STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
34G319	A. BUILDING _____ B. WING _____	12/02/2020

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTRY FIELD ROAD GROUP HOME	135 DAUGHTRY FIELD ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED 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	NOVA will review and update, as necessary, its EP on an annual basis, which is a Federal regulation. This activity will be documented in a new policy. This Program Director and Facility Support Coordinator will assure by direct review that these activities are completed.	01-29-2021

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gwendolyn Johnson	Program Director	12-17-20

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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 Preparedness (EP) plan was reviewed and updated every two years. The finding is: The facility's EP plan was not reviewed or updated every two years. Review on 12/1/2020 of the facility's EP plan revealed the date of their plan was 6/1/2018. Further review revealed there was not an updated plan located in the home. During an interview on 12/1/2020, the program director revealed she was not aware if the EP plan had been reviewed or updated every two years.	E 004		

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[signature]	Program Director	12-17-20

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E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) [(b) Policies and procedures. The [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 at least every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	E 020	As a part of the POC under EOO4, a relocation plan/document will be added to the EP. This plan/document will be referenced in the EP Policy, and the Program Director and Facility Support Coordinator will assure by direct review that this plan/document is included in the EP.	01-29-2021

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Jacqueline Johnson	Program Director	12-17-20

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E 020	Continued From page 3 *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop specific policies and procedures to address emergency preparedness (EP) including evacuation locations based on a community and facility risk assessment. The finding is: The facility did not have an emergency plan which included evacuation locations.	E 020	As a part of the POC under EOO4, a relocation plan/document will be added to the EP. This plan/document will be referenced in the EP Policy, and the Program Director and Facility Support Coordinator will assure by direct review that this plan/document is included in the EP.	01-29-2021

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Angelina Johnson	Program Director	12-17-20

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E 020	Continued From page 4 Review on 12/1/2020 of the facility's EP plan revealed the plan did not include information in regards to the facility's evacuation locations in the event of flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing residents or other emergencies. During an interview on 12/1/2020, Staff A reported they knew where to relocate with the clients if they needed to vacate the facility. Further interview revealed the clients would locate to North Drive Group Home. During an interview on 12/1/2020, the program director revealed she was unaware the EP plan did not include information pertaining to alternate evacuate locations. The program manager confirmed the clients would relocate to North Drive Group Home. 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	E 020		

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E 030	Continued From page 5 §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. (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:	E 030	As a component of the POC for EOO4, contact documentation for Consumers, Parents/Guardians and Staff will be updated and current/consistent with the date of the EP annual review. This documentation will be a component of the EP Policy and reviewed by the Program Director and Facility Support Coordinator for compliance.	01-29-2021

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E 030	Continued From page 6 (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. (ii) Entities providing services under arrangement. (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: 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: The facility's EP plan did not include an updated face sheet. Review on 12/1/2020 of the facility's EP plan had the wrong contact information. Further review	E 030		

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E 030	Continued From page 7 revealed the face sheet had the contact information for a client who no longer lived in the home. Additional review revealed a client who was admitted in July 2020 information was not included. Also, the EP plan included former staff and not the new staff. During an interview on 12/1/2020, the program director confirmed the face sheet for the facility contained the incorrect information.	E 030		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: W 189 Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained in the area of safety The findings are: A. Staff were not sufficiently trained in providing safety for the clients. 1. During morning observations in the home on 12/2/2020 at 8:35am, Staff A handed the van keys to client #4 and told him to go ahead outside and start the van. Further observations revealed client #4 going outside alone, putting the key in the door lock of the van, opening the door, reaching in, putting the key in the ignition, turning the ignition, shutting the van door and coming back into the home. At no time did a staff person go outside with Client #4.	W 189	All facility Staff will be issued a Coaching Log documenting the prohibition of the practice of allowing any Consumer access to vehicle keys or activating the ignition of any vehicle. Coaching Logs will be accompanied by a Staff training session referencing the information contained in the Coaching Logs. The training session will be documented in the NOVA Staff Training form and administered and conducted by the QP and Residential Services Supervisor, then reviewed and QA ' d by the Clinical Director.	01-29-2021

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E 189	Continued From page 8 During an interview on 12/2/2020, Staff A revealed she has been trying to "integrate [Client #4] to do normal things." Further interview revealed Staff A had been working in the home for a year and client #4 has been starting the van by himself before that. Additional interview revealed Staff A did not see how client #4 starting the van alone was a safety concern. During an interview on 12/2/2020, the program director revealed client #4 should never had been allowed to start the van by himself. 2. During morning observations in the home on 12/2/2020 at 8:41am, all six clients where observed getting into the van. Further observations revealed while the clients where getting on the van, it was idling in the driveway of the home. Additional observations revealed Staff A and Staff B did not come out of the house until 8:43am. During an immediate interview on 12/2/2020, Staff A did see anything wrong with the clients getting on the van alone. Staff A stated it was good they got on the van, while it was "warming up." During an interview on 12/2/2020, the program director stated the clients should never be left alone on the van. Further interview revealed the staff should have their eyes on the clients at all times. 3. During morning observations on 12/1/2020 at 9:44am, the surveyor entered the day program and introduced themselves. Further observations revealed the staff who opened the door did not	W 189		

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E 189	Continued From page 9 ask the surveyor any health questions or take their temperature. During afternoon observations on 12/1/2020 at 3:30pm, the surveyor entered the home. Further observations revealed the staff who told the surveyor to enter the home, did not ask the surveyor any health questions of take their temperature. During morning observations on 12/2/2020 at 6:18am, the surveyor entered the home and introduced themselves. Further observations revealed the staff who opened the door did not ask the surveyor any health questions or take their temperature. During morning observations on 12/2/2020 at 9:25am, the surveyor entered the day program and introduced themselves. Further observations revealed the staff who opened the door did not ask the surveyor any health questions or take their temperature. During an interview on 12/2/2020, the facility nurse #1 revealed all visitors temperature and health questions should be asked. Further interview revealed she was not sure if staff knew they had to do that. During an interview on 12/2/2020, the facility nurse #2 revealed with the pandemic going on, the surveyors' temperature should have been taken and health questions should have been asked. Additional interview revealed the facility does not have anything in writing pertaining to asking questions or taking the temperature of visitors.	W 189		

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W 249	Continued From page 10	W 249		
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: W 249 Based on observation, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of dining and self help skills. This affected 3 of 6 audit clients (#1, #2 and #5). The findings are: A. Clients #1 and #5 were not prompted to use a knife during dining. 1. During lunch observations at the day program on 12/1/2020 at 11:27am, client #1 was presented with a whole bologna sandwich. Further observations revealed client #1 biting into the sandwich and eating pieces larger than 1/2 inch. At no time was client #1 prompted to cut his sandwich. Further observations revealed client #1 only had a spoon at his place setting. During dinner observations at the home on 12/1/2020 at 5:03pm, client #1 served himself one whole piece of a chicken breast. Further	W 249	Based on historical and direct observation, NOVA will arrange for the Dietician to re-assess Consumer #1 and Consumer #5 regarding the need for food items to be served or consumed in bite-sized pieces. Based on the results of the re-assessment the CFA and IPP will be modified, if necessary, via a Core Team Meeting. Regardless, all Staff will be trained on the appropriate method for food serving for Consumer #1 and Consumer #5, and training documented in the NOVA Staff Training Form. Training will be conducted by the QP and Nursing Staff, and reviewed for compliance by the Program Director. As of 12-07-2020 all utensils have been removed from the lock box and placed in drawers for easy Consumer access. The lock box has been removed from the facility. The Program Director has checked the facility to assure the above actions have been taken. All Staff will receive a Coaching Log and Staff training regarding NOVA ' s expectations for appropriate Consumer attire including: cleanliness; dressing for weather conditions; and dressing for occasions. The corrective actions will be implemented by the QP and QA ' s by the Clinical Director.	01-29-2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 11 observations revealed client #1 picking up the whole chicken breast and eating pieces larger than 1/2 inch. At no time was client #1 prompted to cut his chicken breast. Further observations revealed client #1 only had a spoon at his place setting. During breakfast observations at the home on 12/2/2020 at 7:35am, client #1 served himself one whole piece of french toast. Further observations revealed client #1 pulled the french toast apart into 2 pieces and ate them. At no time was client #1 prompted to cut his french toast. Further observations revealed client #1 only had a spoon at his place setting. Review on 12/2/2020 of client #1's comprehensive functional assessment dated 4/21/2020 revealed he requires "verbal, gestures and modeling" for his dining skills. 2. During lunch observations at the day program on 12/1/2020 at 11:27am, client #5 was presented with a whole bologna sandwich. Further observations revealed client #5 biting into the sandwich and eating pieces larger than 1/2 inch. At no time was client #5 prompted to cut his sandwich. Further observations revealed client #5 only had a spoon at his place setting. During dinner observations at the home on 12/1/2020 at 5:06pm, client #5 served himself one whole piece of a chicken breast. Further observations revealed client #5 picking up the whole chicken breast and eating pieces larger than 1/2 inch. At no time was client #5 prompted to cut his chicken breast. Further observations revealed client #5 only had a spoon at his place setting.	W 249		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angelina Johnson	Program Director	12-17-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G319	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	12/02/2020

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DAUGHTRY FIELD ROAD GROUP HOME	135 DAUGHTRY FIELD ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 12 During breakfast observations at the home on 12/2/2020 at 7:40am, client #5 served himself one whole piece of french toast. Further observations revealed client #5 picking up the whole piece of french toast and eating pieces larger than 1/2/ inch. At no time was client #5 prompted to cut his french toast. Further observations revealed client #5 only had a spoon at his place setting. Review on 12/2/2020 of client #5's comprehensive functional assessment dated 3/17/2020 revealed he requires "verbal, gestures and modeling" for his dining skills. During an interview on 12/2/2020, Staff A revealed how all the forks and knifes in the home are located in an unlocked box, which is located on the counter in the kitchen. Staff A stated the forks and knifes were kept locked because of a former client who resided in the home. Further interview revealed Staff A reported no one had told her to remove the forks and knifes and place them in a drawer in the kitchen. During an interview on 12/2/2020, the program director revealed staff should be giving some type of prompts to clients #1 and #5 to cut their food. The program director stated she was not aware the forks and knifes were not assessable to the clients. B. During observations in the home on 12/2/2020 at 6:18am, client #2 was observed wearing the same yellow colored sweat shirt which he wore on 12/1/2020. Additional observations revealed the shirt had a large stain on the front.	W 249		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jacqueline Gethers	Program Director	12-17-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G319	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	12/02/2020

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W 249	Continued From page 13 Review on 12/2/2020 of client #2's comprehensive functional assessment dated 12/23/2019 revealed client #2 "demonstrates adequate dressing skills although verbal prompts and cues may be necessary at times." During an interview on 12/2/2020, Staff A revealed client #2 can independently "pick out his own clothes and dresses himself." During an interview on 12/2/2020, the program director stated staff should have ensured client #2 wore a clean shirt.	W 249		
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: W 436 Based on observations, record review and interviews, the facility failed to ensure recommended equipment specifically eyeglasses were furnished for 1 of 6 audit clients (#2). The finding is: Client #2 was not prompted to wear his eyeglasses. During observations at the home on 12/2/2020, from 6:18am until 8:53am, client #2 was not prompted to wear his eyeglasses.	W 436	All Staff will receive a Coaching Log and training by the QP regarding the protocol to be followed for Consumer #2 ' s wearing of his eyeglasses. The QP and Residential Services Supervisor will conduct random observations for compliance and report findings to the Program Director.	01-29-2021

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Jacqueline Gethers	Program Director	12-17-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G319	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 436	Continued From page 14 Review on 12/2/2020 of client #2's visual examination dated 6/29/2020 revealed, "Eyeglasses: Full time." Review on 12/2/2020 of client #2's comprehensive functional assessment dated 12/23/2019 stated, "[Client #2] has prescription glasses which he wears full-time." During an interview on 12/2/2020, the program stated client #2 should have been verbally prompted to wear his eyeglasses.	W 436		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: W 441 Based on review of fire drill reports and interview, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients residing in the home. The finding is: Fire drills on first shift were not conducted at varied times. Review of fire drill reports on 12/1/2020 revealed the following: Five fire drills were conducted on third shift: 3:30pm, 3:30pm, 3:00pm, 3:00pm and 3:55pm. During an interview on 12/1/2020, Staff A revealed first shift hours are 6:15am until 6:30pm.	W 441	The Facility Support Coordinator will develop and implement a varied schedule for the fire drills with the involvement of the QP and Residential Services Supervisor. Each drill will be documented on NOVA ' s drill form and reviewed by the Program Director to assure compliance.	01-29-2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jacqueline Johnson	Program Director	12-17-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G319	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 441	Continued From page 15 During an interview on 12/1/2020, the program director confirmed the fire drills conducted on first shift not varied.	W 441		
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 interviews, the facility failed to ensure clients #1, #5 and #6 diets were provided as prescribed. This affected 3 of 6 clients. The findings are: A. Clients #1, #5 and #6 diets were consistently followed. 1. During lunch observations at the day program on 12/1/2020 at 11:27am, client #1 was presented with a whole bologna sandwich. Further observations revealed client #1 biting into the sandwich and eating pieces larger than 1/2 inch. At no time was client #1 prompted to cut his sandwich. During dinner observations at the home on 12/1/2020 at 5:30pm, client #1 served himself one whole piece of a chicken breast. Further observations revealed client #1 picking up the whole chicken breast and eating pieces larger then 1/2 inch. At no time was client #1 prompted to cut his chicken breast. During breakfast observations at the home on 12/2/2020 at 7:35am, client #1 served himself	W 460	See POC for W249. In addition, NOVA ' s Medical Director will be requested to refer Consumer #6 to a Gastroenterologist for an update of his diagnosis and treatment (including diet) recommendations. Until this information is obtained facility Staff will receive a Coaching Log and In-Service training by Nursing Staff regarding this Consumer ' s dietary requirements. The Program Director, QP and Nursing Staff will perform random observations to assure compliance.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Program Director	12-17-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G319	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 460	Continued From page 16 one whole piece of french toast. Further observations revealed client #1 pulled the french toast apart into 2 pieces and ate them. At no time was client #1 prompted to cut his french toast. Review on 12/1/2020 of client #1's nursing evaluation dated 4/6/2020 stated, "Diet: All foods to be cut into 1/4 - 1/2 bite size pieces." Review on 12/1/2020 of client #1's nutritional evaluation dated 1/10/2020 stated, "...all food cut into 1/4 - 1/2 bite size pieces." Review on 12/2/2020 of client #1's physician orders signed on 11/30/2020 stated, "Diet: All food to be cut into 1/4 - 1/2 inch bite size pieces." 2. During lunch observations at the day program on 12/1/2020 at 11:27am, client #5 was presented with a whole bologna sandwich. Further observations revealed client #5 biting into the sandwich and eating pieces larger than 1/2 inch. At no time was client #5 prompted to cut his sandwich. During dinner observations at the home on 12/1/2020 at 5:06pm, client #5 served himself one whole piece of a chicken breast. Further observations revealed client #5 picking up the whole chicken breast and eating pieces larger than 1/2 inch. At no time was client #5 prompted to cut his chicken breast. During breakfast observations at the home on 12/2/2020 at 7:40am, client #5 served himself one whole piece of french toast. Further observations revealed client #5 picking up the whole piece of french toast and eating pieces larger than 1/2/ inch. At no time was client #5	W 460		

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[signature]	Program Director	12-17-20

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W 460	Continued From page 17 prompted to cut his french toast. Review on 12/1/2020 of client #5's nursing evaluation dated 2/28/2020 stated, " Cut all food into 1/4 - 1/2 pieces." Review on 12/1/2020 of client #5's nutritional evaluation (no date) stated, "Cut all food into 1/4 - 1/2 pieces." Review on 12/2/2020 of client #5's physician orders signed on 11/30/2020 stated, "Diet: Cut all food into approx 1/4 - 1/2 inch pieces." 3. During lunch observations on 12/1/2020, client #6 consumed a microwave bowl of spaghetti. Review on 12/2/2020 of client #6's nursing evaluation dated 1/21/2020 stated, "Diet: Avoid...tomato based sauces." Review on 12/2/2020 of client #6's nutritional evaluation dated 11/8/2019 stated, "Diet: Avoid...tomato based sauce." Review on 12/2/2020 of client #6's physician order signed on 11/30/2020 stated, "Avoid...tomato based sauces." During an interview on 12/2/2020, the facility nurse #1 confirmed clients #1, #5 and #6 diets should have been followed as written.	W 460		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature.		NOVA will purchase food warmers to assure that all foods regardless of item or meal will be maintained at an appropriate temperature. All Staff will receive training regarding the competent use of the food warmer and monitor routinely by the QP.	01/29/2021

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Jacqueline Johnson	Program Director	12-19-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G319	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 473	Continued From page 18 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all foods were served at an appropriate temperature. This affected all clients residing in the home. The findings are: Food was not served at an appropriate temperature. During morning observations in the home on 12/2/2020 at 6:57am, Staff B scooped the scrambled eggs into a serving dish, covered them a placed the serving dish onto the kitchen counter. At 7:02am, the serving dish with the eggs where placed on the table. At 7:12am, the serving dish with the french toast was observed on the table. Further observations revealed the clients began eating at 7:35am. At no time where the clients prompted to reheat their food. During an interview on 12/2/2020, Staff B revealed food is allowed to sit out for 30 minutes before it needs to be reheated. Further interview revealed Staff B has never reheated any food for the clients. During an interview on 12/2/2020, Staff A was able to show the surveyor a thermometer which was located in a drawer in the kitchen. Staff A stated food can sit out for 10 minutes before it needs to be reheated. During an interview on 12/2/2020, the program director revealed the food should have been reheated before the clients began eating.	W 473		01/29/2021

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Jacqueline Johnson	Program Director	12-17-20