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 _____	R 02/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORE COUNTY HOME FOR AUTISTIC ADULTS	**1112 DEVONSHIRE TRAIL ABERDEEN, NC 28315**

(X4) ID PREFIX TAG	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 000	INITIAL COMMENTS A revisit was conducted on 2/24/20 for all previous deficiencies cited on 12/17/19. One deficiency was recited and no new area of noncompliance was found. The facility remains out of compliance.	W 000		
{W 186}	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. 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. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure sufficient staff were provided to supervise clients and provide services in accordance with their Individual Program Plan (IPP). This affected 2 of 2 audit clients (#3, #6). The finding is: Sufficient direct care staff were not provided in the home during first shift to meet each client's needs. Upon arrival at the group home on 2/24/20 at 6:27am, Staff A was working in the home alone with six clients. At 6:41am, clients were assisted with breakfast tasks. After breakfast all six clients gathered in the living room of the home. Throughout the observations from 6:27am - 7:53am, client #3 repeatedly pointed to her head/hair and was told by the staff she needed to	{W 186}		

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

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{W 186}	Continued From page 1 "Wait" or "Hold on" to get her hair washed. At 7:12am, client #6 spilled a drink on his shirt. The front of his shirt was soaked from top to bottom. The client began yelling and pulling his shirt up towards his head. Staff A stated more than once, "Hold on, we gonna change your shirt." During this time, client #3 was not assisted with grooming her hair and client #6's wet shirt was not changed. The staff and six clients remained in living room/activity room of the home until 7:53am when Staff B arrived. Once Staff B entered the home, one client immediately ran down the hall. Another client jumped up from the couch and ran from one end of the home to the other hitting the walls. Staff B immediately began passing medications at 7:55am. Another staff, Staff C, arrived in the home at 8:00am. Interview on 2/24/20 with Staff A, who is the Home Manager (HM), revealed she had worked the night before (3rd shift) alone because the staff scheduled to work was a "no call, no show." Additional interview indicated first shift starts at 7:00am and the two staff scheduled to work had car trouble and this was why they were late. Interview on 2/24/20 with Staff B revealed she had car trouble this morning and this is why she was late. The staff indicated when they are running late, they generally call the HM to let her know. Review on 2/24/20 of client #3's IPP dated 5/17/19 revealed a need to gain proper grooming skills. Additional review of the client's Adaptive Behavior Inventory (ABI) dated 4/1/19 revealed she cooperates with being groomed and cannot independently style her hair. The IPP also noted, "[Client #3] continues to require 24 hour	{W 186}		

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{W 186}	Continued From page 2 monitoring and supervision." Review on 2/24/20 of client #6's ABI dated 9/5/19 he cannot independently change his clothes when they become dirty. Additional review of his IPP dated 10/10/19 indicated, "[Client #6] continues to require 24 hour supervision and monitoring provided by the group home." Continued review of the facility's "Hours of Work" policy (revised 2/20/19) revealed, "Supervisors and/or Home Managers are responsible for coverage of shift to ensure safety of all consumers. If an employee fails to report to work or leaves before shift ends...and there is no other coverage, Supervisors and/or Home Managers are responsible to cover shift." Interview on 2/24/20 with the Habilitation Specialist confirmed two staff should be working on each shift and if a staff is running late, the staff on-site must remain at work until the late staff arrives. Interview via phone on 2/24/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility's staff to client ratio continues to be 2 to 6 and at least two staff should be working on each shift. The QIDP acknowledged adequate coverage must be maintained on each shift.	{W 186}		