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	34G170	A. BUILDING ______ B. WING ______	09/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNN ROAD	**515 LYNN ROAD DURHAM, NC 27707**

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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.	E 004	E 004 The unit Safety Chairperson or the designee will train all staff on the home specific Emergency Plan. The Emergency Plan will include updated names and contact information for staff, patients, volunteers, patient's physicians and other facilities. Training will be monitoring by the Administrator and Safety Chairperson to ensure staff are trained on Emergency plan when hired and on a yearly basis as Emergency plans change. In addition, the QIDP will review the Emergency Preparedness Plan at each House Meeting. In the future the Administrator will ensure the Emergency Preparedness Plan is reviewed and updated annually. DHSR - Mental Health OCT 9 2020 Lic. & Cert. Section	11/24/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/01/20

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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E 004	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and/or updated. The finding is: The facility's EP plan was not reviewed or updated. Review on 9/21/20 of the facility's EP plan revealed no date on the plan. Additional review of the plan did not include evidence of a review or update. Interview on 9/22/20 with the Qualified Intellectual Disabilities Professional (QIDP) indicated she could not be sure if the EP plan had not been reviewed and/or updated.	E 004		
E 037	EP Training Program CFR(s): 483.475(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037	E 037 The QIDP will ensure staff are trained on the use of the Emergency Plan for the group home when they are hired and then annually to ensure they are knowledgeable regarding the implementation of the plan. The Administrator will monitor new hire training in-services to ensure training occurs. In addition, the Emergency Plan will be reviewed by the QIDP during each House Meeting. In the future, the Administrator will ensure all staff are trained on Emergency Plans.	11/24/20

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E 037	Continued From page 2 (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years.	E 037		

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E 037	Continued From page 3 (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's	E 037		

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E 037		E 037		

Continued From page 4

emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:

(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least every 2 years.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must

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E 037	Continued From page 5 demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all new staff were trained on the facility's Emergency Preparedness (EP) plan. The finding is: All staff had not been trained on the facility's EP plan. Review on 9/21/20 of the facility's EP plan (no date) did not indicate any new or existing staff had received training on the EP plan. Interview on 9/22/20 with two staff (Staff A, Staff B) revealed they had recently started working in the home after the day program closed due to COVID-19. The staff indicated they had received some EP training while working at the day program but not in the home. During an interview on 9/22/20, the Qualified Intellectual Disabilities Professional (QIDP) indicated no documentation of EP training could be located for any staff working in the home.	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises	E 039	E039 The QIDP will train all new hires and transferred staff on the Facility Emergency Preparedness Plan upon being hired. All staff will be re-trained on the plan yearly unless the plan is activated. In addition, the Emergency Plan will be reviewed by the QIDP during each House Meeting. Training will be monitored by the Administrator and Safety Chairperson to ensure staff are trained to conduct a full-scale community base or individual facility-based exercise or a tabletop emergency plan quarterly. In the future the Administrator will ensure the requirement for home and client specific training for emergency plan is met.	11/24/20

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E 039	Continued From page 6 to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct	E 039		

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E 039	Continued From page 7 exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is	E 039		

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E 039	Continued From page 8 not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,	E 039		

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E 039	Continued From page 9 facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,	E 039		

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E 039	Continued From page 10	E 039		

facility-based functional exercise.

(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.

(B) If the ICF/IID experiences an actual

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E 039	Continued From page 11 natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from	E 039		

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E 039	Continued From page 12 engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure facility/community-based or tabletop exercises to test their Emergency Preparedness (EP) plan were conducted. This potentially affected all clients in the home. The finding is: The facility's EP plan did not include completion of facility/community-based or tabletop exercises. Review on 9/21/20 of the facility's EP plan (no date), did not include a full-scale community-based or tabletop exercise. Interview on 9/22/20 with the Administrator indicated he thought a tabletop exercise had been conducted at the home over the past year; however, no documntation could be located.	E 039		
W 217	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the Comprehensive Functional Assessment (CFA) for 2 of 5 audit clients (#1, #4) included their nutritional status. The findings is:	W 217		

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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
W 217	Continued From page 13 Clients (#1, #4) did not receive an assessment of their nutritional status. Review on 9/21/20 of client #1's record revealed he had been admitted to the facility on 4/15/20. Additional review of the client's Individual Program Plan (IPP) dated 5/14/20 revealed his nutritional assessment was "Pending". Further review of the record did not include a nutritional assessment. Review on 9/21/20 of client #4's record revealed he had been admitted to the facility on 2/10/20. Additional review of the client's record did not include a nutritional assessment. Interview on 9/22/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the clients were in need of a nutritional assessment; however, one had not been completed for client #1 or client #4 as of the date of the survey.	W 217	W 217 The Dietitian will ensure Client #1 and #4 has a completed Nutritional Assessment. The QIDP will in-service staff on the recommendations from the assessment and amend the PCP to reflect the outcome of the Nutritional Assessment. Monitoring will occur with the QIDP completing a chart review and a Q-Review to ensure the assessment was completed. The Clinical Team will complete a Mealtime Assessments twice a week in the home for the next 30 days and on a routine basis to ensure the recommendations are implemented. In the future, QIDP will ensure evaluations are completed, placed in the record and ensure all staff are in-serviced on updated recommendations.	11/24/20
W 218	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #4's Comprehensive Functional Assessment (CFA) included an assessment of his sensorimotor development. This affected 1 of 5 audit clients. The finding is: Client #4's CFA did not include an Occupational Therapy (OT) assessment.	W 218		

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W 218	Continued From page 14 Review on 9/21/20 of client #4's record revealed he had been admitted to the facility on 2/10/20. Additional review of the record did not include an OT assessment. Interview on 9/22/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 was in need of an OT assessment; however, one had not been completed as of the date of the survey.	W 218	W 218 The OT will ensure Client #4 has a completed OT Assessment. The QIDP will in-service staff on the recommendations from the assessment and the QIDP will amend the PCP to reflect the outcome of the OT Assessment and in-service staff on any recommendations. Monitoring will occur with the QIDP completing a chart review and a Q-Review to ensure assessment was completed. In the future, QIDP will ensure evaluations are completed, placed in the record and staff is in-serviced on any updates and recommendations.	11/24/20
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, record review and interviews, the facility failed to ensure 4 of 5 audit clients (#3, #4, #5, #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of meal preparation, adaptive equipment use and medication administration. The findings are: 1. Clients were not prompted or assisted to participate with cooking tasks.	W 249	W 249 #1 A Team Meeting will be held to discuss each client's needs as it relates to meal preparation. The Habilitation Specialists will in-service staff on results of Team Meeting. The QIDP will revise Person Centered Plan to include results of team meeting. The Clinical Team will complete a Mealtime Assessments twice a week in the home for the next 30 days and on a routine basis to ensure clients are participating at skill level in accordance to task. In the future the QIDP will ensure each client has a continuous active treatment program consisting of needed interventions and services indicated in Person Centered Plan.	11/24/20

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W 249	Continued From page 15 During morning observations in the home on 9/22/20 from 7:05am - 7:37am, staff prepared all breakfast food items (scrambled eggs, bacon, toast) without any participation from clients in the home. During this time, client #3 and client #4 walked in/out of the area unengaged. Interview on 9/22/20 with Staff B revealed due to behaviors, only some of the clients participate with meal preparation tasks. The staff indicated client #4 does not assist in the kitchen because his attention span is short and he has behaviors. Additional interview noted all other clients in the home "can help" with meal preparation. Review on 9/22/20 of client #3's IPP dated 9/26/19 revealed he, "likes assisting staff with meal preparation". Additional review of his Adaptive Behavior Inventory (ABI) dated 9/23/19 identified needs in the area of meal preparation. Review on 9/22/20 of client #4's ABI dated 2/25/20 indicated needs in the area of meal preparation. Interview on 9/22/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients should be prompted and assisted to complete cooking tasks such as stirring, baking, mixing and pouring. 2. Clients (#3, #4) were not prompted or assisted to wear their eye glasses. During morning and evening observations in the home on 9/21/20, client #3 and client #4 did not wear eye glasses. Client #3 participated in virtual class work on his laptop throughout the morning until lunch time. Client #4 put small pieces of a	W 249	W249 #2 A team meeting will be held to discuss client #3 and #4 use of eyeglasses. The Habilitation Specialist will in-service staff on results of team meeting. The QIDP will revise the Person Centered Plan to include results of team meeting. The clinical team will monitor through Interaction Assessments completed 2x's a week for the next 30 to ensure client #3 and client #4 are assisted with wearing their glasses. In the future the QIDP will ensure each client has a continuous active treatment program consisting of needed interventions and services indicated in Person Centered Plan.	11/24/20

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W 249	Continued From page 16	W 249		

puzzle together, looked at videos on his laptop and colored/marked on a sheet of paper. The clients were not assisted or encouraged to wear eye glasses.

Interview on 9/22/20 with Staff B indicated only client #3 wears eye glasses in the home for 15 minutes at a time.

Review on 9/21/20 of client #3's IPP dated 9/26/19 revealed an objective to wear his eye glasses as tolerated for up to 30 minutes with 80% verbal prompts for two consecutive review periods (implemented 12/21/19). Additional review of the client's objective indicated, "He will be encouraged to put the glasses on and staff will compliment him on how well they look on him..." The plan also noted, "Other opportunities will occur when [Client #3] needs to wear his glasses." Further review of the client's vision exam report dated 9/19/19 noted, "bilateral, mild myopia, borderline astigmatism...Glasses prescribed to be worn as needed."

Review on 9/21/20 of client #4's IPP dated 3/11/20 revealed he wears his eye glasses "daily as needed". Additional review of the client's vision exam report noted, "Myopia with astigmatism...wears eye glasses as needed."

Interview on 9/22/20 with the QIDP confirmed client #3 and client #4 have been prescribed eye glasses. Additional interview indicated they should be prompted to wear their eye glasses as the opportunity arises.

3. Client #5 was not provided his appropriate dining equipment.

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W 249	Continued From page 17 During lunch observations in the home on 9/21/20 at 12:10pm, client #5 utilized regular cups, a non-skid mat, a sectioned plate and a clothing protector while consuming his meal. Interview on 9/22/20 with Staff B revealed client #5 uses adaptive cups and a clothing protector at meals. Review on 9/22/20 of client #5's IPP dated 5/10/20 revealed his adaptive dining equipment consists of a non-skid mat, a cup with a lid and straw and a clothing protector. The plan did not indicate he should utilize a sectioned plate. Interview on 9/22/20 with the QIDP confirmed client #5 should have been provided his adaptive cups with a lid and straw at lunch. The QIDP indicated he does not require a sectioned plate at meals. 4. Clients (#1, #3, #4) were provided with unnecessary adaptive dining equipment. During meal time observations throughout the survey on 9/21 - 9/22/20, all six clients, with the exception of one client at lunch, were provided with non-skid mats positioned underneath their plates. Review on 9/21/20 of client #1, client #3, and client #4's IPP (dated 5/14/20, 9/26/19 and 3/11/20, respectively) did not indicate a non-skid mat should be utilized at meals. Interview on 9/22/20 with the QIDP confirmed the clients did not require a non-skid mat at meals and it should not have been provided at meals.	W 249	W249 #3 and #4 The Habilitation Specialists will in-services all staff on client's adaptive dinning equipment. The clinical team will complete meal time assessments 2x's per week for the next 30 days to ensure staff are implementing all dinning equipment per the Person Centered Plan. In the future the QIDP will ensure each client has a continuous active treatment program consisting of needed interventions and services indicated in Person Centered Plan.	11/2420

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W 263	Continued From page 18	W 263		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive Behavior Support Plan for 1 of 5 audit clients (#3) was only conducted with the written informed consent of the legal guardian. The findings is: Client #3's BSP did not include written informed consent from the guardian. Review on 9/21/20 of client #3's BSP dated 8/27/19 revealed an objective to transition to Lynn Road without (0 episodes) display of self-injurious behavior and physical aggression for 6 consecutive months. The plan identified the use of Prozac, Haldol and Cogentin. Further review of the record did not include a current written informed consent for the BSP from the client's guardian. Interview on 9/22/20 with the Qualified Intellectual Disabilities Professional (QIDP) indicated a written informed consent had been sent to client #3's guardian; however, it had not been returned.	W 263	W 263 The Behavior Analysis will obtain consent for Client #3's BSP to ensure all required consents are in place. Monitoring will occur with the QIDP completing a chart review and an Q-Review to ensure all required consents for Restrictive Interventions and BSP are obtained. In the future, QIDP will ensure consents are received for BSP and placed in the record.	11/24/20
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum	W 323		

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W 323	Continued From page 19 includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #1 had an evaluation of his vision and hearing. This affected 1 of 5 audit clients. The finding is: Client #1 had not received an evaluation of his vision and hearing. Review on 9/21/20 of client #1's record revealed he had been admitted to the facility on 4/15/20. Additional review of his Individual Program Plan (IPP) indicated his vision and hearing examinations were "Pending". Interview on 9/22/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 had not received an assessment of his vision and hearing as of the date of the survey.	W 323	W 323 To ensure timely completion of assessments the nurse will schedule Client #1 for a hearing and vision assessment. Monitoring will occur with the QIDP completing a chart review and a Q-Review to ensure assessment are scheduled and obtained upon admission and annual as needed. In the future the QIDP will ensure assessments are completed within 30 days of admission.	11/24/20
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #1 received a comprehensive dental examination at least annually. This affected 1 of 5 audit clients. The finding is:	W 352		

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W 352	Continued From page 20 Client #1 had not received a dental examination. Review on 9/21/20 of client #1's record revealed he had been admitted to the facility on 4/15/20. Additional review of his Individual Program Plan (IPP) indicated his dental examination was "Pending". Interview on 9/22/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 had not received a dental examination as of the date of the survey.	W 352	W 352 To ensure dental services are provided the nurse will schedule Client #1 for a dental exam. Monitoring will occur with the QIDP completing a chart review and a Q-Review to ensure dental exams are scheduled and occur as ordered. In the future, the QIDP will ensure dental exam is completed within 30 days of admission.	11/24/20
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications were administered in accordance with physician's orders. This affected 1 of 3 clients (#3) observed receiving medications. The finding is: Client #3's Gavilax powder was not administered according to physician's orders. During morning observations of medication administration in the home on 9/22/20 at 7:30am, Staff A obtained a capful of Gavilax powder, added it to 4 - 6 oz of water and gave the glass to client #3. The powder was not stirred or dissolved in the glass. Client #3 consumed the Gavilax with other medications. After drinking the	W 368	W368 The nurse will in-service all staff on Medication Administration to ensure all individuals including Client #3 are administered medication properly. Monitoring will occur with The Clinical Team completing an Medication Assessment twice a week for 30 days and on a routine basis to ensure medication is being administered properly. In the future, the Nurse will ensure staff are properly trained to administer medication according to physician orders.	11/24/20

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W 368	Continued From page 21 water, an undetermined amount of Gavilax powder remained at the bottom of the glass. Immediate interview with Staff A revealed she normally does not give medications in the morning. When asked about not stirring the powder, the staff indicated the Gavilax just needs to be "dissolved" in the water. Review on 9/22/20 of client #3 physician's orders dated 7/13/20 revealed an order for Gavilax, "dissolve 17gm (1 capful to the line) in 4 - 8 oz of liquid and drink..." Interview on 9/22/20 with the facility's nurse confirmed the Gavilax powder should have been dissolved as written on the orders or stirred to ensure it had dissolved completely.	W 368		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications were administered without error. This affected 1 of 3 clients (#3) observed receiving medications. The finding is: Client #3 did not receive the prescribed amount of Gavilax powder. During morning observations of medication administration in the home on 9/22/20 at 7:30am,	W 369	W369 The nurse will in-service all staff on Medication Administration to ensure all individuals including Client #3 are administered medication properly. Monitoring will occur with The Clinical Team completing an Medication Assessment twice a week for 30 days and on a routine basis to ensure medication is being administered properly. In the future, the Nurse will ensure staff are properly trained to administer medication without error per Physician Orders.	11/24/20

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W 369	Continued From page 22 Staff A obtained a capful of Gavilax powder, added it to 4 - 6 oz of water and gave the glass to client #3. The powder was not stirred or dissolved in the glass. Client #3 consumed the Gavilax with other medications. After drinking the water, an undetermined amount of Gavilax powder remained at the bottom of the glass. Immediate interview with Staff A revealed she normally does not give medications in the morning. When asked about not stirring the powder, the staff indicated the Gavilax just needs to be "dissolved" in the water. Review on 9/22/20 of client #3 physician's orders dated 7/13/20 revealed an order for Gavilax, "dissolve 17gm (1 capful to the line) in 4 - 8 oz of liquid and drink..." Interview on 9/22/20 with the facility's nurse confirmed the Gavilax powder should have been dissolved as written on the orders or stirred to ensure it had dissolved completely.	W 369		
W 440	EVACUATION DRILLS CFR(s): 483.470(I)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were held at least quarterly for each shift. This potentially affected all clients residing in the home. The finding is: Fire drills were not conducted as indicated.	W 440		

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W 440	Continued From page 23 Review on 9/22/20 of facility fire drills revealed documentation for drills completed on 2/29/20 and 8/6/20. No other fire drill reports were available for review. Interview on 9/22/20 with the Qualified Intellectual Disabilities Professional (QIDP) indicated Home Managers were responsible for conducting fire drills and she could not be sure if more drills had been completed and/or documented.	W 440	W 440 The Administrator will in-service all Home Managers on the Fire Drill Schedules and holding Fire and Disaster Drills on each shift quarterly. The Administrator and Safety Chairperson will monitor on a monthly basis to ensure Fire/Disaster Drills are completed per the Fire Drill Schedule during the monthly safety meeting. In the future, the Administrator will ensure Fire and Disaster Drills are completed at least quarterly for each shift.	11/24/20
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 5 audit clients (#1, #5) received modified and specially-prescribed diets as indicated. The findings are: Each client's (#1, #5) modified food consistency was not followed. A. During lunch observations in the home on 9/21/20 at 12:10pm, client #1 consumed two whole grilled cheese sandwiches and Cheetos. The sandwich was not cut up and the Cheetos were varied in size up to 1 inch pieces. During dinner observations in the home on 9/21/20 at 5:15pm, client #1 consumed two whole slices of bread with his meal. Interview on 9/22/20 with Staff B revealed client	W 460	W 460 A and B The QIDP will in-service staff all individuals including Client #1 and #5 diet consistency. Monitoring will occur with The Clinical Team completing an Mealtime Assessment twice a week for 30 days and on a routine basis to ensure individuals diets consistency is being followed. In the future, the QIDP will ensure staff are trained and implement per Physician Orders on all the individuals diet consistencies.	11/24/20

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W 460	Continued From page 24 #1's food did not need to be cut up. Review on 9/21/20 of client #1's Individual Program Plan (IPP) dated 5/14/20 and his physician's orders dated 7/13/20 revealed he receives a regular diet with food cut in "1/2 inch" pieces. Interview on 9/22/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1's food should be cut into 1/2 inch pieces as indicated. B. During lunch observations in the home on 9/21/20 at 12:10pm, client #5 consumed a grilled cheese sandwich and whole large pretzels. The food items were not cut up. Interview on 9/22/20 with Staff B revealed client #5's food needs to be cut up. Review on 9/22/20 of client #5's IPP dated 5/10/20 and his physician's orders dated 7/13/20 noted he receives a regular diet with food cut in "1/4 inch" pieces. Interview on 9/22/20 with the QIDP confirmed client #5's food should be cut into 1/4 inch pieces as indicated.	W 460		

October 1, 2020

Ms. Wilma Worsley-Diggs
2718 Mail Service Center
Raleigh, North Carolina 27699

Re: Recertification Survey Completed September 21 – 22, 2020
Lynn Road Home, 515 Lynn Road, Durham, NC 27703
Provider Number 34G170
MHL# 032-058

Dear Ms. Worsley-Diggs:

Thank you for your recent survey of Lynn Road. It was a pleasure working with you. We look forward to your follow up return to ensure all deficient practices have been corrected.

Enclosed you will find the plan of correction for all deficiencies cited. Please do not hesitate to contact me if additional information is needed.

Sincerely,

Morris Thomas
Administrator

Enclosures

DHSR - Mental Health
OCT 9 2020
Lic. & Cert. Section

To:	Wilma Worsley-Diggs	Fax:	919-715-8078
From:	Morris Thomas	Date:	12/06/19
Re:		Pages:	27 (Including Cover)
CC:			

Urgent	For Review	As Requested	Please Reply	Please Recycle

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Last Modified: 7/7/2006

Form #: 2011-RTP

DHSR - Mental Health
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