		ID HUMAN SERVICES				APPROVED	
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		34G019	B. WING	B. WING		09/23/2020	
NAME OF PROVIDER OR SUPPLIER MICHIGAN STREET HOME				10	TREET ADDRESS, CITY, STATE, ZIP CODE 006 MICHIGAN STREET ANNAPOLIS, NC 28081		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EAC			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	LD BE COMPLETION		
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 observations, record review, and interviews, the facility failed to assist 2 of 3		W 4	136			
	sampled clients (#4 and #5) to use and make informed choices relative to using adaptive equipment. The findings are: A. The facility failed provide teaching to client #4 relative to the use of wrist splints.						
	home on 9/22/20 from revealed client #4 to p activities including col with staff assistance. on 9/22/20 from 4:15 client #4 to participate as a coloring activity, dinner, and participate hand over hand staff during the observation observed to wear wrise Morning observations	barticipate in various loring and music activities Subsequent observations PM to 6:30 PM revealed in various activities such preparing his meal for ing in the dinner meal with assistance. At no point in period was client #4					
	staff assistance such	e in various activities with as grooming, prepping for nd participating in a music					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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.

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G019 B. WING 09/23/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1006 MICHIGAN STREET** MICHIGAN STREET HOME **KANNAPOLIS, NC 28081** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 436 Continued From page 1 W 436 activity. Continued observation at 8:15 AM revealed the Home Manager (HM) loading client #4 into the van to be transported to a doctor's appointment. At no point during the observation period was client #4 observed to wear wrist splints. Review of the record for client #4 revealed a plan of care (POC) dated 5/15/20. Further review of the record revealed an Occupational Therapy (OT) assessment dated 6/22/20 which stated client #4 has the following adaptive equipment: wheelchair, long handled spoon, hand splints, shirt protector, and knee immobilizers. Further review of the 6/22/20 OT assessment revealed that client #4 should wear bilateral Comfy splints for two 2-hour sessions: once in the afternoon, alternating hands and once in the evening and into the night, alternating hands. Further review of the record revealed a daily OT data sheet which indicated that client #4 should wear splints for two 2-hour sessions during 1st and 2nd shifts and alternating hands at each session. Interview with the HM on 9/23/20 verified that client #4's guidelines for wearing hands splints had recently changed. Further interview with the HM verified that client #4 should wear his hand splints on both hands for two hours twice a day and not when he is being transported. Further interview with the HM confirmed that client #4 did not wear hand splints throughout the survey period. Continued interview with the HM confirmed that client #4 should wear hand splints as prescribed. Interview with the Qualified Intellectual Disabilities Professional (QIDP) verified that client #4's goals and objectives were current. Further interview with the QIDP confirmed that client #4 should wear his wrist

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	-	D HUMAN SERVICES				FORM	: 09/28/2020 APPROVED		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
34G019			B. WING	B. WING			09/23/2020		
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE				
MICHIGAN	STREET HOME			1006 MICHIGAN STREET					
			ĸ	ANNAPOLIS, NC 2808	31				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
W 436	Continued From page splints as prescribed.	2	W 436						
	B. The facility failed to provide teaching to client#5 relative to the use of a shoulder harness.								
	home on 9/22/20 reve in various activities in	as client #5 observed							
	#5 to participate in va grooming, assisting w participating in the bro	eakfast meal, and ation. At no point during the as client #5 observed							
	revealed a plan of car Further review of the therapy (PT) evaluation stated that client #5 h equipment: wheelcha supports, removable shoulder strap, seat b bilateral foot plates w the POC for client #5	for client #5 on 9/23/20 re (POC) dated 3/20/20. record revealed a physical on dated 12/23/19 which as the following adaptive air, foot flip back arm head support, H-harness relt, contoured seat, and ith shoe straps. Review of did not include guidelines H-Harness shoulder strap.							
	H-Harness shoulder s observation period or with the HM confirme	me Manager (HM) on lient #5 did not wear her strap throughout the survey 9/22/20-9/23/20. Interview d that client #5 could benefit ve to wearing an H-Harness							

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROV CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03								
STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
	34G019		B. WING			09	09/23/2020	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
MICHIGAN STREET HOME				1006 MICHIGAN STREET KANNAPOLIS, NC 28081				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
W 436	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		KANNAPOLIS, NC 28081 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO TAG CROSS-REFERENCED TO THE APPRO		BE COMPLETION			

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