<br><br>Review on 12/17/19 of client #6's ABI dated 9/5/19 indicated he is totally independent with pouring from a small pitcher.<br><br>Interview on 12/17/19 with the HM and QIDP confirmed clients can pour their drinks with assistance and client #1 was capable of serving herself.<br><br>4. Clients (#3, #5) were not prompted to assist with grooming their hair.<br><br>During morning observations in the home on 12/16/19 at 11:35am and 12:01pm, Staff A proceeded to blow dry, brush and style client #3's and client #5's hair without their participation. The clients were not encouraged to assist with this grooming task.<br><br>Interview on 12/16/19 with Staff A revealed client #3 can assist with her hair care; however, client #5 usually wants staff to do it for her.<br><br>Review on 12/17/19 of client #3's ABI dated 4/1/19 noted she cannot independently dry or style her hair.<br><br>Review on 12/17/19 of client #5's IPP dated 2/15/19 identified needs to comb and shampoo her hair. The client's ABI dated 1/15/19 indicated she is partially independent with combing/brushing, styling and shampooing her hair. | W 249 | | |

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| W 249 | Continued From page 13<br>Interview on 12/17/19 with the HM and QIDP confirmed client #3 and client #5 can assist with grooming their hair.<br><br>5. Clients (#3, #6) were not encouraged or assisted to cut their food.<br><br>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.<br><br>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.<br><br>Review on 12/17/19 of client #3's ABI dated 4/1/19 indicated the client cannot independently use a knife for cutting.<br><br>Review on 12/17/19 of client #6's ABI dated 9/5/19 revealed he requires assistance to use a knife for cutting.<br><br>During an interview on 12/17/19, the HM and QIDP acknowledged client #3 and client #6 can assist with cutting their food. | W 249 | | |
| W 252 | PROGRAM DOCUMENTATION<br>CFR(s): 483.440(e)(1)<br><br>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.<br><br>This STANDARD is not met as evidenced by: | W 252 | | |

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| W 252 | Continued From page 14<br>Based on observations, record reviews and interviews, the facility failed to ensure data relative to the accomplishment of Individual Program Plan (IPP) objectives was documented in measurable terms. This affected 2 of 6 audit clients (#2, #5). The findings are:<br><br>1. Client #5's target behaviors were not documented as indicated.<br><br>During observations in the home on 12/16/19 at 4:20pm, staff prompted clients outside for a walk. Once outside, client #5 indicated she wanted to go back inside and began whining, screaming and banging/kicking the front and side door of the home. After briefly walking around outside, client #5 went back inside with several other clients and staff.<br><br>Review on 12/16/19 of client #5's Behavior Intervention Plan (BIP) dated 2/17/19 revealed objectives to address target behaviors of inappropriate touching, profanity, falling to the floor, non-compliance, self wetting, pica, crying, begging for food, loud vocalizations and severe disruption. Additional review of the BIP noted severe disruption includes, " a variety of behaviors including whining, tearing clothes and temper tantruming..." The plan also indicated all target behaviors should be documented.<br><br>Further review on 12/17/19 of client #5's behavior data collection sheet for December 2019 did not indicate the behaviors observed on 12/16/19 had been documented.<br><br>Interview on 12/17/19 with the Home Manager (HM) confirmed client #5's behaviors had not been documented. | W 252 | All staff will be inserviced by 1/20/20 on documentation to include behavior plan documentation. Implementation of appropriate documentation will be monitored by Home Manager weekly, bimonthly by Hab Spec and QIDP monthly. | 1/20/20 |

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| W 252 | Continued From page 15<br><br>2. Client #2's target behavior was not documented as indicated.<br><br>During morning observations in the home on 12/17/19 at 7:01am, client #2 was prompted to assist with setting the table and making muffins. While in the kitchen, client #2 reached out to hit the HM. His attempt was immediately blocked by the manager's right arm.<br><br>Review on 12/16/19 of client #2's BIP dated 2/17/19 revealed objectives to address target behaviors of non-compliance, self-injurious behavior, inappropriate touching, loud vocalizations, and physical aggression. Additional review of the BIP indicated physical aggression was defined as "any attempt to physically harm another person, including but not limited to hit, kick, punch, head butting (whether attempt is successful or not...)." The plan also noted target behaviors should be documented.<br><br>Further review of client #2's behavior data sheet for December 2019 did not indicate the observed behavior had been documented.<br><br>Interview on 12/17/19 with the Home Manager (HM) confirmed client #2's behavior had not been documented. | W 252 | | |
| W 288 | MGMT OF INAPPROPRIATE CLIENT BEHAVIOR<br>CFR(s): 483.450(b)(3)<br><br>Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. | W 288 | | |

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| W 288 | Continued From page 16<br><br>This STANDARD is not met as evidenced by:<br>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:<br><br>Client #3's use of Trazodone was not included in an active treatment program.<br><br>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, feces 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.<br><br>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 288 | By Jan 10, 2020 client #3 IPP will be reviewed and revised to include the use of Trazadone as required. | 1/10/20 |
| W 369 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(2)<br><br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. | W 369 | | |

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| W 369 | Continued From page 17<br><br>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all medications were administered without error. This affected 2 of 3 clients (#3, #6) observed receiving medications. The findings are:<br><br>1. Client #6's medications were not administered as ordered.<br><br>During observations of medication administration in the home on 12/17/19 at 8:00am, Staff D assisted client #6 to ingest Clonidine, Depakote Sodium, Zoloft, Risperdal and Antacid. The client was not observed to receive any other medications at this time.<br><br>Review on 12/17/19 of client #6's physician's orders dated 11/26/19 revealed orders for Ativan .5mg, take 1 tablet by mouth twice daily at 8am and 8pm and Keppra 1000mg, take 1 tablet by mouth twice a day at 8a and 8pm.<br><br>Interview on 12/17/19 with the Staff D confirmed client #6 did not receive Ativan and Keppra at the med pass.<br><br>Interview on 12/17/19 with the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6 should have received Ativan and Keppra at the 8:00am med pass.<br><br>2. Client #3's medications were not administered as ordered.<br><br>During observations of medication administration in the home on 12/17/19 at 8:17am, Staff D | W 369 | By Jan 24, 2020 all staff will be inserviced on medication administration by RN to include documentation, appropriate medication and protocol. Implementation will be monitored by Home Manager weekly, Hab Specialist bimonthly and Nurse monthly. | |

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| W 369 | Continued From page 18<br>assisted client #3 to ingest Prenatal, Depakote Sodium 250mg, Magnesium Oxide and Folic acid. The client was not observed to receive any other medications at this time.<br><br>Review on 12/17/19 of client #3's physician's orders dated 11/26/19 revealed orders for Depakote Sodium 500mg, take 1 tablet by mouth twice daily at 8am and 8pm; Zyrtec 10mg, take 1 tablet by mouth in the morning at 8am; Kenalog .025%, apply behind both ears three times daily at 8am, 2pm and 8pm; and Onfi 10mg, take 1 tablet by mouth in the morning, one tablet in the afternoon and three tablets at night at 8am, 2pm and 8pm.<br><br>Interview on 12/17/19 with Staff D confirmed client #3 did not receive Depakote 500mg, Zyrtec, Onfi and Kenalog.<br><br>Interview on 12/17/19 with the HM and QIDP confirmed client #3 should have ingested Depakote 500mg, Zyrtec, Onfi and Kenalog at the 8:00am med pass. | W 369 | | |
| W 454 | INFECTION CONTROL<br>CFR(s): 483.470(l)(1)<br><br>The facility must provide a sanitary environment to avoid sources and transmission of infections.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interview, the facility failed to ensure the potential for cross-contamination was prevented. This affected 1 of 6 audit clients (#4). The finding is:<br><br>Client #4 consumed a contaminated drink. | W 454 | All staff will be inserviced on universal precautions and monitored for implementation More specifically, for client #4 consuming other client's liquids. Implementation will be monitored daily and documented weekly by | 12/4/19 |

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| W 454 | Continued From page 19<br><br>During lunch observations in the home on 12/16/19 at 12:14pm, a client took a sip of a drink, put the glass back on the table and pushed it over to client #4. Client #4 picked up the drink and consumed the remaining portion of it. Although, five staff were in the area during this time, client #4 was not prevented from consuming another client's drink.<br><br>Review on 12/17/19 of the facility's policy regarding Universal Precautions (last revised 4/2/19) revealed staff should follow "universal precautions at all times to prevent and control infections".<br><br>During an interview on 12/17/19, the Home Manager and Qualified Intellectual Disabilities Professional (QIDP) acknowledged client #4 likes to take food and drinks which do not belong to him and needs to be monitored. The QIDP agreed this incident has the potential for cross-contamination.<br><br>During an interview with the facility's nurse via phone on 12/17/19, the nurse stated, "They (staff) know better." | W 454 | Home Manager and monthly by Hab Specialist | 1/24/20 |
| W 460 | FOOD AND NUTRITION SERVICES<br>CFR(s): 483.460(a)(1)<br><br>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure modified | W 460 | By 1/10/20 all staff will be inserviced on following diets as written, to include though not limited to serving portions in bite size portions. Implementation will be documented weekly by Home manager, | |

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| W 460 | Continued From page 20<br>diets were followed for 2 of 6 audit clients (#3, #6). The finding is:<br><br>Clients (#3, #6) modified diets were not followed as written.<br><br>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.<br><br>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.<br><br>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".<br><br>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". | W 460 | | |

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

## Fax Cover Sheet

| Send To: | From: Jeane Bhone |
|---|---|
| Attention: Wilma Diggs | Date: 12/31/19 |
| RE: POC | Office Location: Fay NC |
| Fax Number: 919 715-8078 | Phone Number: 910 321-0069 |

- ☐ Urgent
- ☐ Reply ASAP
- ☐ Please Comment
- ☑ Please Review
- ☐ For your Information

Total pages, including cover:

**Comments:** Please call if you have questions

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