STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G163	A. BUILDING _____ B. WING _____	09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMAS STREET HOME	348 THOMAS STREET JEFFERSON, NC 28640

(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 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to assure techniques used to manage inappropriate behavior for 1 of 6 clients (#3), were not used as a substitute for an active treatment program. The finding is: Observations in the group home on 9/9/20 from 5:30 PM to 6:00 PM revealed client #3 to sit at the table in preparation for dinner. Continued observation revealed client #3's wheelchair to have a rear fastening seatbelt. Observations on 9/10/20 from 7:45 AM to 9:00 AM revealed client #3 to sit at the dining table in preparation for breakfast with the rear fastening seatbelt fastened behind his chair. Interview with staff A on 9/10/20 revealed staff to identify the location of the fastening point of client #3's wheelchair then demonstrate how to tilt the wheelchair. Staff revealed client #3 has had several incidents where the client has slid out of his wheelchair and had been discovered by staff on the floor. Additional interview with staff A revealed the rear fastening seatbelt and wheelchair tilt were used to prevent the client from sliding out of his wheelchair. Review of client #3's records on 9/10/20 revealed an admission date of 7/28/20. Continued record review revealed a person centered plan (PCP)	W 288	W 288 The interim QIDP will meet with the team and identify target behaviors for client #3 to be addressed by a Behavior Support Plan. Behavior Specialist will in service staff on Behavior Support Plan and the QIDP will monitor behavioral data to ensure adequate implementation and documentation. Implementation of client #3's Behavior Support plan will be monitored through Interaction Assessments in the home twice a week for one month and then on a routine basis. Facility Administrator will in service QIDPs on completion of PCPs within the first 30 days. In the future Administrator will ensure the PCP is completed by the 30th day. Completed by November 9, 2020	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lacey Rominger — TITLE: Regional Administrator — (X6) DATE: 9/30/20

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.

DHSR Mental Health

OCT 0 5 2020

Lic. & Cert. Section

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W 288	Continued From page 1 meeting was conducted on 9/4/20. Further review of records revealed a signed consent by the guardian for a rights limitation relative to a rear fastening seatbelt. A review of incident reports since admission of 7/2020 through 9/2020 revealed the following: On 7/29/20, client #3 slid out from under seatbelt to the floor. On 7/31/20 client #3 slid himself out of his wheelchair with buckle on and landed on the floor. On 8/13/20 while outside, client #3 rolled himself off the patio and flipped his chair. On 8/31/20, staff found client #3 on the floor in his bedroom when staff went to get him to go to the medication closet. Staff noted client #3's seatbelt was on but staff forgot to tilt the chair. Interview with the interim qualified intellectual disabilities professional (QIDP), on 9/10/20 confirmed client #3's wheelchair to have a rear fastening seatbelt due to behaviors of unlocking his seatbelt. Continued interview with the interim QIDP verified client #3 has had multiple incidents since admission of sliding out of his wheelchair and being found by staff in the floor. The interim QIDP further verified client #3 had not had any serious injuries related to sliding out of his wheelchair. Subsequent interview with the interim QIDP revealed client #3's PCP was in development since the team meeting on 9/4/20. The interim QIDP verified neither a behavior support plan nor guidelines to address behaviors of client #3 had been developed since admission in 7/2020. The interim QIDP additionally verified the use of a rear fastening seatbelt and wheel chair tilt to address behaviors of client #3 should be tied to a behavior plan.	W 288		