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STRICKLAND BRIDGE HOMES A & B	**1818 STRICKLAND BRIDGE ROAD** **FAYETTEVILLE, NC 28304**

(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
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and	E 015		

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

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 015	Continued From page 1 pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on observations, policy review and staff interviews, the facility failed to ensure emergency provisions for subsistence needs for staff and clients included adequate water as identified in the emergency preparedness (EP) plan. This potentially affected all clients in the home. The finding is: During observations in the home on 12/29/20 at 3:00 pm, a tour was conducted of the pantry to check their emergency food provisions. In a plastic container, contained boxes and cans of food, with a date 9/1/20 written on the packages. On the shelves, there was no evidence of bottled water. An additional observation on 12/30/20 at 6:55 am revealed that the facility had not replenish their inventory of emergency bottled water. A review of the facility's emergency response plan dated 5/16/13 revealed that emergency food should be rotated every 6 months and be sufficient for clients and staff over 3 days. An interview was conducted on 12/29/20 with the residential manager (RM) revealed that the facility was out of water and that she "was about to repurchase."	E 015		

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E 015	Continued From page 2 An interview was conducted on 12/30/20 with the administrator revealed that she expected to have at least 2 gallons of water per person. When including staff, the administrator said there should be at least 14 gallons of bottled water available.	E 015		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure client #1 had the right to a legal guardian. This affected 1 of 6 audit clients (#3). The finding is: Review on 12/29/20 of client #3's record revealed her individual program plan (IPP) was dated 8/26/20. Review of client #3's IPP revealed she had the following diagnoses: Moderate intellectual disabilities, Bipolar Disorder, Multiple Sclerosis, Thyroid Cancer, Diabetes, Hypertension and had recently been diagnosed with Carbapenem resistant enterobacteriacae (CRE), MRSA and Covid-19. Additional review revealed her parents were appointed as Co-guardians of the person on 7/31/2000 in Cumberland County. Review on 12/29/20 of her behavior support program (BSP) for her target behaviors of severe disruption, aggression, property destruction which contained the use of Haldol 5mg. by mouth at 8am and other restrictive components including	W 125		

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W 125	Continued From page 3 the use of a helmet and the locking up of knives for her protection and the protection of others was signed by her Co-Guardians on 8/17/20 and then another consent was signed by her father on 10/26/20. Review on 12/29/20 of a note dated 9/7/2020 by the qualified intellectual disabilities professional (QIDP) revealed the team had been notified by client #3's father that client #3's mother was deceased on September 7, 2020. Interview on 12/30/20 with the QIDP revealed there had not been any further discussion with client #3's father or the Cumberland County Clerk of Court to amend the current guardianship order to make client #3's father sole guardian since 9/7/20.	W 125		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and confirmed by interviews the facility failed to ensure direct care staff protected the privacy of 2 of 6 clients (#5, #6). The finding is: During morning observations in the facility on 12/30/20 at 6:20am staff B assisted client #5 to the bathroom and left the bathroom door open while she was toileting. Several minutes later staff B walked back to the bathroom and closed the	W 130		

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W 130	Continued From page 4 bathroom door when he went inside to assist her. During observations in the facility on 12/30/20 at 7:11am staff B walked into client #6's bedroom pulled the sheet back that was covering her in bed exposing her naked body below the waist. Her bedroom door was open. Interview on 12/30/20 with the qualified intellectual disabilities professional (QIDP) and administrator revealed staff B has worked in the facility several months and has been trained on providing privacy to the individuals that live in the facility. Additional interview confirmed both clients #5 and #6 need assistance to ensure their privacy during toileting and dressing.	W 130		
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 staff interviews, the facility failed to ensure a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the area of dining skills. This affected 1 of 6 audit clients (#5). The finding is:	W 249		

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W 249	Continued From page 5 During breakfast observations in the home on 12/30/20 at 9:10 am, Staff B asked client #5 did she want him to feed her and she responded yes. Staff B fed client #5 waffles and scrambled eggs and never offered any hand over hand assistance. On 12/30/20, review of the IPP dated 4/14/20 revealed that client #5 ate fast and talked with food in mouth and only needed verbal prompts to slow down. On 12/30/20 staff B was interviewed and acknowledged that he transferred to the home a few months and had not familiarized himself with client #5's IPP. On 12/30/20 the administrator was interviewed and stated she has worked with client #5 for a long time and that she had a "strong will to be independent and did not like to be fed."	W 249		
W 254	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that contribute to an overall understanding of the client's ongoing level and quality of functioning. This STANDARD is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to ensure a client's individual program plan (IPP) was reviewed and revised as necessary. This affected 1 of 6 audit clients (#5). The finding is: On 12/30/20, a review of client #5's IPP dated	W 254		

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W 254	Continued From page 6 4/14/20 revealed that 2 of her goals contained language that she required verbal prompts 90% of the time to gather her place setting and 95% of the time to brush her teeth. An additional review of the December 2020 data book for client #5's goals illustrated that she was not meeting her objective. Everyday client #5 required full physical assistance to brush her teeth and full partial assistance to set up place setting. On 12/30/20, client #5's record further revealed that the qualified intellectual disabilities professional (QIDP) had not recorded any monthly notes. An interview with the QIDP was conducted on 12/30/20. She acknowledged that she was unaware that client #5 had not made progress and that she might have misplaced her monthly notes. An interview with the administrator on 12/30/20 revealed that progress notes should be placed immediately on the chart and the QIDP notes should be done monthly.	W 254		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations and staff interviews, the	W 340		

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nurse failed to ensure competency when training staff to prevent cross contamination, while providing services to 1 of 6 audit clients (#5) on isolation as well as failed to maintain the proper fit of a face shield while interacting with all the clients in the home. The findings include:

A. During two days observations in the home on 12/29/20-12/30/20, staff A, B and the residential manager (RM) failed to consistently cover their noses while wearing a face shield. Staff were also observed touching the front of the mask when making adjustments, and not observed washing or sanitizing their hands afterwards.

An interview with Staff B on 12/30/20 revealed that he wore the mask underneath his nose, to prevent his eyeglasses from fogging up.

An interview with the licensed practical nurse (LPN) on 12/30/20 revealed that staff have been trained that masks should be worn over the nose and under the chin and changed daily. The LPN stated that she "had to stay on them to readjust to proper fit."

B. During observations in the home on 12/30/20 at 7:30 am, staff E put on an isolation gown and was observed in the living area talking to other staff and clients engaged in activities. Staff E mentioned that she was getting ready to get client #5 up who was in her room on isolation.

Further observations in the home on 12/30/20 at 9:10 am, staff B put on an isolation gown and took a tray of food into the room for client #5 who was on isolation. Staff B had to leave the room, three times to retrieve items from the kitchen and dining room, while still wearing the same gown.

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W 340	Continued From page 8 Interview on 12/30/20 with the licensed practical nurse (LPN) revealed that staff have been trained that they should not put on isolation gown until they are ready to provide care inside of the room. Before staff leave the room, they should discard the gown and bag it to take outside and place in trash. The LPN commented that by wearing the gown in the room it helped to prevent cross contamination.	W 340		
W 363	DRUG REGIMEN REVIEW CFR(s): 483.460(j)(2) The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team. This STANDARD is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility's pharmacist failed to report irregularities in medication administration during the last quarter reviewed for 2 of 6 audit clients (#2 and #6). The findings include: A. During afternoon medication administration in the home on 12/29/20 at 4:15 pm, the residential manager (RM) checked client #2's blood sugar on his left finger. Review on 12/29/20 of client #2's physician's orders dated 10/22/20 reflected a new order on 8/25/20 to check blood sugar once daily at 8 am which replaced an old order from 5/18/09 to check twice a day. A further review of the consultant pharmacist progress note dated 10/28/20, revealed that after the medications were reviewed, no recommendations were made	W 363		

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W 363	Continued From page 9 to the physician. B. During medication administration observation in the home on 12/29/20 at 4:20 pm, the RM crushed a pill of Metoclopram 10 mg and placed it in pudding and fed it to client #6. Dinner was not served in the home until 6:15 pm. Review on 12/29/20 of client #6's physician's orders that originated on 9/2/20 revealed that Metoclopram 10 mg should be taken four times a day 30 minutes before meals and bedtime. The times assigned were 8 am, 12 pm, 4 pm and 8 pm. A further review of the consultant pharmacist progress note dated 10/28/20, revealed no recommendation to client #6's physician to clarify the order. Interview on 12/30/20 with the LPN acknowledged that both the nurse and the pharmacist were supposed to review the orders for accuracy.	W 363		
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 reviews and interviews, the facility failed to ensure all medications were administered without error. This affected 2 of 6 audit clients (#2 and #6). The findings include: A. During afternoon medication administration in	W 369		

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the home on 12/29/20 at 4:15 pm, the residential manager (RM) placed two drops of Systane, seconds apart into the left eye of client #2. In addition, the RM checked client #2's blood sugar on his left finger.

Review on 12/29/20 of client #2's physician's orders dated 10/22/20 reflected a new order on 8/25/20 to check blood sugar once daily at 8 am which replaced an old order from 5/18/09 to check twice a day. The orders also revealed that client #2 should receive 2 drops of Systane in left eye four times a day. It noted that "when you apply more than 1 eye drop at the same time of day, wait 5 minutes in between drops."

Interview on 12/30/20 with the licensed practical nurse (LPN) revealed she thought the order was still to check blood sugar twice a day. After the LPN reviewed client #2's chart, she could not locate a current order to check blood sugar at 4 pm. The LPN also explained that when multiple drops of given, they should be administered 5 minutes apart so that the 2nd drop does not wash out the 1st drop.

B. 1). During afternoon medication administration in the home on 12/29/20 at 4:20 pm, the RM crushed a pill of Metoclopram 10 mg and placed it in pudding and fed it to client #6. Dinner was not served in the home until 6:15 pm.

Review on 12/29/20 of client #6's physician's orders dated 10/22/20 revealed that Metoclopram should be taken four times a day 30 minutes before meals and bedtime.

Interview on 12/30/20 with the LPN revealed that she needed to speak to the doctor to have the

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orders clarified, since client #6 was not getting dinner until after 5:30 pm.

2). During observations on 12/30/20 of the medication administration pass for client #6 at 8:08am revealed she was administered the following medications: Reglan 10mg. (1) tablet, Trileptal 100mg. (1) tablet, Dilantin 100 mg. (1) tablet, Protonix 40mg. (1) tablet, Oyster Calcium 250mg. (1), Macrobid 10 mg. (1) , Singulair 10 mg. (1), Aspirin 325 mg. (1), Lasix 20 mg. (1), Gabapentin 100 mg. (1), Prostat (15 ml), Ferrous Sulfate (5 ml), Potassium Chloride Suspension (15 ml.).

Review on 12/30/20 of the physician orders for client #6 dated 10/22/20 revealed she was to receive the following medications at 8am: Reglan 10mg. (1) tablet (to be given 30 minutes before meals), Trileptal 100mg. (1) tablet, Dilantin 100 mg. (1) tablet, Protonix 40 mg. (1) tablet, Oyster Calcium 250mg. (1), Macrobid 10 mg. (1) , Singulair 10 mg. (1), Aspirin 325 mg. (1), Lasix 20 mg. (1), Gabapentin 100 mg. (1), Prostat 15 ml, Ferrous Sulfate 5 ml., Potassium Chloride Suspension (15 ml.) . In addition, client #6 was to receive the following medications at 8am: Atropine Sulfate, Install 3 drops under the tongue for drooling and Calcitonin Nasal spray install (1) spray into 1 nostril for bone health.

Observations on 12/30/20 in the facility of breakfast for client #6 revealed the meal started at 9:00am which was 52 minutes after she received her Reglan 10 mg. (1) which was to be administered 30 minutes before meals.

Interview on 12/30/20 with the facility Nurse confirmed client #6 should have received Atropine

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W 369	Continued From page 12 Sulfate, Install 3 drops under the tongue for drooling and Calcitonin Nasal spray install 1 spray into 1 nostril for bone health as prescribed by the physician. Additional interview confirmed staff should have administered client #6's Reglan 10mg. (1) within the 30 minutes before her meal as prescribed by the physician.	W 369		
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 interview, the facility failed to ensure a client was taught to use and make informed choices about her eyeglasses. This affected 1 of 6 audit clients (#1). The finding is: Throughout observations in the facility on 12/29/20 from 3:00pm-6:30pm and on 12/30/20 from 6:00am-9:19am client #1 was not observed to wear glasses. During an observation on 12/29/20 when asked if she wore glasses, client #1 stated, "They are broken. I don't wear glasses anymore." Review on 12/29/20 of client #1's record revealed she was seen at the eye clinic on 1/24/19 and was diagnosed with Hyperopic Astigmatism and that she was prescribed corrective lenses.	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G152	A. BUILDING ______ B. WING ______	12/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRICKLAND BRIDGE HOMES A & B	**1818 STRICKLAND BRIDGE ROAD FAYETTEVILLE, NC 28304**

(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 436	Continued From page 13 Review on 12/29/20 of client #1's individual program plan (IPP) dated 8/30/20 revealed eyeglasses guidelines (OS# 12) to assist [client #1] with wearing her eyeglasses and ensuring her glasses are clean as well as ensure she has her glasses case. Will assist client #1 with storing her glasses. Review on 12/30/20 of client #1's notes by direct care staff on OSG #12 revealed client #1 had her glasses and was being encouraged to wear them on 3/13/20, 6/9/20 and on 9/9/20. Interview on 12/30/20 with the qualified intellectual disabilities professional (QIDP) and the facility nurse revealed client #1's glasses are broken and have not been repaired since October 2020.	W 436		
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, record review and staff interviews, the facility failed to follow dietary orders for modified diets for 1 of 6 audit clients (#5). The finding is: During morning observations in the home on 12/30/20 at 9:15 am, staff B assisted client #5 with her breakfast. Staff B cut up waffles without precision, providing large pieces, averaging 1" to client #5 being fed. Client #5's mouth was full of	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G152	A. BUILDING ______ B. WING ______	12/30/2020

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STRICKLAND BRIDGE HOMES A & B	1818 STRICKLAND BRIDGE ROAD FAYETTEVILLE, NC 28304

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W 460	Continued From page 14 waffles. Review on 12/29/20 of client #5's nutritional evaluation dated 4/1/20 indicated that she receive a regular calorie, 1/4" consistency diet. Interview on 12/30/20 with staff B, he revealed that he was aware that client #5 was on a 1/4" diet and that he forgot when cutting up her food. Interview on 12/30/20 with the licensed practical nurse (LPN) indicated that client #5 was supposed to get a 1/4" bite size pieces to prevent choking per dietician's guidelines.	W 460		