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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 observation and interview, the facility failed to assure sufficient direct care staff were available to manage and supervise 4 of 6 clients in the home (#1, #2, #5 and #6) in accordance with their individual habilitation plan (IHP). The finding is: Observation in the group home on 2/26/20 at 6:45 AM revealed one staff on shift, staff A. Continued observation revealed staff A to sit at the kitchen table with clients #1 and #6 while the clients ate breakfast. Observation at 6:50 AM revealed loud vocalizations to be repeated from the back hallway of the group home. Further observation at 6:55 AM revealed client #1 to take his breakfast dishes to the kitchen and walk to his bedroom. Subsequent observation at 6:57 AM revealed client #5 to exit her bedroom in a sleep shirt and walk towards the kitchen area until staff A redirected client #5 to her bedroom to get dressed. Observation at 7:00 AM revealed staff A to enter the bedroom of client #4 due to ongoing vocalizations of the client and to assist client #4 with going to the bathroom. Client #6 was observed to complete her breakfast meal and to return to her bedroom area at 7:12 AM. Observation at 7:10 AM revealed staff B and C 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 enter the group home for support with the morning shift. Interview with staff A on 2/26/20 at 6:45 AM revealed she was the only staff on shift and other staff should arrive by 7:00 AM although she did not know who was scheduled to work as the facility had been short staffed. Continued interview with staff A at 6:55 AM revealed staff to verify client #4 was making vocalizations from her bedroom because she wanted to get up. Staff A further verified she could not assist client #4 to get up until additional staff support arrived. Subsequent interview with staff A at 7:00 verified staff ratio in the home was 1 staff to 3 clients and she was out of ratio as clients #1, #5, #6 were up and #2 was awake and yelling for support with ambulation to get up. Interview with the facility qualified intellectual disabilities professional (QIDP) on 2/26/20 verified staff ratio in the group home is 1 staff to 3 clients. Further interview with the QIDP revealed staff B and C should have arrived at the group home earlier than they did and she had not been contacted that staff were late. The QIDP further verified the facility was out of ratio from 6:57 until 7:10 AM, with 4 clients needing support and supervision with 1 staff on shift until additional staff arrived.	W 186		
W 189	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.	W 189		

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W 189	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure staff were sufficiently trained relative to the adaptive equipment needs for 1 of 3 sampled clients (#5). The finding is: Observation in the group home on 2/25/20 at 4:30 PM revealed client #5 to participate in leisure activity with sitting in the living room watching television with a helmet on. Continued observation of client #5 throughout survey observations on 2/25/20 revealed the client to ambulate throughout the group home wearing a helmet. Observation of client #5's bedroom, with staff D and client #5, on 2/25/20 revealed knee braces and an AFO in client #5's room. Subsequent observation throughout survey observations on 2/25/20 after locating the adaptive equipment in client #5's bedroom revealed the client to continue ambulation throughout the group home without redirection or prompts from staff to wear the knee braces or AFO. Observation on 2/26/20 at 7:05 AM revealed client #5 to ambulate to the kitchen area of the group home without wearing a helmet. Continued observation revealed client #5's helmet to be placed in the living room of the group home on a table. Further observation revealed client #5 to ambulate throughout the group home and to conduct morning activity to include breakfast preparation without wearing a helmet. Observation at 7:45 AM revealed staff to verbally prompt client #5 to put on her helmet to which the client replied "no". Observation at 7:52 AM revealed client #5 to enter the living room and to	W 189		

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put on her helmet, leaving the chin strap unfastened and to sit on the couch and watch television. Observation at 7:55 AM revealed client #5 to locate a cell phone in the couch of the group home and to ambulate throughout the group home calling for staff A with the chin strap still unfastened to her helmet. Subsequent observation at 8:05 AM revealed client #5 to ambulate down the hallway of the group home to the kitchen area where staff verbally prompted client #5 to fasten the strap on her helmet to which the client complied.

Review of records for client #5 on 2/25/20 revealed an individual habilitation plan (IHP) dated 3/20/19. Review of the IHP revealed adaptive equipment for client #5 to include bilateral knee braces, soft helmet, AFO, and a mouth partial. Additional review of the IHP for client #5 revealed soft helmet toleration guidelines to indicate client #5 is to wear a soft helmet due to behavior issues, client #5 will bang her head when upset. Subsequent review of the soft helmet guidelines for client #5 revealed the client is only to take the helmet off at night to sleep, during bath time and for 10 minutes every two hours.

Continued review of client #5's records revealed physician orders dated 1/28/20. Review of the current physician orders revealed AFO and knee braces, on in morning and off at bedtime. Further review of the 1/2020 physician orders revealed client #5 is to wear a helmet during waking hours.

Interview with the facility qualified intellectual disabilities professional (QIDP) on 2/26/20 verified client #5 should wear prescribed bilateral knee braces and AFO at all times during

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W 189	Continued From page 4 ambulation. Continued interview with the QIDP verified client #5 should also wear a soft helmet when ambulating and when awake except during her bath and during a break of 10 minutes every two hours. Continued interview with the QIDP verified client #5 has had past training regarding the wear and use of adaptive equipment and objectives were discontinued as the client met criteria and completed training. The QIDP further indicated client #5 requires prompts from staff to encourage the use of adaptive equipment and staff should have redirected the client when adaptive equipment was not worn as prescribed.	W 189		
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 observation, review of records and interview the individual habilitation plan (IHP) failed to have sufficient training objectives relative to sleep environment and behavior management for 1 of 3 sampled clients (#3). The findings are: A. The IHP dated 11/5/19 for client #3 failed to include training to address the need to sleep in his bedroom. For example: Observation in the group home on 2/26/20 at 6:45 AM revealed client #3 to sleep on the couch in the living room of the group home. Continued observation revealed client #3 to remain asleep	W 227		

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on the couch of the group home until 8:30 AM when staff supported client #3 to wake up and take a shower. Client #3 was observed to sleep throughout morning observations while other clients in the home ambulated through the living room area, completed morning routines and utilized the living room for leisure in watching television.

Review of records for client #3 on 2/26/20 revealed an individual habilitation plan dated 11/5/19. Review of the IHP revealed training objectives to address bathing, oral hygiene, remain seated, activity choice and sorting silver. Continued review of the IHP revealed a behavior support plan (BSP) dated 2/13/20 for target behavior of non-cooperation, aggression, self injurious behavior, tantrum behavior, inappropriate toileting and AWOL. Subsequent record review revealed client #5 to have a history of disrupted sleep with strategies to support sleep to include: offer a consistent bedtime routine, provide a quiet environment while client #5 is trying to sleep and the bed is bolted to the floor to prevent moving around.

Interview with staff A on 2/26/20 at the group home revealed client #3 sleeps in the living room on the couch almost every night as he will not stay in his room. Further interview with staff A revealed she just lets client #3 stay on the couch if he is asleep on the couch. Staff A further revealed she was unaware of any guidelines to support client #3 with sleeping in his room.

Interview with the qualified intellectual disabilities professional (QIDP) on 2/26/20 verified client #3 does not like to sleep in his room and will sleep on the couch of the living room. Further interview

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with the QIDP verified strategies or guidelines to support client #3 with sleeping in his room had not been developed although various strategies had been tried informally. Subsequent interview with the QIDP verified client #3 could benefit from formal training strategies to address the need of sleeping in his bedroom.

B. The IHP dated 11/5/19 for client #3 failed to include training to address behavior management specific to putting inappropriate items such as clothing in the trash. For example:

Observation in the group home on 2/26/20 at 8:45 AM revealed client #3 to open the bathroom door and to gather his clothing off the floor in preparation to leave the bathroom after his morning shower. Continued observation revealed client #3 to put all his clothing in the bathroom trash. Subsequent observation revealed staff B to walk by and observe client #3 in the bathroom. Staff B then looked into the trash can for the client's belongings. Client #3 was verbally directed by staff B to take his clothing out of the trash and assisted with putting items into a laundry bin in the laundry room.

Review of records for client #3 on 2/26/20 revealed an IHP dated 11/5/19. Review of the IHP revealed training objectives to address bathing, oral hygiene, remain seated, activity choice and sorting silver. Continued review of the IHP revealed a BSP dated 2/13/20 for target behavior of non-cooperation, aggression, self injurious behavior, tantrum behavior, inappropriate toileting and AWOL. Subsequent review of the BSP for client #3 revealed no behavior or intervention strategies to address throwing away clothing or personal belongings.

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W 227	Continued From page 7 Interview with staff B revealed client #3 throws everything away without supervision. Continued interview with staff B revealed client #3 throws things away including his clothing all the time and has been throwing things away for a while. Interview with the QIDP verified client #3 has a behavior history of throwing clothing into the trash. Further interview with the QIDP revealed she did not know why placing items such as clothing in the trash was not part of client #3's behavior program although it should be.	W 227		
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 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 interviews, the facility failed to ensure objectives listed in the individual habilitation plans (IHP's) were implemented as prescribed for 3 of 3 sampled clients (#3, #5 and #6). The findings are: A. The facility failed to ensure a communication objective was implemented as prescribed for client #3. For example:	W 249		

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Observation in the group home on 2/26/20 at 6:45 AM revealed client #3 to sleep on the couch in the living room of the group home. Continued observation revealed client #3 to remain asleep on the couch of the group home until 8:30 AM when staff supported client #3 with verbal prompts to wake up and take a shower. Observation at 8:50 AM revealed staff to walk client #3 to a communication board in the hallway of the group home and assist client #3 with moving visual aids for shower, program and van to the right side of the board. Additional observation revealed client #3 to return to the living room to sit on the couch.

Review of records for client #3 on 2/25/20 revealed a IHP dated 11/5/19. Review of client #3's IHP revealed a communication objective dated 10/21/19. Further review of client #3's communication objective on 2/26/20 revealed the client will follow a task schedule with steps to include: 1) Staff should show the symbol of the activity that he needs to complete. Once the client is shown the the symbol it should be placed on the schedule board so client #3 will be able to independently see what he should be doing 2) Once client #3 completes the targeted activity, show him the next activity symbol and place it on the schedule board. 3) Steps 1 and 2 should be repeated for each activity 4) staff should train goal in order listed: (1st shift) shower, breakfast, brush teeth, medications, program goals, chore, leisure activity, get on van.

Interview with the facility QIDP on 2/26/20 revealed the communication program for client #3 remains current with using visual aids to support an activity schedule. Continued interview with the QIDP verified with each activity staff should bring

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client #3 a visual aid relevant to the targeted activity and follow the prescribed steps of the program. Further interview with the QIDP verified staff should not support client #3 with completing activities without use of the appropriate visual aid, then assist the client with moving all visual cues to the completed side of the board after all appropriate activities are completed.

B. The facility failed to ensure meal guidelines and a communication objective was implemented as prescribed for client #5.

1. The facility failed to ensure meal guidelines were implemented as prescribed for client #5. For example:

Observation on 2/25/20 at 5:35 PM revealed client #5 to participate in the dinner meal that included beef stew, cole slaw and dinner rolls. Continued observation revealed staff to serve client #5 all menu items in individual serving dishes that client #5 opened and placed on her high sided, divided dish. Further observation revealed staff D to sit beside client #5 and to provide verbal prompts throughout the meal to "slow down", "chew", and "rest your fork". Client #5 was observed to place all menu items on her plate at the same time within the divided sections of her dish and to have staff D supervision throughout the meal.

Review of records for client #5 on 2/25/20 revealed an IHP dated 3/20/19. Review of client #5's IHP revealed safe eating guidelines dated 12/11/19. Review of the safe eating guidelines for client #5 revealed a prompt sequence to include: 1) Tolerates two bites of food on plate 2) Avoids picking up food with fingers 3) Uses correct

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utensil 4) Thoroughly chews food 5) Swallows before taking the next bite.

Interview with the facility qualified intellectual disabilities professional (QIDP) on 2/26/20 revealed client #5 has a fast rate of eating and needs staff supervision to support safe eating. Further interview with the QIDP revealed client #5 should have no more than two bites of food on her plate at a time as in the prompt sequence of the client's safe eating guidelines. Subsequent interview with the QIDP verified staff should not have allowed client #3 to place all food items on her dish at the same time.

2. The facility failed to ensure a communication objective was implemented for client #5. For example:

Observation in the group home on 2/26/20 at 6:57 AM revealed client #5 to exit her bedroom and to walk towards the dining room. Continued observation revealed staff A to verbally redirect client #5 to her bedroom to get dressed. Further observation revealed client #5 to return to her bedroom to get dressed and exit her bedroom. Additional morning observations revealed client #5 to carry out activities of participating in the breakfast meal, medication administration, leisure activity and loading the facility van for transport to the vocational site. Subsequent observation revealed client #5 to carry out morning activities through client initiation or verbal prompts from staff.

Review of records for client #5 on 2/25/20 revealed an IHP dated 3/20/19. Review of client #5's IHP revealed a training objective relative to a "to-do" schedule. Review of the objective

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revealed client #5 will follow a "to-do" schedule to complete her morning routine with identified steps to include: 1) Get dressed 2) Puts on leg braces 3) Puts in partials 4) Help prepare breakfast 5) Eat breakfast 6) Clean up 7) Take meds 8) Brush teeth 9) Pack lunch 10) Choice of liesure 11) Get on van.

Interview with the facility QIDP on 2/26/20 revealed the training objective for client #5 to complete a "to-do" list for a morning routine remains current. Continued interview with the QIDP revealed the morning "to-do" list should be in client #5's room and staff should support the client with completing the list by taking the client to her room to review the list with each activity. Subsequent interview with the QIDP revealed directives for client #5 by staff should not be limited to verbal directives as observed during survey observations.

C. The facility failed to ensure a communication objective was implemented as prescribed for client #6. For example:

Observation in the group home on 2/26/20 at 6:45 AM revealed client #6 to sit at the dining table and to participate in the breakfast meal with client #1. Continued observation revealed client #6 to finish her breakfast meal and return to her bedroom and transfer from her wheelchair to her bed. Further observation revealed additional staff (B and C) to arrive at the group home at 7:10 AM and to verbally check on client #6 throughout the morning. Observation at 8:50 AM revealed client #6 to leave her bedroom area and to ambulate towards the exit of the group home for transport on the facility van to the vocational site. At no time during morning observations was it observed

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W 249	Continued From page 12 for client #6 to communicate with the use of a communication device. Review of records for client #6 on 2/25/20 revealed an IHP dated 1/22/20. Review of client #6's IHP revealed a communication objective that client #6 will converse with staff using a dynavox device. Review of the communication objective revealed in the mornings, staff should approach client #6 and begin a morning greeting. Review of steps involved in the objective revealed 1) Staff should say "Good Morning" and client #6 should respond with "Good Morning" 2) Staff should ask "Did you sleep good?" and client #6 should respond with "yes" or "No" 3) Staff should ask "Are you ready to get dressed?" and client #6 should respond with "yes" or "No". Interview with the QIDP on 2/26/20 revealed client #6 has a communication device that is used for the communication objective listed in the IHP. Continued interview with the QIDP verified staff should have used the communication device throughout the morning to converse with client #6.	W 249		
W 287	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: Based on observations and staff interviews, the interdisciplinary team failed to assure techniques used to manage inappropriate behavior for client	W 287		

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#3, were not used for the convenience of staff. The finding is:

Observation in the group home on 2/26/20 at 9:00 AM revealed staff B to verbally and physically prompt client #3 to the facility van for transport to a medical appointment. Continued observation revealed client #3 to refuse verbal and physical prompts by staff B and to attempt to run to the bathroom of the group home to drink water. Staff B was observed to follow the client to the bathroom and stop the client from getting water while verbally telling the client he had a medical appointment and could get a drink after the appointment. Client #3 was observed to exit the bathroom and return to the living room couch with redirection of staff B.

Observation at 9:05 AM revealed staff B to request staff C attempt to get client #3 to the van for transport while staff B provided support to all other clients on the facility van. Staff C was observed to verbally and physically prompt client #3 to the facility van while the client refused cooperation and darted to the hallway bathroom with staff C behind the client. Client #3 was redirected by staff C verbally from the bathroom and returned to the living room couch. Observation at 9:08 revealed client #3 to put on a transport harness with assistance of staff C. Client #3 was then observed to attempt to run back to the bathroom when staff C grabbed the client by the transport harness and the client began to pull from the staff until the client fell in the floor of the living room. Staff C was then observed to let go of the client and client #3 returned to the couch. Staff C walked to the exit of the group home towards the facility van and at 9:10 client #3 was observed to get off the couch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G109	A. BUILDING _____ B. WING _____	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNY LANE II	2830 HIGHWAY 70 EAST CLAREMONT, NC 28610

(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
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and walk to the facility van. Staff B and C then assisted client #3 with securing the client in his seat on the van utilizing the client's harness and seat restraints.

Review of records for client #3 on 2/26/20 revealed an IHP dated 11/5/19. Review of the IHP revealed training objectives to address bathing, oral hygiene, remain seated, activity choice and sorting silver. Continued review of the IHP revealed a behavior support plan (BSP) dated 2/13/20 for target behavior of non-cooperation, aggression, self injurious behavior, tantrum behavior, inappropriate toileting and AWOL. Further review of the BSP revealed non-cooperation behavior to include dropping to the floor, and refusal to follow staff requests. Review of strategies to address non-cooperation revealed interventions to include: allow time to cooperate, provide second prompts while attempting to assist client in being successful. Subsequent review of the BSP for client #3 revealed the client should wear a 5 point harness during travel due to difficulty staying in his seat and is likely to get up and move around when the van is moving.

Interview with the qualified intellectual disabilities professional QIDP) on 2/26/20 revealed client #3's harness should only be used for transport only. The QIDP further revealed client #3 has aggressive behaviors and has had issues with moving around on the facility van while the van is moving. Additional interview with the QIDP revealed staff should not use the harness to maneuver or physically restrict or redirect the client.