STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G284	A. BUILDING _____ B. WING _____	01/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW RESIDENTIAL	359 FIRETOWER ROAD RICHLANDS, NC 28574

(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
E 030	Names and Contact Information CFR(s): 483.475(c) (1) [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs.	E 030	DHSR - Mental Health JAN 22 2020 Lic. & Cert. Section	

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

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

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E 030	Continued From page 1 (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff.	E 030		

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E 030	Continued From page 2 (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: The facility failed to develop an Emergency Plan (EP) that included a complete communication plan as evidence by interview and record review. The finding is: The facility Emergency Plan (EP) did not reflect updated information regarding Management contact information. Review of the facility's EP on 1/7/20 revealed a general emergency plan that did not contain information updated with current contact names and phone numbers specific to the home. For example, review of the EP revealed information sheets with management staff phone and addresses for individuals who no longer worked for the company. Interview on 1/6/20 with the Corporate Quality Assurance (QA) consultant confirmed the individuals listed on the management contact list no longer worked for the company.	E 030	The program manager and QP will ensure that the Emergency Preparedness Plan (EPP) reflect current contact names of applicable staff and their phone numbers. Updates to the plan will occur immediately when changes to staff and/or reassignments take place. The program manager will provide updates to the plan (EPP) to reflect current staff names and contact. The ICF Director and/or QA will monitor the EPP quarterly to ensure continued compliance.	3/7/2020
W 124	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(2) The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	W 124		3/7/2020

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W 124	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure one of five audit client's (#3) guardian understood the alternatives to proposed treatments and the possible consequences/alternatives to such refusal of treatment if any. The finding is: The interdisciplinary team failed to coordinate a meeting with the legal guardian for client #3 to discuss recommended medical procedures and the consequences of refusing these treatments. During observation in the facility on 1/7/20 between 6-9am client #3 told the residential manager (RM) that she had started her menstrual cycle. Several times client #3 was prompted by the RM to go into the bathroom to start her grooming and self care as part of her morning routine. Client #3 repeatedly told the RM she did not want to change her clothing. At 9:00am client #3 told the RM she was not going to the vocational program. Review on 1/7/20 of client #3's consultation with the Neuropsychiatrist on 10/29/19 revealed her mood was worsening around the time of her cycle every month and she was refusing to comply with completing activities of daily living around this time of the month . Further notation during this physician's visit notated her legal guardian was not in agreement with starting on her birth control pills. Additional review of this visit noted that client #3 insisted on staying in bed all day during her menstrual cycle and that one occasion she had become combative, refusing to take her	W 124	The facility will ensure that each client's legal representative is presented with alternatives to proposed treatment and potential consequences if treatment is refused. For Client #3, the QP will coordinate with the legal guardian and schedule a team meeting to discuss the Neuropsychiatrist's recommendations of starting a birth control medication and Prozac-as possible alternatives to increased behaviors around the client's menses cycle. The QP will document the results of the meeting and update the IPP to reflect the disposition and implementation of any recommendations as approved by the treatment team. QA and/or Director will monitor on a monthly basis, all clients' treatment status and any guardian refusal of treatment to ensure appropriate response, and documentation for continued compliance.	3/7/2020 3/7/2020 3/7/2020

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W 124	Continued From page 4 medication, kicked staff and had to be restrained. The recommendations by the Neuropsychiatrist included: Continuing her current medication, talking with her guardian about starting her on birth control and the possibility of starting client #3 on a low dose of Prozac to stabilize her mood. Review on 1/6/20 revealed client #3's record revealed she has been adjudicated incompetent and that her Grandmother is her legal guardian. Further review of the qualified intellectual disabilities professional (QIDP) notes revealed no documentation of any discussion of the risks versus the benefits of these medications with the legal guardian or interdisciplinary team members.	W 124	The facility will ensure that staff receive training and demonstrate competencies in areas relative to preparing thickened liquids, treating clients with dignity and promoting independence during medication adminstration. The Home Manager and QP will provide in-service training to all staff relative to addressing appropriate preparation of thicken liquids, treating clients with dignity and promoting independence during medication administration. Client #5 will use her adaptive spoon during medication administration. For Client #2, staff will communicate with her and seek her input and choice in the daily routine. The QP will provide staff training on the use of sign language as applicable to designated clients in the home. QP will provide training to all staff on appropriate communication (dignity) with clients at all times-to include but not limited to the situation when Client #6 expressed concern about the safety of her peer. The home manager and/or QP will conduct weekly morning and evening observations in the home to ensure continued compliance.	3/7/2020 3/7/2020
W 189	Interview on 1/7/20 with the Regional Director revealed the QIDP is out on medical leave and there has not been discussion with either the interdisciplinary team or the legal guardian about the risks versus benefits of starting birth control medication and Prozac at the recommendation of the Neuropsychiatrist. STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) 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. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff were sufficiently trained to address the needs of the clients for whom they were responsible in the areas of : preparing thickened liquids as prescribed, treating	W 189		

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W 189	Continued From page 5 clients with dignity and ensuring independence was promoted during medication administration. This affected 3 of 5 sampled clients (#2, #5 #6). The findings include: 1. Staff failed to promote independence during medication administration for client #5. During observations of medication administration on 1/7/20 at 8:14am client #5 was seated in a chair in the facility office. Direct Care staff C prepared her medication, crushed and mixed them with applesauce. Staff C then used a plastic spoon and fed client #5 her medications and applesauce. During observations of lunch and supper meals on 1/6/20 and breakfast on 1/7/20 client #5 was observed to use a built up spoon to feed herself using a high sided scoop bowl. Review on 1/7/20 of her individual program plan (IPP) dated 5/10/19 revealed client #5 uses a built up spoon and nosey cup for liquids. Review on 1/7/20 of client #5's Adaptive Behavior Inventory (ABI) dated 11/4/19 revealed client #5 is partially independent in eating with a spoon. In addition, in the area of self-administration of medication, client #5 is partially independent in taking her own pills. Review on 1/7/20 of client #5's annual medical evaluation dated 4/12/19 revealed that client #5 routinely takes her medication and participates in the administration as directed by staff. In addition, she has a strength of adequate dining skills using adaptive dining equipment.	W 189		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PRINTED: 01/09/2020
FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 359
COUNTRYVIEW RESIDENTIAL	**FIRETOWER ROAD RICHLANDS, NC 28574**

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W 189	Continued From page 6 Interview on 1/7/20 with the regional director confirmed staff should have encouraged client #5 to use an adaptive spoon to take her medication and applesauce. Further interview revealed direct care staff had been trained on client #5's strengths during medication administration. 2. Staff failed to promote dignity to client #2 when communicating her wants and needs. During observations of the medication pass on 1/7/20 at 8am, the surveyor asked client #2 if it was okay to observe the administration of her medications. When client #2 did not initially respond, the surveyor used sign language to communicate with her. Direct care staff C stated, " That is a waste of time, she can't understand that." When sign language was used again, client #2 signed "Yes." Review on 1/6/20 of client #2's individual program plan (IPP) dated 1/28/19 revealed she is non-verbal and will occasionally use sign language to indicate when she has to use the toilet. Further review of her record did not reveal a speech evaluation. Further review of her IPP indicated client #2 uses gestures, some signs (such as toilet) to communicate her wants and needs. Interview on 1/7/20 with the program manager confirmed direct care staff have not had any training in sign language although 3 clients in the facility (#2, #4, #5) are non-verbal. Interview on 1/7/20 with the regional director confirmed direct care staff C should have treated client #2 with dignity in communicating with her. Further interview confirmed client #2 has good	W 189		

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W 189	Continued From page 7 receptive language skills. Additional interview revealed staff have been trained on client rights and how to promote dignity with clients. 3. Staff failed to promote dignity to client #6 when communicating with her regarding the needs of client #5. During early morning observations in the facility on 1/7/20 at 6:00am staff A was assisting another client. Client #6 went into the hallway and told staff A that she needed to assist client #5 with putting on her shoes and that client #5 needed assistance tying her shoes. Staff A told client #6 that she needed to, " Stay in her lane and quit trying to do my job." When client #6 observed staff A putting on client #5's shoes and then walking out of the bedroom, she stated " Don't leave her shoes untied, she will fall." Staff A told client #6, "Don't worry about it, I will take care of it later." Review on 1/7/20 of client #5's IPP dated 5/10/19 revealed she uses a walker to assist her with ambulation and that she is a fall risk with fall prevention guidelines.	W 189		
W 210	Interview on 1/7/20 with the regional director confirmed that direct care staff A should have responded differently to client #6 who was showing concern for client #5. Further interview confirmed that all precautions should to be taken to prevent falls for client #5. Additional interview revealed direct care staff have been trained on client rights and how to promote dignity with clients. INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)	W 210		

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W 210	Continued From page 8 Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to assure the interdisciplinary team performed accurate assessment(s) within 30 days after admission. This affected 2 of 2 newly admitted audit clients (#3, #6). The findings include: The interdisciplinary team failed to complete initial evaluations for 2 of 2 newly admitted clients. 1. The interdisciplinary team failed to complete initial evaluations for client #6. Review on 1/6/20 of client #6's record revealed she was admitted on 1/9/19. Further review of client #6's record revealed no speech, occupational therapy (OT) or physical therapy (PT) assessments since her admission. Interview on 1/6/20 with the corporate quality assurance consultant revealed the qualified intellectual disabilities professional was out on medical leave and these assessments had not been completed. 2. The interdisciplinary team failed to complete initial evaluations for client #3. Review on 1/6/20 of client #3's IPP dated 2/5/19 revealed she was admitted to the facility on	W 210	The facility will ensure that initial evaluations are completed on all new admissions within 30 days. For Clients #3 and #6, the QP will coordinate with the Physical Therapist (PT) and Occupational Therapist (OT) to schedule the initial evaluations. The IPP will be updated by the QP and team to reflect recommendations from the OT and PT evaluations. The QP will provide in-service training to all applicable staff in the home and day program on PT and OT evaluations; recommendations therein to address areas of client care and habilitation. QA and/or Director will monitor records and verify appropriate assessment of clients are completed within 30 days of admission.	3/7/2020 3/7/2020

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W 210	Continued From page 9 1/5/19. Further review of client #3's record on 1/6/20 revealed no assessments were obtained in the areas of occupational therapy (OT), physical therapy (PT), speech, audiological and dental. Interview on 1/6/20 with the facility QA consultant revealed that no assessments in the areas of OT, PT, speech, audiological and dental were obtained following client #3's admission to the facility.	W 210	For all clients, the facility will ensure consideration for formal training when significant and emerging needs of clients are identified through observation and ongoing documentation and assessment.	3/7/2020
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and confirmed by interviews, the facility failed to consider client #3 for training when the need was identified to address her non-compliance in evacuating from the facility during evacuation drills. This affected 1 of 5 audit clients. The finding is: The interdisciplinary team did not consider client #3 for training to increase her compliance during evacuation drills. Interview on 1/7/20 with third shift staff A revealed fire drills have not been conducted in the middle of third shift as client #3 refuses to comply with being awakened on third shift and becomes very agitated.	W 227	For Client #3, the QP will schedule a team meeting to discuss non-compliance to evacuation drills. The psychologist will be involved in the team meeting. The IPP and/or BSP will be updated to address non-compliance and strategies to promote responsiveness to evacuation drills. The QP will in-service all staff on updates to Client #'3 IPP/BSP to address non-compliance during evacuation drills. QA and/or Director will review client records and evacuation drills on a quarterly basis to ensure emerging needs are addressed accordingly.	3/7/2020 3/7/2020

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W 227	Continued From page 10 Review on 1/7/20 of client #3's record revealed her individual program plan (IPP) was held on	W 227	For all clients, the facility will ensure the implementation of individual program plan (IPP) interventions to promote consistent use of	

W 249	2/5/19. Further review revealed no active treatment programs to increase compliance during evacuation drills in the facility. Interview on 1/7/20 with the corporate quality assurance consultant confirmed client #3 does not currently have training to address her compliance during facility evacuation drills. PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 3 of 5 audit clients (#2, #3, #5) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of consistent use of assistive devices, program implementation, and adaptive dining equipment use. The findings include: 1. Client #5's assistive devices were not used. Observations in the home on 1/7/20 revealed the	W 249	assistive devices, consideration of furniture to address program needs; and staff support during toileting for specific clients during their daily routine. For clients' #2, #3 and #5 the QP will provide in-service training to all staff on the IPP/BSP to address use of assistive devices, adaptive spoon, behavior techniques, client support during toileting; and client access to furniture in the environment in accordance with any IPP recommendations. For Client #3, The QP will convene a team meeting to discuss the Psychologist's recommendations of a rocking chair or swing in the home. The guardian's input will be solicited as well. The QP will document updates to the IPP to address any furnishing changes. The home manager and/or QP will provide weekly observations in the home of the routine and medication pass to ensure continued compliance.	3/7/2020 3/7/2020

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W 249	Continued From page 11 residential manager walking with client #5 into the bathroom. Client #5 was using a walker. At 7:44am, the residential manager came out of the bathroom and client #5 was still inside. At 7:48am, the residential manager went to the bathroom door	W 249		

	and asked client #5 "Are you ready?" The residential manager was observed to say "Sit down." At 7:51am, client #5 and the residential manager exited the bathroom. The only assistive device in the bathroom was a shower chair. Review of client #5's IPP dated 5/10/19 revealed that client #5 utilizes a raised toilet seat to prevent falls and injuries. Review of client #5's record on 1/7/20 revealed a annual medical evaluation dated 4/12/19 which states she remains on strict fall precautions in and out of the home. Additional review of client #5's record on 1/7/20 revealed a physical therapy (PT) evaluation dated 10/17/18. The PT evaluation stated that client #5 is involved in fall precaution and safety guidelines and tips to prevent spinal compression fracture. In addition, she remains a moderate to high risk for falls. The PT evaluation recommends continuing fall prevention and safety guidelines. Interview on 1/7/20 with the residential manager revealed that client #5 is able to be in the bathroom by herself. The residential manager stated that once client #5 is in the bathroom, staff can check on her or be outside around the bathroom door to hear her in case she falls or needs assistance. 2. Client #3's psychological recommendations			

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W 249	Continued From page 12 were not followed up on. Review of client #3's record on 1/6/20 revealed a psychological statement dated 8/22/19 to establish care. In the psychologist plan of	W 249		

	care, it is recommended that a rocking chair or swing be placed in the main area of the home as this might be a way for client #3 to be more social while also self soothing. Interview on 1/7/20 with the regional director confirmed that after speaking with the qualified intellectual disabilities professional (QIDP), they were unaware of the recommendation for a rocking chair or swing so this was not followed up on. 3. Client #2 was not provided assistance as needed. During observations in the home on 1/7/20 at 7:37am, client #2 was observed to go into the bathroom. At 7:39am, client #2 was heard to flush the toilet and immediately exited the bathroom without washing her hands. At 8:44am, client #2 signed to Staff C and Staff C was observed to say "Well go to the bathroom then," Client #2 went to the bathroom but did not go behind her. At 8:47am, client #2 was heard to flush the toilet and immediately exited the bathroom without washing her hands. Review of client #2's record on 1/7/20 revealed an Adaptive Behavior Inventory (ABI) dated 11/4/19. The ABI revealed that client #2 requires assistance when toileting. She is partially independent in the areas of flushing, handwashing, wiping, etc.			

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	34G284	A. BLDG _____ B. WING _____	01/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW RESIDENTIAL	359 FIRETOWER ROAD RICHLANDS, NC 28574

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W 249	Continued From page 13 Interview on 1/7/20 with the residential manager revealed that client #2 needs assistance in the bathroom. The residential manager stated that staff should follow client #2 to the bathroom to assist her because she is not thorough with cleaning herself after toileting and needs assistance with washing her hands. The residential manager confirmed that a staff should have	W 249		

	followed client #2 to the bathroom. 4. Client #3's behavior support plan (BSP) was not implemented. During observations at the day program on 1/6/20 at 12:00pm, client #3 was prompted by staff to get her lunch. Client #3 refused. At 12:07pm, client #3 got up and went to the bathroom. After exiting the bathroom, Staff B asked client #3 if she wanted to sit at the table in the other room by herself to eat her lunch. Client #3 went to the table and sat down. At 12:12pm, Staff B prompted client #3 to get her water and tea for lunch but she refused. During observations in the home on 1/6/20 at 3:48pm, client #3 was prompted by Staff E to get her snack. Client #3 refused. During observations in the home on 1/7/19 at 6:05am, Staff A knocked on client #3's bedroom door, opened the door and turned the light on and prompted her to get up. Client #3 refused. Client #3 got up out of bed, turned the light on and hit her hand on the door. Staff A was observed to say "She's in her mood this morning, I ain't messing with her." At 6:58am, the residential manager was observed in the bedroom with client #3. She was prompting client #3 to put on clothes different from the ones she slept in and			

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W 249	Continued From page 14 wore the previous day. Client #3 was observed to state "I don't want it." The residential manager stated "Ok, but it's clean clothes." Client #3 did not change her clothes. Review on 1/6/20 of client #3's IPP dated 2/5/19 revealed a diagnosis of Intermittent Explosive Disorder. In addition, the IPP stated that client #3 is supported by a BSP for aggression, severe disruptive behaviors, inappropriate toileting and failure to make responsible choices.	W 249		

	Review on 1/6/20 of client #3's BSP dated 1/30/19 revealed aggressive behavior is defined as hitting, kicking, biting, spitting, scratching, the use of her upper body or any object as a weapon and threatening behavior. Consequences for aggression include verbal reprimand and exclusionary time out. Failure to make responsible choices is defined as client #3 refusing to comply with reasonable requests from staff. Consequences for failing to make responsible choices includes prompt redirection and prompt guidance. In addition, the BSP stated for behavior prevention techniques, if client #3 appears agitated, she should be prompted to calm down and take a break. Staff should never give demands, but instead offer choices. Interview on 1/7/20 with the residential manager revealed "The psychologist suggested giving client #3 choices, but we ask and then come back 5 minutes or so later and ask again. She just does things on her own time." 5. Staff did not use client #5's adaptive spoon during medication administration. During observations of medication administration			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PRINTED: 01/09/2020
FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

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W 249	Continued From page 15 on 1/7/20 at 8:14am client #5 was seated in a chair in the facility office. Direct Care staff C prepared her medication, crushed and mixed them with applesauce. Staff C then used a plastic spoon and fed client #5 her medications and applesauce. During observations of lunch and supper meals on 1/6/20 and breakfast on 1/7/20 client #5 was observed to use a built up spoon to feed herself using a high sided scoop bowl. Review on 1/7/20 of her individual	W 249		

W 263	program plan (IPP) dated 5/10/19 revealed client #5 uses a built up spoon and nosey cup for liquids. Review on 1/7/20 of client #5's Adaptive Behavior Inventory (ABI) dated 11/4/19 revealed client #5 is partially independent in eating with a spoon . In addition, in the area of self-administration of medication, client #5 is partially independent in taking her own pills. Review on 1/7/20 of client #5's annual medical evaluation dated 4/12/19 revealed that client #5 routinely takes her medication and participates in the administration as directed by staff. In addition, she has a strength of adequate dining skills using adaptive dining equipment. Interview on 1/7/20 with the regional director confirmed staff should have encouraged client #5 to use an adaptive spoon to take her medication and applesauce. PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs	W 263	

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W 263	Continued From page 16 are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure written informed consent was obtained from client #3's guardian for her restrictive Behavior Support Plan (BSP). This affected 1 of 5 audit clients. The finding is: A current written informed consent was not provided for client #3's BSP. Review on 1/7/20 of client #3's BSP dated 1/30/2019 revealed an objective to address target	W 263	As applicable to any clients, the facility will ensure that written informed consent from the legal representative is obtained for behavior support programs incorporating the use of psychoactive medications and other such restrictions. For Client #3, the QP will secure written consent from the guardian on the behavior support plan (BSP) incorporating the use of Xanax, Doxepin and Seroquel. The QP will review all clients' BSPs as applicable to ensure written consent is obtained given restrictive components such as the use of psychoactive medications. QA and/or ICF Director will monitor monthly to ensure compliance. .	3/7/2020 3/7/2020 3/7/2020

W 441	behaviors of aggression, severe disruptive behavior, property destruction, self-injurious behavior, inappropriate toileting and failure to make responsible choices. The plan also incorporated the use of Xanax, Doxepin and Seroquel. Additional review of the client #3's record indicated that verbal consent was obtained on 3/1/19 but written informed consent was not obtained. Interview on 1/7/20 with the regional director confirmed no current written informed consent for the BSP had been obtained from client #3's guardian. EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions.	W 441	

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W 441	Continued From page 17 This STANDARD is not met as evidenced by: Based on review of fire drill reports and interview, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients residing in the home. The finding is: Fire drills were not conducted at varied times. Review of fire drill reports on 1/6/20 revealed the following: For the quarter between September-December 2019 there were 5 fire drills conducted. There were two drills completed on second shift, Two drills wee conducted on first shift. There was one drill completed on third shift which was on 12/14/19 at 6:20am. For the quarter between March 2019-July 2019 there were seven fire drills conducted. Six of these drills were completed on second shift. There was one third shift fire	W 441	The facility will implement a system to ensure that evacuation drills are conducted at varied times quarterly for all shifts, with a special emphasis on 3rd shift. The home manager will review and update a schedule for staff in the home to implement evacuation drills quarterly for all 3 shifts (1st, 2nd and 3rd). Special emphasis will be placed on 3rd shift evacuation at varied times such as during the middle of the night and before cleints are awakened for the morning routine. The QP will in-service all staff on the updated evacuation schedule with a specific emphasis on conducting quarterly drills during varied times on 3rd shift. QA and QP will monitor the evacuation drills on a monthly basis to ensure continuous compliance.	3/7/2020 3/7/2020 3/7/2020

	drill on 4/17/19 that was conducted at 6:20am. Interview on 1/6/20 with the Residential Manager confirmed there were no other drills available. Further interview confirmed the clients are awakened in the mornings about 5:30am by direct care staff. Interview on 1/7/20 with third shift staff A revealed fire drills have not been conducted in the middle of third shift as client #3 refuses to comply with being awakened on third shift and becomes very agitated. Further interview revealed client #3's non compliance during fire drills has not been reported to facility management. Interview on 1/7/20 with the regional director			

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W 441	Continued From page 18 revealed there were no additional fire evacuation drills to review. Further interview revealed staff had not reported to management client #3's non compliance during evacuation drills on third shift. FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)	W 441		3/7/2020
W 460	Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the area of providing prescribed diet consistencies. This affected 1 of 3 audit clients (#5). The findings are: Client #5's mealtime guidelines were not	W 460	The facility will ensure that all clients receive their specially prescribed diets as indicated by the ISP and physician's orders. For Client #5, all staff in the home and day program will be in-service on thickener guidelines for "Nectar" consistency as it pertains to multiple liquids such as orange juice, water, milk, nutritional supplement etc. The specific written guidance on the actual preparation of "Nectar" thicken liquids will be accessible to all staff in the home. The QP and/or the Home Manager will provide in-service training to day program and group home staff on all clients' prescribed diets. The QP, QA and program manager will monitor meals in the group home and day program weekly to ensure continued compliance.	3/7/2020 3/7/2020 3/7/2020

	followed. Observations in the home on 1/6/20 at 6:05pm revealed client #5 eating dinner. Staff E was observed to put one scoop of thickener in client #5's nutritional supplement, stir it, and put one additional scoop of thickener in the supplement using the large scoop on the scooper. Observations in the home on 1/7/20 at 7:19am revealed Staff C putting thickener in client #5's nutritional supplement and orange juice. Staff C put 2 and a 1/2 scoops of thickener in the orange juice and 2 and a 1/2 scoops of thickener in the nutritional supplement using the large scoop on the scooper.			

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W 460	Continued From page 19 Additional observations in the home on 1/7/20 at 8:14am revealed Staff C getting a glass of water for client #5 to take her medications. Staff C put 3 scoops of thickener in the glass of water using the large scoop on the scooper. Review on 1/7/20 of client #5's individual program plan (IPP) dated 5/10/19 revealed that client #5's diet consists of nectar thick liquids. Review on 1/7/20 of client #5's annual medical evaluation dated 4/12/19 revealed that client #5 has a tendency to choke on regular liquids and drinks thickened beverages. Review on 1/7/20 of thickener directions for "nectar" thick consistency revealed that for water, 3 and a 1/2 to 4 teaspoons of thickener are added. For orange juice, 3 to 3 and a 1/2 teaspoons of thickener are added. For nutritional supplements, 4 to 4 and a 1/2 teaspoons of thickener are added. The enclosed scoop for the	W 460		

	thickener has a small scoop scoop on one end (teaspoon) and a large scoop on the other end (tablespoon). Interview on 1/7/20 with the residential manager revealed that the staff should have followed the appropriate guidelines for each liquid. Interview on 1/7/20 with the QA consultant revealed that staff have been trained by the facility dietician to follow the recommended dosages for thickener to prevent the liquid from being too loose or too thick.			

January 15, 2020

Ms. Kimberly McCaskill, MSW, QIDP
Facility Compliance Consultant I
Mental Health Licensure and Certification Section
N.C. Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Annual Recertification Survey completed January 7, 2020
Countryview Residential
359 Firetower Road
Richlands, NC 28574
MHL#067-019, Provider # 34G283

Dear Ms. McCaskill:

See attached hard copy of the plan of correction (POC) for the Countryview Residential Home survey. We hope that you will find the attached POC acceptable. If you have questions, feel free to contact the QP (Shanna Colman) directly or myself, Julia Johnson. Otherwise, we very much look forward to your follow-up visit.

Kindest regards,

Julia Johnson, Director Periodic Services- Community Innovations