STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G120	A. BUILDING ______ B. WING ______	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS FORK HOMES I AND II	**1358 & 1388 LEWIS FORK BAPTIST CHURCH RD** **FERGUSON, NC 28624**

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure privacy was maintained for 1 of 3 sampled clients (#1) during medication administration. The finding is: Observation in Lewis Fork II on 12/17/19 at 7:25 AM revealed client #1 to sit in the medication administration area, located in a small room outside the dining room, with a curtain covering the doorway for privacy. Continued observation outside the medication area revealed clients #8, #5 and #3 to sit in the dining area, near the medication room, with staff engaged in conversation and assisting clients with the breakfast meal. Further observation during client #1's medication pass revealed staff K to repeatedly interrupt staff J conducting the medication pass by verbally addressing staff J. At 7:33 AM staff K was observed to stand at the medication room curtain and ask staff J for an ointment relative to client #6. At 7:35 Staff K again asked staff J for an ointment for client #6 stating "I need the ointment for client #6's ass". Staff K then requested the surveyor to pass the ointment to the staff at which time staff K was informed she needed to wait until client #1 had finished his medication pass. At no time during the observation of the med pass of client #1 was staff K redirected relative to talking through the medication curtain to staff conducting the medication pass or was staff observed to limit	W 130	W130 The RN will in-service all staff Medication Administration protocol with emphasis on privacy. The clinical team will monitor through Medication Observations Assessments two times a week for one month and then on a routine basis to ensure staff are following Medication Administration Protocol. In the future the RN will ensure staff are trained to ensure privacy during medication pass with no interruptions. DHSR - Mental Health JAN 8 2020 Lic. & Cert. Section	2-21-19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Luray Rominger | TITLE: Regional Administrator | (X6) DATE: 1/7/2020

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 130	Continued From page 1 distractions in the dining room that could be heard in the medication area. Interview with the facility administrator verified privacy should be provided during medication administration for all clients. Further interview with administration revealed staff should not be attempting to interrupt a medication pass by talking through the medication curtain and staff should not utilize inappropriate language in the presence of clients. Subsequent interview with the acting qualified intellectual disabilities professional and facility administrator verified distractions outside the medication area should be limited to support the privacy of the medication pass.	W 130		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure for 1 of 4 sampled clients (#2) that clothing fit properly. The finding is: Observations in Lewis Fork II on 12/17/19 revealed client #2 to wear loose fitting denim pants. Further observation at 8:10 AM revealed client #2 enter the medication room with her pants falling down exposing her underwear. Further observation at 8:35 AM revealed client #2 to ambulate into the kitchen area to place her breakfast dishes in the kitchen when her pants	W 137	W 137 The Qualified Professional will In-service the staff on ensuring all clients have clothing that fits appropriately and notify the Qualified Professional of any clothing needs. The Home Manager will complete a Clothing Inventory for all people supported and inappropriate or ill-fitting clothing will be disregarding and new clothing will be purchased. The clinical team will monitor through Appearance Checklist two times a week for one month and then on a routine basis to ensure all clients have clothing that is appropriate and fits. In the future the Qualified Professional will ensure all clients have the right to retain and use appropriate personal possessions and clothing.	2-21-2020

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W 137	Continued From page 2 and undergarments slipped off her waist and fell down exposing the client's bare backside until staff assisted the client with pulling up her pants. Observation at 8:56 AM revealed client #2 to ambulate in the group home when her pants again began slipping off her waist. Subsequent observation revealed staff J to inform the home manager (HM) that client #2 needed her pants changed due to the pants fitting to big. The HM was then observed to assist client #2 to her room to change her pants. Interview with the HM on 12/17/19 revealed client #2 has been fluctuating in pant sizes and therefore some of her pants were too big. Continued interview with the HM revealed client #2 had a current belt although the belt was too big. Interview with the acting qualified intellectual disabilities professional verified all clients should have clothing that is appropriately sized and supporting accessories such as a belt that also fits appropriately.	W 137		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to include opportunities for choice and self-management for 4 sampled clients (#1, #3, #6 and #12) relative to medication administration and hygiene. The findings are: A. Staff failed to ensure client #12 the opportunitiy for choice and self-management	W 247	W 247, A, B, C, and D The Habilitation Specialist and Qualified Professiona will in-service staff on client choice and self-management relevant to medication administration, hygiene and bathroom choice. The clinical team will monitor through Interaction Assessments two times a week for one month and then on a routine basis to ensure staff are providing choices regarding eating and medications times, encouraging hygiene, and choic with bathroom shower or tub preferences. In the future the Qualified Professional will ensure staff are trained and are implementing opportunities for choice and self-management.	

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W 247	Continued From page 3 relative to morning medication administration. For example: Observation on 12/17/19 at 7:15 AM revealed client #12 to particpate in the breakfast meal. Continued observation revealed staff F to prompt client #12 to the medication closet for morning medications. Staff F directed Staff E to assist another client while she escorted client #12 to the medictation closet to administer his medication. Client #12 then returned to the dining room table to finish eating. Staff did not offer client #12 a choice to receive medications or finish eating when staff interrupted client #12's breakfast. Interview with the acting qualified intellectual disabilities professional (QIDP) on 11/17/19 confirmed client #12 should have been offered a choice to finish his meal before medications were administered. B. Staff failed to ensure client #3 the opportunity for choice and self-management relative to hygiene. For example: Observation in the group home on 12/17/19 at 6:50 AM revealed client #3 to exit his bedroom and sit in the dining room. Observation of client #3's appearance revealed the client's hair to be disheveled and unbrushed. Client #3 was observed to remain in the dining area throughout the remaining observations of the morning. Additional observation revealed no observation of staff to prompt client #3 to conduct any additional hygiene after 6:50 AM. Interview with client #3 at 9:25 AM, after loading the facility van, revealed the client did not have his hair brushed on 12/17/19. Interview with staff assisting clients load the van revealed they were	W 247		

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W 247	Continued From page 4 unsure if client #3 had his hair brushed as they did not assist the client with morning hygiene on the current day. Interview with the acting QIDP verified all clients should have the option of getting their hair brushed before leaving the group home. C. Staff failed to ensure client #6 the opportunity for choice and self-management relative to hygiene. For example: Observation in the group home on 12/17/19 at 8:20 AM revealed client #6 to sit in the dining area and to participate in the morning meal at 8:25 AM. Client #6 was further observed to sit in the dining room after the morning meal, to drink coffee, return to his room before returning back to the dining area, participate in medication administration and to socialize with staff throughout the morning observations. At no time during the morning observations was it observed for staff to prompt client #6 to conduct additional hygiene after 8:20 AM before loading the facility van for transport to the vocational site. Interview with client #6 on 12/17/19 at 9:30 AM revealed he did not have his hair or teeth brushed during his morning hygiene care. Continued interview with client #6 revealed he would have liked the opportunity to brush his teeth before leaving for work. Interview with staff revealed client #6 did not have his teeth brushed as they were running late. (It should be noted during the staff interview, staff unloaded client #6 from the facility van and took the client back into the group home to complete hygiene care before leaving for the vocational site at surveyor request). Interview with the acting QIDP revealed all clients should be given encouragement and opportunity to	W 247		

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W 247	Continued From page 5 complete all hygiene care at all times before leaving the group home. D. Staff failed to ensure client #1 the opportunity for choice and self-management relative to hygiene, relative to bathroom choice. For example: Observation in the group home on 12/17/19 at 8:35 AM revealed client #1 to walk to a bathroom in the back hallway of the home with extra clothes on a hanger. Staff was observed to meet client #1 in the back hallway and to open the bathroom door and to verbally indicate to the client the need to go to another bathroom as there were shower chairs in the client's preferred bathroom. Client #1 was then assisted by staff to another bathroom in the group home. Interview with the facility home manager (HM) on 12/17/19 revealed staff should move the shower chairs into the hallway of the group home if shower chairs are in a bathroom, a client needs to shower and doesn't require a shower chair. Further interview with the HM verified client #1 should not have had to change bathrooms because staff did not want to wheel the shower chairs out of the bathroom. Interview with the acting QIDP on 12/17/19 revealed client #1 should be able to utilize any available bathroom in the group home.	W 247		
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	W 249	W 249 A and B The Habilitation Specialist and Qualified Pro-fessional will complete and Active Treatment Schedule for the morning routine. The Habilitation Specialist will in-service staff on client training objectives identified in the Person Centered Plan, active treatment, and Active Treatment Schedule. The clinical team will	2-21-2020

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W 249	Continued From page 6 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, review of records and interview the facility failed to ensure sufficient interventions were implemented to assure that objectives listed in the person centered plan (PCP) were implemented as prescribed to ensure a continuous active treatment program for 2 of 6 sampled clients (#3 and #5). The findings are: A. The facility failed to provide continuous active treatment for client #3. For example: Observation in the Lewis Fork II group home on 12/17/19 at 7:15 AM revealed client #3 to exit his bedroom area and enter the dining room and prepare for his breakfast meal. Client #3 was observed to participate in the breakfast meal and to sit in the dining room until 8:40 AM. Client #3 was observed to sit unengaged in the dining room from 7:35 until 8:40 AM ambulating to different locations of the dining room and sleeping. Observation at 8:40 AM revealed client #3 to enter the medication area of the group home and to return to the dining area at 8:52 AM. Observation from 8:55 AM until client #3 loaded the facility van at 9:25 AM, client #3 was observed to sit in his wheelchair and sleep. Review of records for client #3 on 12/17/19 revealed a PCP dated 6/10/19. Review of the 6/2019 PCP revealed current objectives to include counting, hygiene and following a	W 249	monitor through Interaction Assessments two times a week for one month and then on a routine basis to ensure staff are implementing training objectives, Active Treatment Schedule and engaging clients in active treatment. In the future the Qualified Professional will ensure staff are trained and implement Person Centered Plans to ensure a continuous active treatment program.	

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W 249	Continued From page 7	W 249		

schedule. Further review of the 6/10/19 PCP revealed a behavior support plan dated 4/15/19 for target behavior of cooperation difficulty, tantrums, aggression, inappropriate sexual behavior and property misuse.

Interview with the acting qualified intellectual disabilities professional (QIDP) on 12/17/19 revealed staff should have prompted client #3 throughout the morning regarding activities to engage the client. Further interview with the QIDP verified staff should have offered various activities to client #3, during the 85 minutes of unengaged observation time, to support active treatment and efforts to reduce target behaviors of the client.

B. The facility failed to provide continues active treatment for client #5. For example:

Observation in the Lewis Fork II group home on 12/17/19 at 7:07 AM revealed client #5 to exit her bedroom and go to the dining room. Observation at 7:15 AM revealed client #5 to participate in medication administration and exit the medication area at 7:20 AM. Client #5 was further observed to stand in the dining room with headphones listening to music throughout the rest of morning observations until the client loaded the facility van for transport to the vocational site. Observation of client #5 from 7:20 AM until 9:25 AM revealed the client to walk to her room various times and to stand in the kitchen area with headphones on.

Review of records for client #5 on 12/17/19 revealed a PCP dated 2/28/19. Review of the 2/2019 PCP revealed current training objectives of client #5 to include privacy, load dishwasher, hygiene and to follow work behaviors in the

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W 249	Continued From page 8 classroom. Further review of the 6/2019 PCP revealed a behavior support plan dated 1/14/19 for target behaviors of cooperation difficulty, obsessive compulsive behaviors, pestering and PICA. Interview with staff I on 12/17/19 revealed client #5 ate breakfast prior to survey arrival at the group home at 6:50 AM on 12/17/19. Interview with the acting qualified intellectual disabilities professional (QIDP) on 12/17/19 revealed staff should have prompted client #5 throughout the morning regarding activities to engage the client. Further interview with the QIDP verified staff should have offered various activities to client #5, during the 125 minutes of unengaged observation time, to support active treatment and efforts to reduce target behaviors of the client.	W 249		
W 268	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1)(i) These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to promote the growth and independence of 6 of 6 clients (#1, #2, #3, #5, #6 and #8) with regard to dignity related to the use of inappropriate language. The finding is:	W 268	W 268 The Administrator will in-service staff on supporting client dignity and using appropriate language while working with clients and in the work environment. The clinical team will monitor through Interaction Assessments two times a week for one month and then on a routine basis to ensure staff interactions and language are appropriate. In the future the Qualified Professional will ensure staff are trained and implement dignity and appropriate language when interacting with clients and in the work environment.	2-21-2020
	Observations in Lewis Fork II on 12/17/19 at 7:25 AM revealed client #1 to sit in the medication are for his morning medication pass with staff J. Further observation at 7:35 AM revealed Staff K to stand outside the curtain covering the			

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W 268	Continued From page 9 medication area doorway and request staff J to hand her an ointment for client #6 stating "I need the ointment for client #6's ass". Continued observation on 12/17/19 at 8:35 AM revealed staff K to assist client #1 in the bathroom with a shower. Subsequent observation revealed staff to talk to client #1 loudly in the bathroom and state "I 'm putting it here for when you piss and shit". Observation at 8:44 AM revealed client #1 to exit the bathroom with staff K. Interview with staff K on 12/17/19 revealed the terms "piss and shit" were used with client #1 while the client was in the bathroom to explain to the client why a towel was placed on the floor near the toilet. Further interview with staff K verified she should not be using cuss words around the clients as it was inappropriate. Staff K further revealed she was a new staff and had not received all her training yet. Interview with the facility administrator and acting qualified intellectual disabilities professional (QIDP) on 12/17/19 verified staff are provided training relative to supporting client dignity and not using inappropriate language around clients.	W 268		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, review of records and interview, the facility's system for ensuring drugs were administered in compliance with physician's orders failed for 1 sampled client (#6). The	W 368	W 368 The RN will in-service staff on administering medications per the physician order and the protocol for notification of the nurse prior to administration of any medications outside of the medication window. The clinical team will monitor through Medication Observations Assessments two times a week for one month and then on a routine basis to ensure stafff are administrating medications per the physician orders without error, and following Medication Administration Protocol. In the future the RN	2-21-2020

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W 368	Continued From page 10 finding is: Observation in the Lewis Fork II group home on 12/17/19 at 9:03 AM revealed staff J to verbally prompt client #6 to the medication room for morning medications. Continued observation revealed client #6 to enter the medication room and exit at 9:25 AM. Observation of the medication pass for client #6 revealed the client to receive: Amitiza 24 mcg, Abilify 15 mg, B-Complex capsule, Cetirizine 10 mg, Depakote ER 750 mg, Cymbalta 60 mg, Fish oil 1000 iu, Gabapentin 600 mg, Lactulose 30 ml, Keppra 1500 mg, Magnesium citrate 800 mg, Vitamin C 500 mg, Zinc 50 mg. Review of records for client #6 on 12/17/19 revealed a person centered plan (PCP) dated 7/8/19. Continued record review revealed physician orders dated 12/3/19. Review of the 12/2019 physician orders revealed all morning medications to be ordered at 8 AM. Interview with staff J on 12/17/19 revealed the medications for client #6 should be administered by 9:00 AM. Further interview with staff revealed she was unaware she had administered client #6 medications after 9:00 AM. Staff subsequently revealed the facility nurse should have been consulted with regard to the time of the administration and was not called. (It should be noted that upon interview with staff, the staff contacted nursing relative to the time of the medication pass for client #6.) Interview with the facility nurse on 12/17/19 verified medications for client #6 were given outside the medication window and therefore out of compliance with physician orders. Continued interview with the facility nurse verified staff J contacted nursing	W 368	will ensure staff are trained and administer all medications in compliance with the physician orders without error.	

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W 368	Continued From page 11 after the medication pass for client #6.	W 368		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure all drugs were administered without error for 1 of 3 clients observed during drug administration (#6). The finding is: Observation conducted on 12/17/19 in Lewis Fork II at 9:03 AM revealed client #6 entered the medication administration area and received medications of Amitiza 24 mcg, Abilify 15 mg, B-Complex capsule, Cetirizine 10 mg, Depakote ER 750 mg, Cymbalta 60 mg, Fish oil 1000 iu, Gabapentin 600 mg, Lactulose 30 ml, Keppra 1500 mg, Magnesium citrate 800 mg, Vitamin C 500 mg, Zinc 50 mg. Client #6 was observed to take all medications followed by coffee. Review of the medication administration record for client #6 following the medication pass revealed an 8:00 AM order for Deep Sea nasal spray and Ear Drops at 8:00 AM and PM. Further review of the 12/3/19 administration record revealed ocean nasal spray: use 5 drops in each nostril daily prior to saline and blow nose. Subsequent review relative to ear drops revealed: Instill 5 drops in each ear twice a month for 5 days.	W 369	W 369 Cross Reference W 368	2-21-2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G120	A. BUILDING ______ B. WING ______	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS FORK HOMES I AND II	1358 & 1388 LEWIS FORK BAPTIST CHURCH RD FERGUSON, NC 28624

(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 369	Continued From page 12 Interview with the facility nurse on 12/17/19 confirmed nasal spray and ear drops should have been administered during the morning medication pass for client #6 on 12/17/19. Further interview with the facility nurse revealed the nurse to confirm with staff J that conducted the medication pass that staff forgot to administer the nasal spray and ear drops to client #6.	W 369		

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

December 30, 2019

Ms. Luray Rominger, Facility Administrator
RHA Health Services, Inc.
176 Wildcat Rd.
Deep Gap, NC 28618

DHSR - Mental Health
JAN 8 2020
Lic. & Cert. Section

Re: Recertification Completed December 17, 2019
Lewis Fork Homes I and II
1338 Lewis Fork Baptist Church Rd. Ferguson, NC 28624
Provider Number 34G120
MHL# 097-011
E-mail Address: lrominger@rhanet.org

Dear Ms. Rominger:

Thank you for the cooperation and courtesy extended during the recertification survey completed December 17, 2019. This survey was required for continued participation in the Medicaid program.

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

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is February 15, 2020.

What to include in the Plan of Correction

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

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

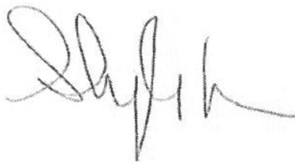
Send the original completed form to our office at the following address within 10 days of receipt of this letter.

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

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call me at (828) 750-2702.

Sincerely,



Shyluer Holder-Hansen
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: QM@partnersbhm.org
dhhs@vayahealth.com
qmemail@cardinalinnovations.org
_DHSR_Letters@sandhillscenter.org