STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	C 11/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 000	INITIAL COMMENTS A complaint survey was completed on 11/18/2020 in addition to the recertification survey. Deficiencies were not cited as a result of the complaint survey for Intake # NC00165776 or NC00166877.	W 000		
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: The facility failed to assure communication objectives contained in the person centered plans (PCPs) for 2 of 3 sampled clients (#1 and #2) were implemented as prescribed to support the achievement of the objectives as evidenced by observations, interview and record verification. The finding is: Review of client #1's PCP dated 9/16/20 revealed a communication objective for client #1 to verbalize requests after staff prompting. Review of client #2's PCP dated 7/26/20 revealed a communication objective for client #2 to use a communication picture album to communicate her needs/desires without modeling from staff. Observations in the group home during the 11/17-18/20 survey revealed neither of the	W 249		

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

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W 249	Continued From page 1 communications objectives were implemented. Observations on 11/17/20 at 5:53 PM revealed client #1 forcefully grabbing staff A's hand and silently pulling her to the pantry to get the snack wafers he wanted to eat. Staff A was observed to verbally try to redirect the client without success but was not observed to prompt the client to verbally state his request. In addition, observations of client #2 throughout the survey revealed all staff to lead the client to activities and make verbal requests of the client without prompting the client to any form of picture cues or picture book. Interview with the interim qualified intellectual disability professional (QIDP) revealed the clients' communication objectives are still appropriate and should be trained daily when opportunities arise.	W 249		
W 295	PHYSICAL RESTRAINTS CFR(s): 483.450(d)(1)(i) The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied. This STANDARD is not met as evidenced by: The facility failed to assure the physical restraints used by 1 of 3 sampled clients (#2) was only used as part of a person centered plan (PCP) that included the less restrictive means of managing and eliminating the mouthing behaviors for which the client's restraints are applied as evidenced by observation, interview and record verification. The finding is:	W 295		

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W 295	Continued From page 2	W 295		

Afternoon observations on 11/17/20 from 3:40 PM until 6:00 PM revealed client #2 to wear large oversized cushioned mittens on her hands that were tied by staff at the wrist. The client's ability to hold or use any objects while wearing the mittens was prevented by the mittens while wearing them. Further observations during the afternoon revealed the only time client #2 was taken out of the restrictive mittens was to wash her hands for supper at 5:35 PM and eating supper afterwards until observations ended at 6:00 PM. Morning observations in the group home on 11/18/20 from 6:50 AM until 8:30 AM again revealed client #2 to wear the gloves throughout the morning with the exception of eating breakfast at 7:10 AM and taking her medications starting at 8:20 AM.

Interviews with staff A, B and C revealed the client wears the cushioned mittens due to the client's "finger sucking" behaviors. Further interviews revealed the client will constantly place her fingers and thumb in her mouth when not wearing the mittens which causes her face and fingers to break out and develop sores from the excess saliva. Continued interviews with staff revealed the mittens are large enough that they prevent the client from putting her hands in her mouth.

Review of client #2's PCP dated 7/26/20 revealed a behavior support plan (BSP) dated 7/31/20 which included hand/finger chewing as a target behavior. Review of the BSP revealed the client is supposed to wear the gloves at all times except when eating, bathing, toileting and sleeping. Further review of the BSP and the PCP, substantiated by the interim qualified intellectual disability professional (QIDP), revealed the

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W 295	Continued From page 3 client's plans did not contain any replacement behaviors or skills being taught to the client to reduce the need for the restraints.	W 295		
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: The facility failed to assure medications administered to 1 of 2 clients observed during the medication pass (#2) were administered without error as evidenced by observation and record verification. The finding is: Morning observations of the medication pass on 11/18/20 revealed client #2 to receive her morning medications given in pudding. The client was also given her dose of "fruit butter" and a sip of water to assure everything was washed down before leaving the medication room. Review of client #2's physician's orders dated 11/2/20 revealed client #2 is also prescribed Miralax 1 capful 17 GM in 8 oz. liquid during the morning medication pass. Observations of the morning medication pass on 11/18/20 revealed client #2's Miralax was not administered as prescribed.	W 369		