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V 000	INITIAL COMMENTS A complaint survey was completed on April 2, 2020. The complaints were substantiated (Intakes #NC00161344, #NC00161303, #NC00161030). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision	V 110		

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V 110	Continued From page 1 plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 4 paraprofessional direct care staff audited (Staff #6) failed to demonstrate knowledge, skills, and abilities required by the population served. The findings are: Review on 4/1/2020 of Staff #6's personnel file revealed: -Date of Hire: 12/9/19 -Position, direct care paraprofessional staff. -Staff #6's trainings included: -12/10/19: Abuse and Neglect of Individuals with Intellectual and Developmental Disabilities -12/2/19: Client Rights -12/11/19: Person Centered Thinking Review on 3/31/2020 of client #2's record revealed: -36 year old female admitted 10/15/19. -Diagnoses included mild intellectual and developmental disabilities, infantile cerebral palsy, paraplegic-spastic. -Individual Service Plan (ISP) dated 10/15/19 documented client #2 was her own guardian, and that it was important to her to make her own decisions. The Crisis Plan within the ISP documented "being treated like a child" may increase her stress and trigger a crisis. Telephone interview on 3/26/2020 client #2's Care Coordinator stated:	V 110		

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V 110	Continued From page 2 -Client #2 reported to her in February 2020 that Staff #6 took her food away as she was eating in her room. -Staff #6 had removed her food because she did not want client #2 to "make a mess" and was going to "teach her a lesson." -Staff #1 returned her meal to her immediately. Telephone interview on 3/31/2020 Staff #1 stated: -The Group Home Manager/ Qualified Professional (GHM/QP) had discussed at a staff meeting the need to get client #2 out of her room to eat her meals, but, she had the right to eat in her room if she made this choice. The GHM/QP coached the staff how to approach client #2 to encourage her to come out and interact with others at meal time without feeling forced. -There was an incident when Staff #1 served client #2 in her room and an on-coming coworker, Staff #6, went to client #2's room and removed her food as she ate. Staff #1 heard client #2 "shout" and could tell she was upset. Staff #1 returned client #2's food to her and notified the GHM/QP. Staff #1 was in another part of the home when the food was taken and did not hear any conversation between client #2 and Staff #6. -Staff #1 thought Staff #6 was trying to follow recent directions of the GHM/QP to encourage client #2 to come out of her room for meals. She did not think Staff #6 was trying to be punitive toward client #2. Telephone interview on 4/1/2020 Staff #6 stated: -In mid-February 2020 she arrived for her shift and client #2 was eating in her room. -The GHM/QP had held a meeting 1-2 days prior and informed staff that client #2 was not to eat in her room because it was causing bugs. -She removed client #2's food and returned it to the kitchen, where client #2 could eat.	V 110		

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-Before she could notify the GHM/QP Staff #1 had already called him.
-When she removed client #2's food she told the client about the meeting and staff had been told she (client #2) was not suppose to eat in her room.
-When she removed the food client #2 started crying.
-Staff #1 returned client #2's food to her room. Then Staff #1 was able to get client #2 to come to the kitchen and finish her meal.
-When asked if client #2 wanted to eat in her room now would this be permitted, Staff #6 stated she did not think client #2 could eat in her room because it caused bugs. Client #2 could not help but drop food when she ate. Staff have to clean up behind her, but she did not have a problem with this.
-The GHM/QP had discussed client rights at staff meetings. She could not recall his discussing a client's right to eat in their room.
-Client #2 now would eat out of her room with everyone else.
-Staff #6 had not received any disciplinary actions, like a verbal counseling or warning, for removing client #2's food. Staff #6 stated she did not to anything wrong; she was following the GHM/QP's directive. In her opinion Staff #1 should have been written up. Staff #1 had been at the meeting when the GHM/QP told staff client #2 was not to eat in her room.

Telephone interview on 3/26/2020 the GHM/QP stated:
-He had been made a aware of an incident in February when client #2 had chosen to eat her dinner in her room and Staff #6 removed her food before she finished her meal.
-He had to reprimanded Staff #6 for this. Staff #6 did this because she wanted client #2 to eat in the

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V 110	Continued From page 4 dining room. The reprimand was a verbal warning. -He had no documentation of the reprimand because it was a verbal warning and these were not documented. When he gave a verbal warning he told the staff they would be written up and removed from the schedule for a few days if there was another problem. -He had covered client's rights to make their own decisions at the weekly staff meetings. He had discussed clients could make there own decisions and staff were there to support them in living their lives.	V 110		
V 115	27G .0208 Client Services 10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to	V 115		

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V 115	Continued From page 5 assist in supervision of the children. This Rule is not met as evidenced by: Based on interviews, the facility failed to make services available 24 hours a day affecting 1 of 2 clients audited (client #2) and ensure nutritious meals for 1 of 2 clients audited (client #1). The findings are: Finding #1: Review on 3/31/2020 of client #2's record revealed: -36 year old female admitted 10/15/19. -Diagnoses included mild intellectual and developmental disabilities, infantile cerebral palsy, paraplegic-spastic. -Individual Service Plan (ISP) dated 10/15/19 documented client #2 was her own guardian, and that it was important to her to make her own decisions. The Crisis Plan within the ISP documented "being treated like a child" may increase her stress and trigger a crisis. Telephone interview on 3/26/2020 client #2's care coordinator stated: -There had there been issues with client #2's wheel chair beginning around Thanksgiving, 2019. Her wheel chair would not hold a charge. -Client #2 stayed in the home (did not attend her Day Program) for a week during this time. -There were issues with the charger, then there were battery issues, and finally the repair company identified the underlying problem and it was fixed. It was no fault of the facility that it took	V 115		

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V 115	Continued From page 6 so long to get it repaired. These delays were due to the repair company response. Telephone interview on 2/26/2020, 3/30/2020, and 4/2/2020 the Group Home Manager/Qualified Professional (GHM/QP) stated: -There had been some battery issues starting around December 2019 with client #2's wheel chair. -There had been one occasion he had to give a verbal counseling to Staff #3 and a former staff because they transported client #2 to the Day Program even though the client had requested to stay at home because of her wheel chair malfunction. -The decision to transport her to the Day Program was made primarily by the terminated staff and Staff #3 accompanied them. -The reason staff took client #2 to the Day Program (when she wanted to stay home) was to attend a staff meeting. Finding #2: Review on 3/27/2020 and 3/31/2020 of client #1's record revealed: -35 year old female admitted 5/7/09. -Diagnoses included severe intellectual and developmental disabilities; BPAN (Beta-Propeller Protein-Associated Neurogeneration); seizures; Anomaly Lissencephally-Bilateral Temporal Lobes; and, Chronic constipation. -Client #1's level of participation had decreased over the prior year and was expected to continue to decline due to her BPAN diagnosis. -She required a soft mechanical diet. Telephone interview on 3/26/2020 client #1's Day Program Director stated client #1 was on a soft mechanical diet. There were times the group home would send a nutrition bar and client #1's	V 115		

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V 115	Continued From page 7 mother said she could not have it. Telephone interview on 3/27/2020 client #1's Care Coordinator stated: -The guardian had sent her a picture on 2/20/2020 of client #1's lunch sent to the Day Program from the Group Home. -In the photograph she could see chunks of meat in mashed potatoes. -Client #1 had lost a lot of weight due to her declining condition and was about 5 pounds from needing a feeding tube. -In the past client #1 loved to eat. Now with her disease progression, she would forget to chew. She was losing her sense of taste. Telephone interview on 4/1/2020 client #1's guardian stated: -In February 2020 there had been an issue at the Day Program regarding client #1's lunch. -She had been assured this was taken care of by the Group Home Manager/Qualified Professional (GHM/QP). -Client #1's syndrome contributed to her weight loss and she had lost 30 lbs. She now weighed 100.5 pounds and when it got low enough they would have to place a feeding tube. Client #1 had a lot of muscle problems in her throat that caused swallowing problems. Telephone interview on 3/26/2020 the GHM/QP stated: -There had been 1 issue with client #1's diet. -Client #1 was on a mechanical soft diet and staff sent meat loaf and mashed potatoes to her Day Program thinking they could be mashed together. -The food was prepared by the 3rd shift staff; he was not sure who the staff were that prepared the meal. -He covered this in a staff meeting and staff had	V 115		

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V 115	Continued From page 8 been instructed to put all of client #1's food through the food processor.	V 115		
V 540	27F .0103 Client Rights - Health, Hygiene And Grooming 10A NCAC 27F .0103 HEALTH, HYGIENE AND GROOMING (a) Each client shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the: (1) opportunity for a shower or tub bath daily, or more often as needed; (2) opportunity to shave at least daily; (3) opportunity to obtain the services of a barber or a beautician; and (4) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil. (b) Bathtubs or showers and toilets which ensure individual privacy shall be available. (c) Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure the the client's right to dignity and humane care in the provision of health, hygiene and grooming for 1 of 2 clients audited (client #1). The findings are:	V 540		

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V 540	Continued From page 9 Review on 3/27/2020 and 3/31/2020 of client #1's record revealed: -35 year old female admitted 5/7/09. -Diagnoses included severe intellectual and developmental disabilities; BPAN (Beta-Propeller Protein-Associated Neurogeneration); seizures; Anomaly Lissencephally-Bilateral Temporal Lobes; and, Chronic constipation. -She had developed pressure ulcers over her sacrum that required home health nursing care. -Client #1's Daily Turn Schedule documented she was to be turned every 2 hours while in her bed and wound status to be updated with every turn. The Log had a column to document if the client's diaper was wet or dry. Review on 3/27/2020 of client #1's Individual Service Plan (ISP) dated 6/1/19 revealed: -Client #1's level of participation had decreased over the prior year and was expected to continue to decline due to her BPAN diagnosis. - Full support was required for all daily hygiene tasks. -She was incontinent; required close monitoring for yeast growing between her fingers due to contractures; and required a soft mechanical diet. -Diligence was needed when brushing her teeth at the group home twice daily, using her electric toothbrush. -She would usually shower in the morning and sponge bath in the evening do address incontinence issues. -Finger nails needed to be trimmed close; fingernails needed to be "rounded." -A bib/apron was necessary to wipe her mouth and prevent soiled clothing from overactive salivary glands.	V 540		

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Review on 3/31/2020 of client #1's February 2020 Daily Turn Schedule from 1/31/2020 - 2/19/2020 revealed:
-Documentation of turning every 2 hours was not consistent. Examples were as follows:
-1/31/2020 at 9:50 pm client was turned to the right; wound status, "open." The next entry was on 2/1/2020 at 7 am, turned to her left and wound status was "open."
-2/2/2020 staff documented they turned client #1 at 4:10 am, and positioned on her right side. The next entry was 2/2/2020 at 7 am, positioned on her left side. In both entries the clients wound status was "open, " and her diaper had been "wet."
-2/3/2020 staff documented they turned client #1 at 2 am and positioned on her left side. The next entry was 2/3/2020 at 5:05 am, positioned on her right side. In both entries the clients wound status was "open" and her diaper had been "wet."
-2/3/2020 staff documented they turned client #1 at 9:10 am positioned on her right side. The next entry was 2/4/2020 at 7:58 am. It was noted the client had been on her back. In both entries the clients wound status was "open."
-2/4/2020 staff documented they turned client #1 at 9:35 am positioned on her right side. The next entry was 2/5/2020 at 7:30 am; positioned on her left side. In both entries the clients wound status was "open."
-2/5/2020 staff documented they turned client #1 at 7:30 am positioned on her left side. The next entry was 2/7/2020 at 7:20 am; positioned on her right. In both entries the clients wound status was "open."
-Wound status documented, "closed" from 2/13/2020 through 2/19/2020.

Telephone Interview on 3/31/2020 client #1's Guardian stated:

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-There had been recurring hygiene issues. Client #1 was sent to the Day Program and her teeth looked like they had not been brushed. She had emphasized this and felt there was a lack of follow through.
-Overall she felt she had to "ask" or things did not get done. An example was an observation she made in February of client #1's outer ear. It was extremely dirty.
-She went to the home within the past 2 months to give client #1 a haircut. She arrived around 10 am and observed poor hygiene.
-Client #1 is totally non-ambulatory. She had developed 3 bedsores since July 2019 and the facility staff had not been the ones to identify any of the 3. She could not understand this given the staff had to do diaper changes. The bedsores were over her sacrum, a few inches above her rectum.
-The 2nd bedsore had been found at the Day Program, and the 3rd was identified during a family visit at the facility when she was turned/changed. On that occasion the family found client #1 wearing dirty pajamas and a very old wet diaper.
-Client #1 was on an every 2 hour turn schedule. Staff were to follow this schedule during the night. It was not a concern that her sleep would be interrupted. Client had medications that helped her sleep and she took naps in the daytime.

Telephone Interview on 3/27/2020 client #1's Care Coordinator stated:
-She received pictures from client #1's family frequently documenting poor oral hygiene. She had not seen anything herself.
-She would get pictures from the family showing client #1 had "crustiness" in her eyes, and food around her mouth.
-She had received pictures from client #1's family

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of her fingernails. With her BPAN progression, 1 hand is particularly clinched. She had not seen poor nail hygiene herself.
-In the pictures she received from family she could see what the family was concerned about. She had been able to see evidence food on her clothing, jagged fingernails, crusts in her eyes.
-On 2/20/20 pictures were sent by the family that were taken at the Day Program. In the photos she could see some build up of something on her teeth, and it looked like her teeth needed to be brushed. She could also see a crust on the side of one of client #1's eyes.

Telephone Interview on 3/26/2020 client #1's Day Program Director stated:
-Client #1 typically arrived at the Day Program around 10:30 am.
-Over the past few months client #1's care had greatly improved.
-There had been times she may have crusts in her eyes or a film on her teeth. Client #1's eyes water; she cannot say if this precipitates the crustiness.
-She had not seen food on her clothing when she arrived. Client #1's diaper was dry.
-Client #1 had a body odor like someone who wore a diaper; not like body odor from poor hygiene.
-Client #1 had a history of bedsores on her sacrum and had nursing visits for wound care. She noted a small area of breakdown not long ago and called the Group Home Manager/ Qualified Professional (GHM/QP). He had client #1 seen right away. The area was less than 1 inch in size. She thought this happened after the last DHSR survey (11/27/19). Nursing visits resumed and the area healed right away.

Telephone Interview on 3/26/2020 the GHM/QP

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON HOME	28 BEAUREGARD DRIVE WILMINGTON, NC 28412

(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) COMPLETE DATE
V 540	Continued From page 13 stated: -He had received a complaint from client #1's mother that her finger nails had not been cut properly. Her nails had been cut short, which is what the mother wanted, but the staff had cut them "square," not rounded. He was not sure if the mother had been this specific about how she wanted client #1's nails cut. Client #1 had not scratched herself. -When client #1's mother had complained, he went to see the client. The client did not have an odor. -He had been told by the Day Program staff that client #1's eyes water and she accumulates "crustiness." Her gums also bleed easily throughout the day and she required ongoing mouth and eye care. Her bleeding gums may be due to medications she took, but he was not sure. -Client #1 wore diapers. Client #1's mother dropped in on a Saturday in February 2020 and said her diaper had not been changed. We had a log in place for staff to document diaper changes/checks every 2 hours. The staff had documented they had changed her diaper 1 hour prior to mother's arrival on the client's Daily Turn Schedule. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 540		