DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G115	A. BUILDING _____ B. WING _____	12/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DARTMOUTH ROAD GROUP HOME	210 DARTMOUTH ROAD RALEIGH, NC 27606

(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 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 This deficiency will be corrected by the following actions: A. The Area Supervisor will develop and/or update the EP plan to include all pertinent information regarding the facility's evacuation locations in the event of flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing residents or other information. This plan is also to include current resident information. B. The Area Supervisor and the Site Supervisor will be responsible for in-servicing staff on the updated EP plan and provide documentation of doing so. C. A member of the Administrative team, or a designated representative, will monitor Dartmouth at least once per month through the Site Review process.	2/12/2021

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

AED 12/28/2020

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 Preparedmess (EP) plan was reviewed and updated as needed. The finding is: Review on 12/14/20 of the facility's EP plan (dated 2/18/20) revealed the plan included information regarding one client who no longer resides at the facility and no information for another client who had been admitted in September 2020. Additional review of the EP plan noted, "This manual will be revised and updated as necessary." Interview on 12/15/20 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the emergency plan should have been updated when the home had a client discharged and another one admitted.	E 004		
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 4 audit clients. The finding is: Review on 12/14/20 of client #1's record revealed she had been admitted to the facility on 9/30/20. Additional review of the record indicated the	W 125	W125 This deficiency will be corrected by the following actions: A. The Clinical Supervisor of the home will initiate contact with a family member and inquire whether he/she wants to seek legal guardianship of client #1. If not, the Clinical Supervisor of the home will initiate the processing	2/12/2021

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W 125	Continued From page 2 client's cognitive functioning was in the Profound/Severe range and she has a seizure disorder for which seizure medications are prescribed. Further review of the client's Individual Program Plan (IPP) dated 3/25/20 noted, "[Client #1's] mother passed away and her brother is currently in the process of applying to become [Client #1's] guardian." Continued review of the record indicated client #1 had made a mark on various documents indicating her signature in the spaces labeled "Legal guardian". These documents/forms (signed 3/25/20) included Consent for Release of Information, Consent for Medications, Emergency Medical/Dental Services, Consent for Management of Funds and Rights Acknowledgement. Further review of the Consent for Medication form (signed 3/25/20) listed the following medications taken by client #1: Calcium D, Depakote, Claritin, Multivitamin, Onfi, Keppra, Topomax, Vitamin C, Curel Ult healing lotion, and Synthroid. The form also noted just above the signature section, "I have received educational information in writing and verbally for each medication listed. I understand the expected beneficial effects and potential side effects of each medication(s) listed." Interview on 12/14/20 with Staff A revealed client #1 does well with making her choices known; however, she does not have good verbal skills and only says a couple of words like "Mama". Additional interview indicated the client does not know the names of her medications, what they are for or their side effects. Interview on 12/15/20 with the Qualified Intellectual Disabilities Professional (QIDP)	W 125	of applying for State Guardianship for client#1. 8. The Program Manager will follow up on the status of this process until the guardianship process has been completed and client #1 has been assigned an LRP to advocate for him.	

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W 125	Continued From page 3 confirmed client #1 does not have a legal guardian and is currently acting as her own guardian. The QIDP acknowledged client #1 does not understand the forms given to her for a signature and has been in need of a legal guardian since her mother passed away.	W 125		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #5's Individual Program Plan (IPP) included specific information to support her independence with processing her food to the appropriate consistency. This affected 1 of 4 audit clients. The finding is: During observations in the home throughout the survey on 12/14 - 12/15/20, staff consistently operated a small food processing device to obtain a pureed consistency for client #5's food. During these times, client #5 stood nearby watching or was prompted to touch the top of the device slightly (which did not effect the operation of the device). Client #5 was not involved with the preparation of her food to obtain its pureed consistency. Interview on 12/14/20 with Staff B revealed they used to have a different device which was used to process client #5's food; however, it was not working. Additional interview indicated client #5	W240	This deficiency will be corrected by the following actions: A. All ISP's will be reviewed and revised as needed to ensure that all objectives are met. B. Community and Home Life Assessments will be reviewed and updated for accuracy. C. All current goals will be assessed, modified, updated, and will include specific information to support client independence or discontinued to meet the areas identified in assessments D. Goals will be implemented after the team meeting addressing need of the consumer E. All people served will be afforded the opportunity to be independent as possible F. The Clinical Supervisor and the Site Supervisor will be responsible for in-servicing and updating staff on active	2/12/2021

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W 240	Continued From page 4 was able to assist with pressing a button on the previous device but does not assist with operating the current device. Review on 12/15/20 of client #5's record revealed she consumes a pureed diet. Additional review of the record did not include specific information to support her independence with processing her food to the appropriate consistency. During interview on 12/15/20, the Qualified Intellectual Disabilities Professional (QIDP) acknowledged client #5's IPP does not include specific information regarding her ability to assist with processing her food.	W 240	treatment and client engagement in all activities in and outside of the home. G. The Site Supervisor will monitor one time a week, per shift and complete an observation sheet. H. A member of the Administrative team, or a designated representative, will monitor Dartmouth at least once per month through the Site Review process.	
W 259	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #5's Individual Program Plan (IPP) was updated at least annually. This affected 1 of 4 audit clients. The finding is; Review on 12/15/20 of client #5's record revealed an IPP dated 8/29/19. Additional review of the record did not indicate a current IPP. Interview on 12/15/20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5's IPP was not current since her annual meeting had not been held.	W 259	W259 2/12/2021 This deficiency will be corrected by the following actions: A. The Clinical Supervisor of the home will be responsible for developing/updating the annual IPP for client #5 B. The Clinical Supervisor will be responsible for in-servicing the staff on client #5's IPP	
W 368	DRUG ADMINISTRATION	W 368	W 368	2/12/2021

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W 368	Continued From page 5 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 observation, record review and interviews, the facility failed to ensure client #3 received her medication in accordance with physician's orders. This affected 1 of 2 clients observed receiving medications. The finding is: During observations of medication administration in the home on 12/15/20 at 6:45am, client #3 ingested Vitamin D3 50mcg (20001U). The client consumed the medication with water. Review on 12/15/20 of client #3's physician's orders signed 10/28/20 revealed an order for Vitamin D3 50mcg (2000IU), take one capsule by mouth once daily "with food". Interview on 12/15/20 with the medication technician confirmed client #3's Vitamin D3 should be taken with food and she usually eats breakfast right after the medication pass; however, this morning the client had refused to eat. During an interview on 12/15/20, the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the physician's orders should have been followed.	W 368	This deficiency will be corrected by the following actions: A. The RN will assess all orders B. All Physician orders will be reviewed for accuracy C. All staff will be in-serviced on the medication procedure and following the guidelines for administering medications as directed (i.e., with food). D. RN will monitor monthly E. The Site Supervisor will monitor one time a week F. Qualified Professional will monitor monthly	

RECEIVED
By DHSR Mental Health Licensure & Certification at 9:23 am, Dec 29, 2020

December 28, 2020

Wilma Worsley-Diggs, M.Ed., QIDP
Facility Consultant 1
Mental Health Licensure & Certification Section
2718 Mail Service Center
Raleigh, NC 27699-2718
919.612-5520 M
919.715.8078 F

Re: Survey Completed December 15, 2020
Survey Conducted December 14th- 15th 2020
Dartmouth Group Home
210 Dartmouth Road
Raleigh, NC 27606
Provider Number 34G115
MHL# -092-022

Dear Mrs. Diggs,

We appreciate the courtesy extended by you while surveying the Dartmouth Group Home, North Carolina.

As Indicated the Plan of Correction, we have will have the deficiencies corrected for the Annual Survey Conducted on **December 15, 2020**, it will be completed by **February 12, 2021**.

We are committed to providing the highest possible care for the people we serve at Dartmouth Group Home.

If you have any questions, please contact Cynthia Bradford, Associate Executive Director at 984.205.2630 ext. 238.

Kind Regards,

AED

Cynthia Bradford, Associate Executive Director
Community Alternatives North Carolina- Raleigh Region
1001 Navaho Drive, suite 101
Raleigh, NC, 27609
276.252.8193
984.205.2630 ext. 403
Cynthiabradford@rescare.com