STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G109	A. BUILDING _____ B. WING _____	C 11/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNY LANE II	2830 HIGHWAY 70 EAST CLAREMONT, NC 28610

(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 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 observation, review of records and interviews, the individual program plan (IPP) failed to include sufficient interventions to address behavior management for 1 of 5 clients (#2). The finding is: Observations in the group home on 11/18/20 revealed 2 staff to work with the 5 clients of the group home. Continued observation revealed client #4 to gesture to this surveyor that client #2 had grabbed her right arm. Further observation revealed client #2 to sit in the living room in a chair directly in front of the television. Additional observation in the group home revealed the refrigerator and pantry to have locks and a small refrigerator to be placed in the dining room with no lock. Observation inside the small refrigerator revealed one small bag of carrots. Review of records for client #2 on 11/18/20 revealed a person centered plan dated 11/5/19 that contained a behavior support plan with a revised date of 10/25/20. Review of the behavior plan for client #2 revealed target behaviors of non-cooperation, agitation, aggression,	W 249		

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

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W 249	Continued From page 1	W 249		

self-injurious behavior, property destruction, tantrum behavior, inappropriate toileting and AWOL. Review of a diagnosis history for client #2 revealed severe intellectual disability, autism and PICA.

Continued review of the behavior plan for client #2 revealed prevention strategies of: structuring leisure activities to assure appropriate engagement, structure leisure that will expend energy. Client #2 has been reported to eat excess amounts of food; refrigerator and pantry will be locked 24 hours a day, mini fridge will be kept in the home where appropriate snacks may be selected by residents. Staff will be within eyesight of client #2 without physical barriers to intervene quickly to prevent AWOL/PICA behavior.

A review of mini-team reports relative to client #2 revealed a meeting dated 10/25/19 that indicated peer on peer aggression; client #2 wanted to sit where client #4 was sitting, client #2 pinched client #4. 1:1 staff in-serviced to monitor and ensure client #2 is not grabbing others. Continued review of mini-team documentation revealed a meeting dated 11/5/19 that indicated: pantry lock; team does not think pantry lock is necessary at this time, 1:1 staff should monitor him. Further review revealed mini-team documentation dated 2/4/20 that indicated to address seeking excessive foods the team agrees to obtain consents to secure pantry and refrigerator during third shift hours to allow staff to monitor all individuals adequately. Subsequent review of mini-team reports revealed no team documentation from 2/5/20-9/10/20.

A review of notes by the qualified intellectual

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W 249	Continued From page 2	W 249		

disabilities professional (QIDP) revealed no documentation since 1/14/19. A review of incident reports for 10/2020 revealed incident reports for client #2 relative to peer on peer aggression dated 10/22/20, 10/23/20, 10/25/20, 10/28/20 and 10/30/20. Continued review of incident reports for client #2 in 10/2020 revealed the need for a mini-team to address peer on peer aggression with no documentation that meetings occurred.

Interview with staff A in the group home on 11/18/20 revealed client #4 had just been grabbed by client #2 as the client has physical aggression behaviors. Continued interview with staff A revealed client #2 controls the living room television and the other clients in the group home usually stay in their rooms. Further interview with staff A revealed locks are kept on the refrigerator and pantry due to excessive eating behaviors of client #2. Staff A additionally revealed the small refrigerator is used to support client #2 with eating in moderation while all clients can eat items kept in the refrigerator. Subsequent interview with staff A revealed she was unaware of any formal guidelines relative to the use of the mini refrigerator.

Interview with the facility QIDP on 11/18/20 verified client #2 has physical aggression behaviors and excessive eating behaviors. Continued interview with the QIDP verified the small refrigerator in the group home is an intervention used to support the excessive eating behaviors of client #2 although no formal guidelines had been implemented to address the refrigerator. The QIDP also revealed she did not know why excessive eating was not identified as

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W 249	Continued From page 3 a target behavior in client #2's behavior plan. Further interview with the QIDP verified an in-service training with staff relative to the use of the small refrigerator had not been conducted. Subsequent interview with the QIDP verified there was a lack of clarity in client #2's supervision needs from the behavior plan and documented team meetings and she was unsure what client #2's supervision requirement was as she had only been the QIDP for the group home a short time. The QIDP additionally verified there was no documentation of mini-teams for client #2 from 9/30/20-11/9/20 although multiple incident reports of physical aggression referenced the need for a mini-team due to incidents of physical aggression.	W 249		