

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES


PRINTED: 03/12/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/10/2020
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NAME OF PROVIDER OR SUPPLIER PLAYMORE GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3252 PLAYMORE BEACH ROAD MORGANTON, NC 28655
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(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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W 242	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii)</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the individual program plan (IPP) included objective training to address self-feeding needs for 1 of 3 sampled clients (#4). The finding is:</p> <p>Observations in the group home on 3/10/20 at 8:15 AM during the breakfast meal revealed client #4 seated at the dining table preparing to eat a biscuit, scrambled eggs and grits. Further observations revealed staff E to be the only staff person at the table assisting all six clients in the home with plating the food family style. Client #4 was the first client served a biscuit, and at 8:17 AM was observed to immediately eat the biscuit in three large bites. Continued observations revealed the client to have an excessive amount of food in his mouth at one time for approximately one minute, without a drink being poured and available. Staff E did not witness client #4 eating the biscuit rapidly because she was busy assisting other clients with plating food. During this time, the home manager was observed sitting in the living area adjacent to the dining area, and staff F was in the medication room. Subsequent</p>	W 242	<p style="text-align: center; color: blue;">DHSR-Mental Health</p> <p style="text-align: center; color: red;">MAR 25 2020</p> <p style="text-align: center; color: blue;">Lic. & Cert. Section</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE	(X6) DATE 3/18/20
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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 242	<p>Continued From page 1</p> <p>observations at 8:22 AM revealed staff F to begin to assist at the dining table, and assist client #4 with pouring a drink of orange juice. Staff F then sat next to client #4, and began prompting him to take drinks after taking bites of eggs or grits.</p> <p>Review of the record for client #4 on 3/10/20 revealed an IPP dated 12/19/19. The "Needs" section of the IPP indicated the client had rate of eating concerns. Further review of the IPP revealed a speech language pathology addendum completed 1/21/19, which included a recommendation to monitor client #4 during meals and snacks to ensure intake of bite size pieces and to ensure chewing and swallowing before taking another bite, and drinking throughout the meal. Continued review of the IPP revealed an occupational therapy evaluation dated 11/7/19 which included a recommendation to supervise and provide verbal and tactile cues for the client to slow down when eating to prevent overstuffing the mouth with food.</p> <p>Further review of the IPP also included a habilitation update dated 12/10/19 which also indicated a need to include rate of eating. Further review of the habilitation plan indicated the client had an other service goal to address rate of eating. Continued review of the IPP did not reveal an other service goal related to rate of eating.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 3/10/20 confirmed client #4 has rate of eating concerns and the need for training. The QIDP also confirmed the client had an other service goal related to rate of eating at some point, but was unable to locate it.</p>	W 242	<p>Staff were inserviced on 3/18/20 about the need to make sure that a staff person is seated next to Client #4 during meal times to closely monitor them and provide necessary physical and verbal prompts to ensure a proper rate of eating. The QP, House Manager, or designee will ensure that staff are assisting Client #4 with their rate of eating at mealtimes through direct observation in the home at least weekly.</p> <p>Additionally, the QP will work with Program Specialist to have a formal rate of eating goal is put into place for Client #4, since they still need support in this area. The QP, House Manager, or designee will ensure that staff are implementing this program through direct observation in the home at least weekly.</p>	5/9/2020
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W 287 W 287	Continued From page 2 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 observation, record review and interview, the facility failed to ensure a technique to manage inappropriate behavior was not used for the convenience of staff for 1 of 3 sampled clients (#4). The finding is: Observations in the group home on 3/9/20 at 5:00 PM revealed staff B to unlock the walk in kitchen pantry door with a set of keys. Client #5 was observed to get an apron from a hook on the inside of the pantry door. Further observation of the inside to the pantry revealed it to be stocked with all facility food, except for what was located in the refrigerator. Interview with staff B at that time revealed the pantry door was kept locked because client #4 has food seeking behavior. Review of the record for client #4 on 3/10/20 revealed an individual program plan (IPP) dated 12/9/19. The diet section of the IPP indicated the client had a history of stealing food. Further review of the IPP revealed a current behavior support plan (BSP) which included prevention strategies and procedures for food stealing/seeking behavior. The procedures indicated that if the client was exhibiting food seeking behavior, the staff should offer water or low calorie edibles, or attempt to get the client involved in an activity, such as walking outside.	W 287 W 287	The QP in-serviced staff on the fact that food cannot be locked up to prevent individuals such as Client #4 from stealing it and that alternative methods of redirecting food seeking behavior should be utilized instead. Additionally, to prevent possible recurrence of staff locking the pantry door for the sake of their own convenience, the QP had ComServ maintenance to replace the door handles on the pantry door with a non-locking version. At this time, the pantry door in PM cannot be locked from either side. The QP, House Manager, or designee will ensure that staff are appropriately redirecting inappropriate food-seeking behaviors of individuals by direct observation in the home at least weekly.	5/9/2020
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W 287	<p>Continued From page 3</p> <p>The BSP procedures did not include locking the pantry door to prohibit client #4, and thus the other five clients in the home from accessing food and drink items.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 3/10/20 confirmed client #4 does frequently have food stealing/seeking behavior, and confirmed the BSP strategies to intervene with the inappropriate behavior were current. The QIDP also confirmed the pantry door should not be locked as a convenience for staff to prevent client #4 from accessing food inappropriately, and as a result also prevent the other five clients in the home from accessing items in the pantry.</p>	W 287		
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