STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G243	A. BLDG _____ B. WING _____	C 12/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTSIDE RESIDENTIAL	467 CREEK ROAD ORRUM, NC 28369

(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 030	**Names and Contact Information CFR(s): 483.475(c)(1)** **[(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:]** **(1) Names and contact information for the following:** **(i) Staff.** **(ii) Entities providing services under arrangement.** **(iii) Patients' physicians** **(iv) Other [facilities].** **(v) Volunteers.** ***[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following:** **(1) Names and contact information for the following:** **(i) Staff.** **(ii) Entities providing services under arrangement.** **(iii) Patients' physicians** **(iv) Other [hospitals and CAHs].** **(v) Volunteers.** ***[For RNHCIs at §403.748(c):] The communication plan must include all of the following:** **(1) Names and contact information for the following:** **(i) Staff.** **(ii) Entities providing services under arrangement.** **(iii) Next of kin, guardian, or custodian.** **(iv) Other RNHCIs.**	E 030	The facility will ensure that the Emergency Preparedness Communication Plan (EPP) is updated to include information on all clients that reside in the home and information regarding all direct support staff assigned to work in the home. The QP and/or Program Manager will update the EPP and include all clients residing in the home and all staff who work in the home. In the future, the QP and/or home manager will provide updates to the EPP relative to changes in clients or staff, and as needed. The ICF Director and/or QA will monitor the EPP quarterly to ensure continued compliance. SR - Mental Health Lic. & Cert. Section	2/6/21 2/6/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Barbara Williams Clinical Supervisor 12/16/20

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.

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E 030	Continued From page 1 (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff.	E 030		

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E 030	Continued From page 2 (ii) Entities providing services under arrangement.	E 030		

W 000	(iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by:	W 000	
W 125	Based on document review and interview, the facility failed to ensure an emergency preparedness (EP) communication plan was developed and maintained in compliance with Federal, State and local laws. The finding is: Review on 12/7/20 of the facility's EP plan did not include any information on the clients who reside in the home. Further review revealed the EP Plan did not include any information about the direct care staff who worked in the home. During an interview on 12/7/20, the qualified intellectual disabilities professional (QIDP) confirmed the EP plan should have included both the information about the clients and the direct care staff. INITIAL COMMENTS A recertification, follow up and complaint were completed on 12/8/20. The intake numbers are: NC00167677, NC00170042, NC00170035, and NC00171538. Deficiencies were cited. 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	W 125	

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W 125	Continued From page 3 to due process. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure clients #5 and #6 had the right to a legal guardian; failed to ensure client #6 had the right to written informed consents for the use of behavioral medications and failed to ensure client #2 had the right to dignity. The affected 3 of 6 audit clients. The findings are: A. Review on 12/7/20 of client #5's IPP dated	W 125	The facility will ensure written informed consent for clients with behavior support plans incorporating the use of psychoactive medications, client right to legal representation, dignity with personal care is obtained/ provided. For Client #6 the QP will complete paper work and start the process to petition the clerk of court for guardianship on the client's behalf.	2/6/21

	8/20/19 revealed client #5 is his own legal guardian and has been signing his own consents, including a behavior support plan (BSP). Interview on 12/8/20 with the QIDP revealed that client #5 is his own legal guardian. The QIDP confirmed that client #5 would benefit from having a legal guardian appointed by the courts. B. During observations in the home on 12/8/20 from 6:15am to 7:26am, client #2 was observed sitting on the couch. During this time, a large incontinence pad was positioned under him. The pad was visible to anyone in the area. Interview on 12/8/20 with Staff D revealed the incontinence pad is used "because sometimes [client #2] wets himself and the furniture and they are just trying to save the furniture." Interview on 12/8/20 with the QIDP revealed that staff should use a throw to cover the seat. The QIDP confirmed this is a dignity issue which should not occur. .		For Client #2, the PM will in-service staff on use of covering to prevent exposure of the incontinence pad. The QP and/or program manager will monitor in the home weekly to ensure compliance. For Client #6 the QP will complete documentation of client rights, money management, use of restrictive interventions, authorization for release of information and secure written informed consent (for BSP incorporating Risperidone and Depakene) from a guardian- or a HRC rep in absence of pending guardian appointment. QP, PM and/or QA will review all clients' legal rep status and BSPs monthly, monitor weekly in home for dignity issues to ensure compliance. For Client #3, privacy will be afforded him during medication administration. The QP will provide in-service training to all staff to ensure privacy is afforded to all clients during medication administration. The program manager and/or QP will conduct observations of the medication pass in the home weekly to ensure privacy for clients during medication administration.	2/6/21 2/6/21

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W 125	Continued From page 4 C. Review on 12/7/20 of client #6's record revealed there is no documentation of guardianship. Further review of client #6's record revealed he also did not have documentation of his client rights, money management, restrictive interventions and authorization of release of information. Additional review revealed client #6 has a behavior support plan (BSP) dated 10/26/20. Further review revealed client #6 has the medications Risperidone and Depakene for his behaviors. Additional review revealed client #6 did not have a consent for the medications.	W 125		

W 154	During an interview on 12/8/20, the qualified intellectual disabilities professional (QIDP) confirmed client #6 did not have a legally appointed guardian. Further interview revealed client #6 also did not have any documentation of his client rights, money management, restrictive interventions and authorization of release of information. The QIDP also confirmed client #6 does not have a consent for his behavior medications. STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to complete a thorough investigation	W 154	

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W 154	Continued From page 5 relative to exploitation, diet, mental well-being, infection control, and supervision. This affected 3 of 6 audit clients (#1, #3 and #5). The findings are: A. Review on 12/7/20 revealed an internal investigation dated 8/19/20. Review of the internal investigation revealed on 7/27/20, client #3's mother made an allegation relative	W 154	The facility will ensure that all client rights investigations are completed thoroughly- and such is relative to any and all alleged rights violations. For Client #3, the program manager will report any future allegations made by the mother or any other party- immediately to the QP and ICF Director. An investigation will be initiated promptly when the allegation is made. For Client #3, the QP will schedule a team meeting to update the CFA and IPP to address money management skills and/or training. The QP and/or Program Manager will in-service staff on updates to Client #3's IPP. For Client #3, the QP will schedule a team meeting to address food stealing, food alternatives within prescribed diet, access to client's bedroom,	2/6/21 2/6/21 2/6/21

	to exploitation, staff not following client #3's diet and client #3's mental well-being relative to noise level in the home. Further review on 12/7/20 revealed the facility did not initiate an internal investigation until 8/6/20. Interview on 12/8/20 with the program manager revealed that client #3's mother made the initial allegation on 7/27/20. The program manager revealed that on 7/27/20, she discussed with the mother that an accountability process would be put in place to ensure client #3's money was accounted for. The program manager revealed that the mother seemed satisfied with this solution until the mother made a complaint to a community entity who also visited the facility, thus making the facility initiate their internal investigation on 8/6/20. Interview on 12/8/20 with the qualified intellectual disabilities professional (QIDP) confirmed that the internal investigation should have been initiated on 7/27/20, when client #3's mother made her initial allegation. Further review on 12/7/20 of the facilities conclusion of the internal investigation revealed recommendations as a result of the internal investigation. These recommendations revealed: - an accountability sheet to track client #3's	review of current behavior support plan for revisions as applicable. The IPP and/or BSP will be updated. The QP will in-service staff on the updated IPP and/or BSP. QA and/or ICF Director will review monthly for continued compliance. in the future, the QP and/or home manager will provide updates to the EPP relative to changes in clients or staff, and as needed. The ICF Director and/or QA will monitor the EPP quarterly to ensure continued compliance.

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W 154		W 15	For Client #2, the QP will schedule a team meeting to review appropriate care, support and dignity during illness such as seizure activity. QP and/or home manager will in-service all staff on Client #2's need for support, dignity and care during illness. Any violations of client's rights, such as lack of support, respect and dignity will be immediately reported to the QP, PM and the ICF Director for prompt and through integration into the allegation.	2/6/21 2/6/21 2/6/21

Continued From page 6

money on hand should continue
- the team will meet and update client #3's comprehensive functional assessment (CFA) and individual program plan (IPP) to address money management skills
- staff would be inserviced on any updates to client #3's CFA and IPP
- the team will meet to discuss client #3's food stealing and the impact this has on her diet - the team will discuss client #3's meal refusals and explore options or alternatives that are within her prescribed diet
- the team should meet to discuss food stealing and access to client #3's bedroom which should be incorporated into her behavior support plan, given the potential intrusion of her privacy.

4

Additional review of the facility's internal investigation and recommendations revealed the facility implemented an accountability sheet to track client #3's money, but did not follow through with the other recommendations from the internal investigation.

Interview on 12/8/20 with the QIDP confirmed that the facility did not follow through with the other recommendations from the internal investigation because there had been a change in QIDP's and the follow-up was not completed.

B. Review on 12/7/20 revealed an internal investigation dated 10/9/20. Review of the internal investigation revealed on 9/22/20 how a staff member stepped over client #2 while he was having a seizure, in order to put plates on the dining room table. Client #2 was being attended by another staff while he was having the seizure. Further review revealed the incident was not

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W 154	Continued From page 7 reported until 9/25/20. Additional review of the investigation revealed the recommendation is for "that all staff in the home are re- in serviced on infection control, sanitation and COVID precautions." C. Review on 12/7/20 revealed an internal investigation dated 10/9/20. Review of the internal investigation revealed on 9/22/20 how a staff member stepped over client #2 while he was having a seizure, in order to put plates on the dining room table. Further review revealed how the incident was not reported until 9/25/20. During the investigation it was discovered how the same staff member had left clients #1 and #5 unattended during their showers and how client #1 had a bowel movement while in the shower and how it was not cleaned up. During an interview on 12/8/20, the QIDP confirmed that the internal investigation should have been initiated on 9/22/20, the day the incident happened. The QIDP stated the recommendations did not occur.	W 154	For Clients #1 and #5, the QP will schedule a team meeting to review appropriate care, support and supervision of clients at all times. Clients will not be left unattended during showers, toileting, or other aspects of personal care as indicated or supported by the IPP document. QP and PM will in-service staff on supervision requirements for all clients. The program manager and/or QP will monitor in the home weekly to address client supervision or client dignity issues. QA and ICF Director will monitor investigations weekly to ensure prompt attention and thoroughness.	2/6/21 2/6/21
W 196	ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status.	W 196		

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W 196	**Continued From page 8** **This STANDARD is not met as evidenced by: Based on record reviews and staff interviews, the team failed to assure that a continuous active treatment program was implemented for 3 of 6 audit clients (#1, #4 and #5) which provided consistent implementation of the individual program plan (IPP). The finding is:** **A. Review on 12/7/20 of client #5's record revealed there was no documentation of an updated IPP.** **Interview on 12/8/20 with the qualified intellectual disabilities professional (QIDP) revealed the interdisciplinary team had not met to update the IPP for client #5.** **B. Review on 12/8/20 of client #4's record revealed no IPP in the record for client #4.** **Interview on 12/8/20 with the QIDP revealed she had a copy of client #4's IPP dated 1/6/19. The QIDP confirmed that no updated IPP had been completed since then.** **C. Review on 12/7/20 of client #1's record revealed an IPP dated 10/19/19. Further review revealed there was no documentation of an updated IPP for client #1.** **During an interview on 12/8/20, the QIDP confirmed client #1 did not have an updated IPP. INDIVIDUAL PROGRAM PLAN** **CFR(s): 483.440(c)(4)**	W 196	For all clients, the facility will ensure implementation of individual program plan (IPP) interventions to include but not limited to updates of the annual IPP and documentation of same in the client files. For clients' #1, #4 and #5 the QP will schedule team meetings to update the annual IPP. The QP will ensure a copy of the updated IPP is filed in the program record for each of these clients. QA and/or ICF Director will monitor client records monthly to ensure continued compliance with updates to the annual IPP.	2/6/21 2/6/21
W 226		W 226		

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W 226	**Continued From page 9**	W 226	The facility will ensure for any newly admitted client, an initial team meeting	

W 249	**Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan.** **This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure each client received an individual program plan (IPP) within thirty days after admission,. This affected 1 of 6 audit clients (#6). The finding is:** **Record review on 12/7/20 of client #6's record revealed he was admitted to the home on 9/28/20. Further review revealed client #6 had a hand written IPP with the date of 11/5/20.** **During an interview in 12/8/20, the qualified intellectual disabilities professional (QIDP) confirmed the hand written IPP was being used. Further interview revealed there was a change in QIDP's and the IPP was did not get signed.** **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:**	W 249	is held and program objectives are put into place within 30 days of admission. The IPP document will be typed and place in the record within 15 days of the initial team meeting. For Client #6, training objectives are in place and the typed IPP document will be filed in the client's record. The QP will ensure a copy of the initial IPP is filed in the program record for any new admission within 15 days of the initial team meeting. QA and/or ICF Director will monitor client records monthly to ensure continued compliance with initial team meetings for new admissions.	2/6/21 2/6/21 2/6/21

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W 249	**Continued From page 10** **Based on observations, record review and interview, the facility failed to ensure 2 of 6 audit clients (#4 and #5) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of program implementation. The findings are:** **A. During medication observations in the home on 12/7/20 at 4:00pm, Staff E was observed to pour client #5's water, punch the pills, put the pills in the med cup and throw**	W 249	For all clients, the facility will ensure implementation of individual program plan (IPP) interventions to address medication administration training. For clients' #4 and #5 the program manager and/or QP will provide in-service training to all staff on medication administration training to include but not limited to allowing clients to locate pill bin, retrieve medication, name medication etc., all as identified in IPP medication training objectives.	2/6/21 2/6/21

	the trash away. Review on 12/7/20 of client #5's record revealed a program for client #5 to "correctly administer his medications" and should be implemented any time client #5 is doing med pass on all shifts. This program states that client #5 is supposed to "locate the pill bind, get medication out of the bind, grasp the medication packet, pour medication from packet, take the medication, drink water and dispose of his trash." Interview on 12/8/20 with the QIDP confirmed that staff should have implemented client #5's program as written. B. During medication observations in the home on 12/7/20 at 4:07pm, Staff E was observed to punch the pills from the pill pack into the med cup, pour client #4's water and throw the trash away. Staff E was not observed to tell client #4 the name of her medication. Review on 12/8/20 of client #4's record revealed a program for client #4 to "independently identify her behavior medications." This program states that medication administration should always start with a review of client #4's medications, by		The program manager and/or QP will provide weekly observations of the medication pass in the home to ensure continued compliance for all clients.	2/6/21

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W 249	Continued From page 11 showing her the medication and saying " [Client #4], this is your..." and allow client #4 to repeat the name of the medication. Interview on 12/8/20 with the qualified intellectual disabilities professional (QIDP) confirmed that staff should implement client #4's program as written.	W 249	The facility will ensure for all clients who have restrictive behavior support plans incorporating the use of psychoactive medications, that the specially constituted committee and/or Designee- approves all behavior support plans as such.	2/6/21
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive Behavior Support Plan (BSP) for 1 of 6 audit	W 262	For Client #5, the human rights committee (HRC) representative will review and approve Client # 5's behavior support plan. QA and/or ICF Director will monitor monthly, all clients' program records to ensure HRC approval of behavior support plans as applicable.	2/6/21

clients (#5) was reviewed and monitored by the specially constituted committee, designated as the Human Rights Committee. The finding is:

Review on 12/8/20 of client #5's record revealed a BSP dated 12/23/19 to address target behaviors to include failure to make responsible choices, severe disruptive behaviors, aggression, property destruction and unfounded accusations of possible abuse/neglect. The plan included the use of Viibryd, Olanzapine and Carbamazepine.

Additional review on 12/8/20 of client #5's record revealed the BSP did not include the review and approval by the Human Rights Committee.

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W 262	Continued From page 12 Interview on 12/8/20 with the qualified intellectual disabilities professional revealed the BSP should have included the review and approval of the Human Rights Committee.	W 262		
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, record review and interview, the facility failed to ensure that staff were sufficiently trained in wearing face masks. This potentially effected all the clients in the home. The finding is: During observations in the home on 12/7/20 through 12/8/20, multiple staff were observed wearing their face mask below their noses and chins. Review on 12/7/20 of signs posted in the home revealed "masks need to be worn at all times."	W 340	Nursing services will provide training to staff on personal protective equipment to include but not limited to when and how the PPE is worn. The nurse and/or program manager will instruct staff or how and when to wear face covering and compliance to posted signage which indicated face covering is to be worn at all times. The QP will secure documentation of the PPE in-service training for the staff training files. Home Manager and /or QP will monitor in the home 3xs weekly or more to ensure that face covering is worn by all staff correctly and at all times to ensure continued compliance.	2/6/21 2/6/21 2/6/21

	Interview on 12/8/20 with Staff D revealed that staff have had no formal training on how to wear face masks. Staff D revealed they have just been told to make sure they wear a face mask. Interview on 12/8/20 with Staff F revealed she had not received any formal training on wearing face masks, but wears one based on being told			

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W 340	Continued From page 13 she needed to. Interview on 12/8/20 with Staff C revealed that staff have received training online through Relias about PPE and the expectation is staff wear the face masks each time they work. Interview on 12/8/20 with the facility nurse revealed that all staff that work for the facility should receive training through Relias about wearing PPE. The facility nurse revealed that all staff should wear face masks that cover their nose and below their chin.	W 340	The facility will ensure medications are administered to all clients in accordance with the physician's orders to include but not limited to pills, eye drops and/or treatments. For Client # 5 the nurse and program manager will provide in-service training to all staff on administration of medications per orders. Staff will be instructed to administer correct number of pills, mixtures, eye drops and cross walk the MAR each time before administering to the client. QA, Home Manager and /or QP will monitor the medication pass weekly in the home to ensure continued compliance.	2/6/21 2/6/21 2/6/21
W 368	Interview on 12/8/20 with the qualified intellectual disabilities professional (QIDP) confirmed that staff should wear face masks that cover their nose and below their chin. DRUG ADMINISTRATION 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 observations, record review and interview, the facility failed to ensure all medications were administered in accordance with physician's orders. This affected 1 of 6 audit clients (#5) observed receiving medications. The findings are: A. During observations of medication administration on 12/7/20 at 4:00pm, Staff E was observed to administer one Gabapentin 300mg tablet to client #5.	W 368		

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W 368	Continued From page 14 Review on 12/8/20 of client #5's physician's orders dated 11/23/20 revealed an order for Gabapentin 300mg, "take one tablet by mouth three times a day at 8am, 2pm and 8pm." Interview on 12/8/20 with the facility nurse confirmed that the Gabapentin should have been given to client #5 at 2:00pm, or an hour before or hour after, as written on the physician's orders. B. During observations of medication administration on 12/7/20 at 4:00pm, Staff was observed to administer Equate Restore Tear Drops to client #5, instilling one drop in each eye. Review on 12/8/20 of client #5's physician's orders dated 11/23/20 revealed an order for Refresh Optive Advanced D, "instill one drop in each eye 3 three times a day." Interview on 12/8/20 with the facility nurse confirmed that the eye drop that should have been administered was Refresh Optive Advance D based on the physician's orders. C. During morning medication administration in the home on 12/8/20 at 7:13am, Staff A assisted client #5 with talking a total of 20 medications. Additional observations revealed Staff A handing the medications to client #6 and not looking at the medication administration record (MAR). Further observations revealed client #5 exiting the medication room and not receiving other medications. Review on 12/8/20 of client #5's physician ordered signed 11/23/20 revealed he also has	W 368		

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TAG			DEFICIENCY)	
W 368	Continued From page 15 orders for the following: Metamucil powder, stool softer and Refresh eye drops. During an interview on 12/8/20, the facilty's nurse confirmed client #5 should have received his Metamucil, stool softer and Refresh eye drops. Further interview revealed the staff who are assisting with the medication administration are suppose to compare the medications with the MAR.	W 368	The facility will ensure that medications are always secured unless when preparing for administration. This would include locking the medication closet and securing the medication in locked container during vehicle transport.	2/6/21
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were kept locked except when being administered. The findings are: A. During observations in the home during medication administration pass on 12/7/20, the door to the medication room was left unlocked. At 4:00pm, the medication technician walked out of the med room and into the bathroom to wash her hands. The door to the medication room remained open. At 4:07pm, the medication technician walked out of the med room with client #5 and came back to the med room with client #4. At 4:11pm, the medication technician walked out of the room and into the kitchen/dining room with client #4. The medication technician closed the door of the med room but did not lock it. The medication technician came back, but walked out	W 382	The QP and/or Program Manager will in-service all staff on the importance of securing the medication room. Staff will be advised to lock the medication room upon exiting and maintain the key on their person. Medications prepared for staff transport will be secured in a locked container. The program manager will evaluate the medication storage system in the home to ensure that medications are stored in bins with locks. The program manager and/or QP will monitor in the home weekly to ensure continued compliance.	2/6/21 2/6/21

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W 382	Continued From page 16 of the room again and to the kitchen, with the door of the medication room remaining open. The medication technician came back with a spoon and container of yogurt, and she walked out of the room again, leaving the door open. Review on 12/8/20 of the facility's medication administration training policy (undated)	W 382		

	revealed, "Medications should always be kept in a locked medication area." Interview on 12/8/2 with the facility nurse revealed that staff have been training to always lock the door of the med room whenever they leave it. The facility nurse confirmed that the medication room should always be secured. B. During morning observations in the home on 12/8/20 at 6:44am, Staff G revealed he was talking client #6 to another group home for the day. Further observations revealed Staff G going into the home's medication room and obtaining client #6's medications for the day. Additional observations revealed client #6's medications were being stored in a small plastic baggie. During immediate interview, Staff G stated he had a locked box in his car. Further observations revealed Staff G did not have a locked box, but instead a red and black duffle bag, which had no lock. During interview on 12/8/20, Staff G revealed he did have a lock box in the trunk of his car. Further interview revealed the lock box did not have a lock. Staff G then stated he was going to put client #6's medications in the trunk of his car. When asked, Staff G did confirm he had training on how medications need to be kept locked at all			

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W 382	Continued From page 17 times. Review on 12/8/20 of the facility's medication administration training policy (undated) revealed, "Medications should always be kept in a locked medication area." C. During medication administration observations on 12/8/20, Staff A left the medication room door open at 7:02am, 7:09am and 7:15am, when she left the area to obtain a pitcher of water and assist a client to the medication room and then to the dining room. Further observations revealed the medications for the clients in the home are kept in plastic storage bins, which do not have locks on them. During an interview on 12/8/20, the facility's nurse stated all medications are suppose to be kept locked.	W 382		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)	W 436		

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 observation, record review and interviews, the facility failed to ensure adaptive equipment was utilized and kept in good repair for 2 out of 6 audit clients (#4 and #5). The findings are:

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W 436	Continued From page 18 A. During observations in the home on 12/7/20 through 12/8/20, client #4 was observed wearing glasses. The glasses were pieced together in the middle, between each lens, with tape. Interview on 12/8/20 with client #4 revealed that she broke her glasses "a couple of months ago but accidentally sitting on them." Client #4 revealed she did not know when she would be getting new glasses, but probably after her upcoming eye surgery in a couple of weeks. Interview on 12/8/20 with Staff D revealed that client #4's eyeglasses have been broken for two or more months. Staff D revealed she did not know if the glasses would be replaced. Interview on 12/8/20 with Staff F revealed that she had been working at the facility for one month, and client #4's glasses had been broken since she started working there. Interview on 12/8/20 with the qualified intellectual disabilities professional (QIDP) revealed that client #4's eyeglasses should have been replaced when they were broken. B. During observations in the home on 12/7/20 from 11:45am to 12:30pm, client #5 was not wearing his dentures. Client #5 was observed to eat lunch during this time	W 436	The facility will ensure that clients have access and use assistive devices to include but not limited to eyeglasses, dentures, hearing aid and maintain sanitary condition of the walker. For Client #4, the QP will seek a referral to secure new eyeglasses. For Client #5, QP will schedule a team meeting to address refusal to wear dentures and develop protocol, /in-service staff on strategies developed to improve compliance. In addition, the team will discuss wearing of the hearing aid. The QP and program manager will provide in-service training to staff on Client #5's use and application of hearing aid and dentures. For client #3, the program manager will provide in-service training to all staff on cleaning the seat of the rolling walker to include but not limited to after meals or during and after food spillage. QP and home manager will monitor the condition and use of the assistive devices 3x weekly to ensure use,	2/6/21 2/6/21 2/6/21

without any difficulty.

Interview on 12/8/20 with the QIDP revealed that client #5 will sometimes refuse to wear his dentures. The QIDP confirmed that staff should encourage and prompt client #5 to use his dentures, especially when he is eating.

application and availability- for compliance.

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W 436	Continued From page 19 C. During observations in the home on 12/7/20 from 11:45am to 12:30pm, client #5 was not wearing his hearing aid. Client #5 was observed to eat lunch during this time. While eating, staff would prompt client #5 to slow down or prompt him to clean his mouth. Client #5 did not hear the staff when they were prompting him. Review on 12/7/20 of client #5's individual program plan (IPP) dated 8/20/19 revealed client #5 has mild hearing loss in his left ear, and severe hearing loss in his right ear, and wears a hearing aid in his right ear. Interview on 12/8/20 with the QIDP confirmed client #5 should have been wearing his hearing aid. Observation in the group home on 10/27/20 revealed client #3 to utilize a rolling walker during ambulation throughout survey observations. Continued observation of client #3's walker revealed the seat cushion of the walker to have dried spillage or residue on the cover. Further observation at 5:20 PM revealed client #3 to clear his place setting at the dinner table after the dinner meal. Client #3 was subsequently observed to place his dishes from the dinner meal on the seat of the rolling walker and to take his dishes to the kitchen. Observation of client #3's walker after taking dishes to the kitchen revealed the seat cover to have additional food residue from the dinner dishes. Observation in the group home on 10/28/20 at 7:00 AM revealed the rolling walker of client #3 to have dried food residue from observations on	W 436		

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W 436	Continued From page 20 10/27/20. Observation at 8:35 AM revealed client #3 to take his dishes from the breakfast meal to the kitchen using the seat of the rolling walker. Subsequent observation revealed additional food residue to remain on client #3's walker after the client placed his dishes in the kitchen sink. Interview with the qualified intellectual disabilities professional (QIDP) on 10/28/20 verified client #3 utilizes his walker to carry items from various locations when ambulating. Continued interview with the QIDP verified client #3's walker should be clean and staff should clean the seat cover of the client's walker after the client takes dishes to the kitchen to prevent spillage or residue from accumulating on the seat cover.	W 436	The facility will implement an active infection control system in the home to prevent cross contamination and reduce the spread of infections. The home manager will in-service all staff on infection control practices. Such practices will include but not limited to thorough hand washing, working with clients to address appropriate hygiene and infection control practices such as sanitizing or washing their hands during meal preparation, prior to meals and as appropriate to prevent cross contamination.	2/6/21
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure the potential for cross-contamination was prevented. This potentially affected all clients residing in the home. The findings are: A. During observations in the home on 12/8/20 at 7:09am, client #3 was observed assisting Staff D with meal preparation. Client #3 was observed to stir the pot of oatmeal, cough into her open hand, and stir the oatmeal again. Staff D did not prompt client #3 to wash her hands after coughing into it. Interview on 12/8/20 with the qualified intellectual	W 454	Staff will supervise clients during meal preparation to ensure that clients are not coughing in hands or exposure to food does not occur. Staff will encourage all clients to wash or sanitize their hands prior to meals and snacks. Staff will have Client #6 sanitize his hands at the table after he propels his wheelchair to the table. The home manager and/or QP will monitor meals and snacks in the home weekly to ensure continued compliance.	2/6/21 2/6/21

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W 454	Continued From page 21 disabilities professional (QIDP) confirmed that staff should have prompted client #3 to wash her hands after she coughed into it. B. During observations in the home on 12/7/20 at 4:21pm, client #1 and client #4 went into the dining room to have their snack. The snack consisted of a glass of milk and graham crackers, stacked into one pile on a plate in the middle of the table. Client #4 was observed to wash her hands, but client #1 did not. Each client reached into the stack of graham crackers with their bare hands to get two crackers each. At 4:30pm, client #5 was observed to come inside from smoking a cigarette. Client #3 and Client #5 were observed to go into the dining room to have their snack. Client #3 and client #5 did not wash their hands. The were both observed to reach into the stack of graham crackers with their bare hands to get two crackers each. Interview on 12/8/20 with the QIDP confirmed that every client should have washed their hands prior to eating their snack, and should have utilized tongs or some other utensil to get their graham crackers. C. During observations in the home on 12/7/20 through 12/8/20, client #5 was observed at lunch, dinner and breakfast. Prior to eating, staff would prompt and assist client #5 with washing his hands. Client #5 would come to the table and transfer from his wheelchair to his chair at the dining table. During the transfer, client #5 was observed to propel himself using the wheels on his wheelchair, set the brakes on his wheelchair, use his hands to take his legs on the footrests and flip the footrests up, and use his hands to swing the footrests back. Client #5 was never	W 454		

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W 454	Continued From page 22 prompted to sanitize his hands after touching the wheels, brakes, footrests and legs of the footrests. Interview on 12/8/20 with the QIDP confirmed that client #5 should have sanitized his hands after touching all the parts of his wheelchair	W 454	The facility will ensure that all clients receive their specially prescribed diets as indicated by the ISP and physician's orders. For Clients #1, #4 and #5 all staff in the home will be in-service on their diets as prescribed to include finely	2/6/21

W 460	and prior to eating. 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 interviews, the facility failed to ensure clients #1, #4 and #5 diets were provided as prescribed. This affected 3 of 6 clients. The findings are: A. During dinner observations at the home on 12/7/20 at 6:01pm, client #1 first scooped chicken pot pie on her plate and then she scooped potato salad on her plate. Further observations revealed chunks of chicken visible while client #1 ate. Additional observations revealed Staff D using client #1's fork to mash the potato salad. Further observations revealed there were chunks of potato visible while client #1 ate. At 6:11pm, client #1 coughed three times and at 6:19pm, coughed an additional three times. During breakfast observations at the home on 12/8/20 at 8:00am, client #1 scooped scrambled eggs on her plate. Client #1 was observed eating all of the scrambled eggs. Further observations	W 460	chopped, ground meat, meat chopped or cut consistencies, vegetarian as indicated in the ISP, diet, mealtime protocols, and Menu guidelines. 2/6/21 The QP and home manager will provide in-service training and instruct all staff on the specific requirements of each client's diet in the home. 2/6/21 The QP and/or program manager will monitor meals in the group home weekly to ensure continued compliance to diet orders and/or requirements for all clients.

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W 460	Continued From page 23 revealed real eggs where used to make the scrambled eggs. Review on 12/8/20 of client #1's medical evaluation dated 10/25/20 stated, "...finely chopped diet." Review on 12/8/20 of client #1's nutritional evaluation dated 12/8/19 stated, "Diet: Ground meats...egg beaters for eggs." Review on 12/7/20 of the diet sheet dated 11/2/20 (revised) revealed client #1's diet	W 460		

is finely chopped with ground meats.

During an interview on 12/8/20, the qualified intellectual disabilities professional (QIDP) stated client #1's meat should been grounded and her potato salad should have been chopped, using the homes' blended. Further interview revealed client #1 should have received egg beaters at breakfast.

B. During dinner observations at the home on 12/7/20 at 6:07pm, client #4 scooped chicken pot pie on her plate. Further observations revealed client #4 eating around the chicken and putting it on another side of her plate. At no time was client #1 offered and alternate meal/food.

Review on 12/7/20 of the diet sheet dated 11/2/20 (revised) stated, "Vegetarian: Offer regular menu items with alternates: fish, peanut/jelly sandwich, eggs, cheese/cheese sandwich, yogurt (Greek) vegetable pattie."

During an interview on 12/8/20, the QIDP confirmed client #4 should have been offered an alternative to replace the chicken.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G243	A. BUILDING _____ B. WING _____	C 12/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTSIDE RESIDENTIAL	467 CREEK ROAD ORRUM, NC 28369

(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 460	Continued From page 24 D. During observations in the home on 12/7/20 at 12:02pm, client #5 was observed eating lunch. On his plate was a large slice of meatloaf served as a whole, mashed potatoes and mixed vegetables. Client #5 was observed to use his spoon to cut off large pieces of the meatloaf to consume it, and at times mix the pieces of meatloaf with mashed potatoes and mixed vegetables in large bites. Review on 12/7/20 of client #5's IPP dated 8/20/19 revealed a regular diet with meats cut or chopped. Interview on 12/8/20 with the QIDP confirmed that client #5's meatloaf should have been cut or chopped, or staff should have prompted client #5 to cut or chop his meatloaf into smaller pieces.	W 460		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

December 11, 2020

Melissa Bryant, Director
Community Innovations
80 Alliance Drive
Whiteville, NC 28472

Re: Recertification, Complaint and Follow Up Survey December 7 - 8, 2020
467 Creek Road, Orrum, NC 28369
Provider Number 34G 243
MHL# 078-049
E-mail Address: mbryant@communityinnovations.com
Intake Number: NC00167677; NC00170042; NC00170035; NC00171538

Dear Ms. Bryant:

Thank you for the cooperation and courtesy extended during the recertification, complaint and follow up surveys completed on December 7 - 8, 2020.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is **February 6, 2021**.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Eugina Barnes at 919-819-8182.

Sincerely,

Eugina Barnes

Eugina Barnes, BSW, QIDP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

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DHSRreports@eastpointe.net
_DHSR_Letters@sandhillscenter.org
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
File