STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G301	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTERFIELD GROUP HOME	2287 HARTLAND ROAD MORGANTON, NC 28655

(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 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 program plan (IPP) failed to have sufficient training objectives or interventions relative to behavior management for 1 of 4 sampled clients (#5). The finding is: Observation in the group home on 3/11/20 at 7:35 AM revealed client #5 to exit his bedroom and walk to the medication room of the group home. Continued observation at 7:50 AM revealed client #5 to sit at the kitchen table and to eat breakfast. Client #5 was then observed to get upset with staff A and to make aggressive hand gestures toward staff to distance from him while verbalizing "go home". Observation of client #5 at 8:10 AM revealed client #5 to walk to the medication room of the group home and to repeatedly yell "It's gone". Client #5 continued to walk in and out of the med room and the living room area yelling "It's gone". Further observation revealed staff A to assist client #5 with looking for what the client was referring to as "it's gone". Staff A was also observed to attempt to redirect client #5 with other morning tasks such as to pack his lunch and to help assist staff in the kitchen. Subsequent observation revealed staff B to enter the medication room and exit with a small toy car that	W 227	The QP, Program Specialist, Residential manager, and staff psychologist met via conference call on 3/26/20 to discuss Client #5's behavioral challenges in the. The consensusof this meeting was that Client #5's Behavior Support Program should be updated to more explicitly address this fact and that specific, detailed intervention strategies should be developed and put into the plan. The staff psychologist will update the BSP to reflect these changes. Upon approval of the guardian and ComServ's Human Rights Committee, the Program Specialist and QP will in-service staff in the home on these changes and how they should be followed consistently. Staff will also be inserviced on the need to cooperate together during difficult behaviors to best ensure that the needs of the clients are continuing to be met appropriately. The QP, Residential Manager, Program Specialist and/or designee will ensure that these changes to the BSP are implemented correctly and consistently and that staff respond appropriately to behavioral challenges through direct observation done in the home at least weekly. DHSR-Mental Health MAR 31 2020 Lic. & Cert. Section	5/11/20

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

QP | 3/26/20

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 227	Continued From page 1 client #5 agreed was what he was looking for. Client #5 was then observed to return to his bedroom and to go back to bed. Observation at 8:30 AM revealed staff A to enter the bedroom of client #5 and to verbally prompt the client to get up to which client #5 ignored the staff. Continued observation at 8:33 AM revealed staff A to verbally prompt client #5 with "lets go", "get your jacket" to which client #5 began yelling at the staff "go home". Further observation at 8:34 AM revealed client #5 to exit his bedroom with staff A behind the client. Staff A was further observed to walk behind client #5 providing physical direction when the client would stall in the hallway. Client #5 was observed to yell at staff "go home" and to blow his breath on staff A. Additional observation at 8:37 revealed client #5 to walk into the kitchen area and staff A to prompt the client to get his lunch. Client #5 was observed to reach for his lunch on the kitchen counter and grab staff A instead. Client #5 was then observed to grab staff A by the head with both hands, pulling staff A around the kitchen area until staff C intervened to provide support. Client #5 was observed to attempt to hit staff C and to yell at both staff, A and C, during the intervention. Observation at 8:52 AM revealed client #5 to walk with staff A and C in a therapeutic walk to the time out room of the group home. Continued observation revealed staff C to sit at the door of the time out room and monitor client #5 until the client appeared calm and exited the time out room at 9:06 AM. Subsequent observation revealed client #5 to complain to staff A and C of a hand injury and for the client to be directed to the facility van for transport to the vocational program.	W 227		

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W 227	Continued From page 2 Observation of client #5 on the facility van at 9:07 AM revealed the client to have bleeding from his hand. Continued observation revealed staff B to address client #5's injury with a band-aid. Interview with staff A on 3/11/20 revealed client #5 can be difficult in the mornings although he had not had a behavior with physical aggression in a while. Review of records for client #5 on 3/11/20 revealed an IPP dated 6/13/19. Review of the current IPP for client #5 revealed a behavior support plan (BSP) dated 1/8/18 for target behaviors of non-compliance, verbal aggression, spitting, bothering/teasing others, property destruction and physical aggression. Further review of the IPP for client #5 revealed no training objectives or specific strategies and interventions relative to morning difficulty. Interview with the facility qualified intellectual disabilities professional (QIDP) on 3/11/20 verified mornings are often difficult for client #5. Interview with the facility behaviorist verified client #5 had recently had an increase in behaviors and had an upcoming psych appointment to address behavior increase. Further interview with the facility behaviorist verified client #5 has a hard time in the mornings with getting up and completing morning routine tasks. Subsequent interview with the QIDP and behaviorist verified client #5 should have specific intervention strategies and a morning routine to address behavior difficulties although this was not part of the current IPP or BSP for the client.	W 227		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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W 249	Continued From page 3 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 program plans (IPP's) were implemented as prescribed for 1 of 4 sampled clients (#5). The finding is: Observation in the group home on 3/11/20 at 7:35 AM revealed client #5 to exit his bedroom and walk to the medication room of the group home. Continued observation at 7:50 AM revealed client #5 to sit at the kitchen table and to eat breakfast. Client #5 was then observed to get upset with staff A and to make aggressive hand gestures toward staff to distance from him while verbalizing "go home". Observation of client #5 at 8:10 AM revealed client #5 to walk to the medication room of the group home and to repeatedly yell "It's gone". Client #5 continued to walk in and out of the med room and the living room area yelling "Its gone". Further observation revealed staff A to assist client #5 with looking for what the client was referring to as "it's gone". Staff A was also observed to attempt to redirect client #5 with other morning tasks such as to pack his lunch	W 249	Staff will be re-inserviced on how to correctly follow the two prompt procedure and how it should be implemented as laid out in Client #5's current BSP. The QP, Program Specialist, Residential Manager and/or designee will ensure that staff are correctly following the two prompt procedure through direct observation in the home at least weekly.	5/11/20

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W 249	Continued From page 4 and to help assist staff in the kitchen. Subsequent observation revealed staff B to enter the medication room and exit with a small toy car that client #5 agreed was what he was looking for. Client #5 was then observed to return to his bedroom and to go back to bed. Observation at 8:30 AM revealed staff A to enter the bedroom of client #5 and to verbally prompt the client to get up, to which client #5 ignored the staff. Continued observation at 8:33 AM revealed staff A to verbally prompt client #5 with "let's go", "get your jacket" to which client #5 began yelling at the staff "go home". Further observation at 8:34 AM revealed client #5 to exit his bedroom with staff A behind the client. Staff A was further observed to walk behind client #5 providing physical direction when the client would stall in the hallway. Client #5 was observed to yell at staff "go home" and to blow his breath on staff A. Additional observation at 8:37 revealed client #5 to walk into the kitchen area and staff A to prompt the client to get his lunch. Client #5 was observed to reach for his lunch on the kitchen counter and grab staff A instead. Client #5 was then observed to grab staff A by the head with both hands, pulling staff A around the kitchen area until staff C intervened to provide support. Client #5 was observed to attempt to hit staff C and to yell at both staff, A and C, during the intervention. Observation at 8:52 AM revealed client #5 to walk with staff A and C in a therapeutic walk to the time out room of the group home. Continued observation revealed staff C to sit at the door of the time out room and monitor client #5 until the client appeared calm and exited the time out room at 9:06 AM. Subsequent observation revealed client #5 to complain to staff	W 249		

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W 249	Continued From page 5 A and C of a hand injury and for the client to be directed to the facility van for transport to the vocational program. Observation of client #5 on the facility van at 9:07 AM revealed the client to have bleeding from his hand. Continued observation revealed staff B to address client #5's injury with a band-aid. Review of records for client #5 on 3/11/20 revealed an IPP dated 6/13/19. Review of the current IPP for client #5 revealed a behavior support plan (BSP) dated 1/8/18 for target behaviors of non-compliance, verbal aggression, spitting, bothering/teasing others, property destruction and physical aggression. Review of the intervention procedures of the BSP for targeted behaviors of non-compliance revealed staff should follow a two prompt procedure when client #5 refuses to participate in habilitation activities. Ask and wait for client #5's cooperation. At the second prompt (2-5 minutes later) provide client #5 with choices to select from activities when possible. If after two requests, client #5 continues to refuse a necessary habilitation activity attempt to use benign physical prompts to lead him to the activity. If continued refusal, back away and wait approximately 15 minutes then repeat two prompt sequence. Interview with the qualified intellectual disabilities professional (QIDP) on 3/11/20 verified staff should use a two prompt sequence with client #5 as prescribed in the BSP. Interview with the QIDP and behaviorist on 3/11/20 verified 2-5 minutes should be placed between prompts for client #5 so not to over prompt the client. Continued interview with the QIDP and	W 249		

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W 249	Continued From page 6 behaviorist verified a 15 minute wait should have been provided to client #5 after the client remained non-compliant with multiple verbal prompts from staff A to "get up", "get ready", "get your jacket", "lets go".	W 249		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain adaptive equipment in good repair relative to a wheelchair for 1 of 4 sampled clients (#2). The finding is: Observation of client #2 throughout the 3/10-11/20 survey revealed the client to use a wheelchair for ambulation. Continued observation revealed the cover to the right arm rest to be torn with exposed padding. Further observation revealed the exposed padding of the right arm rest to be broken down with a hole beginning to develop in the padding. Review of records for client #2 on 3/11/20 revealed an admission date to the facility on 10/23/18. Further record review revealed an individual program plan (IPP) dated 10/14/19. Review of client #2's current IPP revealed the client is quadriplegic, has a right hip subluxation	W 436	On 3/11/20, when the surveyor made the QP aware of the damage to Client #2's wheelchair, the QP spoke with the Ancillary Service Coordinator, who oversees the upkeep and repair of all PT, OT and other adaptive equipment and informed them of the damage. The ASC has tried to contact NSM (vendor) to arrange for a replacement part to repair Client #2's wheelchair and is still awaiting reply from the customer service representative to place and confirm the order. Staff in the home have been in-serviced on the need to communicate repair/replacement needs for PT/OT equipment in a timely manner and how to do so. The QP, House Manager, ASC and/or designee will ensure that all equipment is in good repair through routine checks done at least monthly or as reported by staff.	5/11/20

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W 436	Continued From page 7 and uses a manual wheelchair for all needs. Interview with staff B on 3/11/20 revealed client #2's right wheelchair armrest became damaged when staff were learning how to attach a lap tray to the chair when the client was admitted to the group home. Interview with the qualified intellectual disabilities professional (QIDP) on 3/11/20 verified a repair order had not been submitted relative to client #2's wheelchair. Further interview with the QIDP verified client #2's wheelchair should have been repaired and a repair request should have been submitted by staff.	W 436		