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

PRINTED: 11/24/2020
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
	34G227	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOWE DRIVE GROUP HOME	628 FLOWE DRIVE CHARLOTTE, NC 28213

(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 000	INITIAL COMMENTS A complaint survey was completed on 11/10/2020 in addition to the recertification survey. Deficiencies were cited as a result of the complaint survey for Intake # NC00161693, NC00163529, NC00164104 and NC00169903.	W 000	DHSR - Mental Health Lic. & Cert. Section	
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to promptly notify a guardian of accidents/incidents while the client (#6) resided in the facility. The finding is: Review of records on 11/10/20 for client #6 revealed an admit date of 7/1/18 and a discharge date of 5/10/20. Continued review of records for client #6 revealed a behavior support plan dated 8/23/19 with target behaviors of verbal aggression, physical/social aggression (grabbing, hitting, pinching, biting and attacking others), property damage, non-compliance, intentional toileting accidents, invading others personal space and elopement. Review of a guardian notification form dated 8/23/19 revealed the guardian requested immediate notification for behavioral and medical issues of the client. Review of internal incident	W 148	QP will ensure that all communication with guardian is met by speaking with the guardian immediately during significant incident, follow up by the Manager checking in with the guardian the next day to ensure the guardian was satisfied with the communication. QP will make sure every guardian fills out a Preference Contact sheet. QP or Manager will reach out to the guardian according to the preference contact sheet that was completed. QP will document all communication that took place with guardian via phone, email or letter. QP will also make sure all incident report is completed before the end of the day and filed. QP will monitor the GHM on this process to ensure the process is being follow anytime during communication with guardian.	11/16/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jch Braun — TITLE: Qualified Professional — (X6) DATE: 11-20-20

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G227	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOWE DRIVE GROUP HOME	628 FLOWE DRIVE CHARLOTTE, NC 28213

(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 148	Continued From page 1 reports from 10/2019-5/2020 revealed no reports from 10/2019-1/2020. A review of incident reports from 2/2020-5/2020 revealed incident reports relative to client #6 on: 2/25/20, 3/13/20, 3/20/20, 3/22/20 and 4/2/20. Further review of the incident reports from 2/2020-5/2020 revealed no guardian documentation for client #6 on incident reports of 2/25/20, 3/13/20, 3/20/20, 3/22/20 or 4/2/20. Interview with the facility qualified intellectual disabilities professional (QIDP) on 11/10/20 verified client #6 was discharged 5/10/20 due to behavioral issues. Continued interview with the QIDP revealed he was unsure why the incident report forms had not been documented to reflect guardian contact as the guardian had been contacted relative to the behaviors of the client. Further interview with the QIDP verified he had no additional documentation to reflect contact with the guardian of client #6 relative to incidents or behavioral issues. Subsequent interview with the QIDP verified he had not conducted a team meeting with the guardian prior to 3/6/20 to discuss concerns with behaviors of client #6 or the inability of the facility to meet the needs of the client.	W 148	QP will facilitate an In-Service with all staff on How to Properly check for expiration dates on all food products. And how to dispose of any food that is expired.	
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: The facility failed to assure staff training relative to the health and safety of 5 of 5 clients in the	W 192	Manager also purchase Fruit Communication Board that would allow all staff to see that fruits are purchase every Monday and that the following Monday 7days fruit needs to be dispose, Communication board will have purchase date & dispose date display. Leads of the home will check throughout the week to ensure the condition of the fruit once checked the Lead will place their initials on the day it was check. GHM will monitor by checking the communication board weekly and purchasing fresh fruits weekly.	11/16/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G227	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOWE DRIVE GROUP HOME	628 FLOWE DRIVE CHARLOTTE, NC 28213

(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 192	Continued From page 2 facility by not ensuring food that was not consumed was discarded timely or prior to the expiration date. The findings are: A. The facility failed to ensure fruit was not over ripe and was thrown away timely. For example: Observation in the kitchen of the group home on 11/9/20 revealed a shelving unit to stand up against a wall of the kitchen. Observation of items on the shelving unit revealed a fruit bowl to sit on the top shelf. Observation inside the fruit bowl revealed a banana that was black in color and had a strong odor. Subsequent observation revealed fruit flies to sit on top of the bowl and to dwell around the over ripe fruit in the bowl. Interview with the home manager on 11/9/20 revealed fruit in the home should be fresh. Continued interview with the home manager (with observation of the fruit bowl on the kitchen shelf unit) revealed fruit that was over ripe should be immediately thrown away and the observation of the fruit and flies was unacceptable. B. The facility failed to ensure milk was discarded prior to the expiration date. For example: Observation on 11/9/20 of items in the refrigerator of the group home revealed a open gallon of milk with an expiration date of 10/29/20. Continued observation in the group home at 6:05 PM revealed client #4 to request "coffee" that the home manager was observed to assist the client with making. Observation at 6:17 PM revealed client #4 to sit at the table and to drink coffee. Interview with the home manager on 11/9/20	W 192	GHM purchase a Communication Board and placed on the refrigerator that have a checklist indicating what date the food was purchase and when the food expire date. GHM will make sure all expiration dates is written on all food that is purchase before going into the refrigerator. GHM will monitor this by make sure when food arrives	11/16/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G227	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOWE DRIVE GROUP HOME	628 FLOWE DRIVE CHARLOTTE, NC 28213

(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 192	Continued From page 3 verified when she assisted client #4 with having a cup of coffee that she added milk to the coffee. Continued interview with the home manager verified she had used the expired milk in the refrigerator as she had not noticed the expired date of 10/29/20. Subsequent interview with the home manager verified expired milk should have not been in the refrigerator and should have been discarded as the milk had been expired 11 days as of the current survey date. The home manager was immediately observed to discard the rest of the expired milk. C. The facility failed to ensure the emergency food supply for the group home did not include expired food items. For example: Observation in the group home on 11/10/20 at 9:00 AM revealed the facility's emergency food supply to be stored in two large plastic bins in a hallway closet. Continued observation of the emergency food supply revealed the food supply to include multiple cans of meat, fruit, vegetables, boxes of crackers and cookies. Further observation revealed the date of 4/21/19 to be written on all of the contents of the emergency food supply. Interview with staff F on 11/10/20 verified that there should be a seven day supply of food and water for emergencies and food should be discarded and replaced every six months. Interview with the qualified intellectual disabilities professional (QIDP) verified that the food that is stored for the emergency supply should be discarded and replaced with fresh food every six months to a year. Further interview with the QIDP confirmed that the expired food would be thrown away and replaced as soon as possible to	W 192	GHM will monitor and check monthly. Emergency Food Supply list was place on the emergency bin and on the outside of the emergency supply closet door. A list of food items with their expiration dates are on all items, group home leads will check the bins every month and initial their names indicating the emergency food supply is good. if any food items needs to be replaced leads would remove the items and contact GHM immediately for the items to be replace with 24hrs. GHM manager will monitor emergency food supply monthly to ensure group home leads are completing the checklist on the emergency food and checking the item to make they're fresh and not expire.	11/16/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G227	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOWE DRIVE GROUP HOME	628 FLOWE DRIVE CHARLOTTE, NC 28213

(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 192	Continued From page 4 ensure an appropriate emergency food supply for the group home.	W 192		
W 201	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(4)(i) If a client is to be either transferred or discharged, the facility must have documentation in the client's record that the client was transferred or discharged for good cause. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the interdisciplinary team failed to demonstrate good cause for discharging 1 of 1 client (#6) from the facility. The finding is: Review of records on 11/10/20 for client #6 revealed an admit date of 7/1/18 and a discharge date of 5/10/20. Continued review of records for client #6 revealed a behavior support plan dated 8/23/19 with target behaviors of verbal aggression, physical/social aggression (grabbing, hitting, pinching, biting and attacking others), property damage, non-compliance, intentional toileting accidents, invading others personal space and elopement. Subsequent review of records for client #6 on 11/10/20 revealed a facility discharge letter addressed to the guardian dated 3/11/20. Review of the discharge letter revealed the letter served as 60 day notice of discharge due to a severity of safety concerns. Continued review of the discharge notice revealed facility concerns with the impulsive and self injurious behaviors of the client towards herself and others. Further review	W 201	QP will ensure during Admissions, Transfers, Discharges are communicated more effectively by providing all documentation that guardian request. QP will also ensure all guardian must signoff on any documentation acknowledge they received proper information. QP will also review all incident reports or behavior logs to verify accurate information is being recorded. QP will also provide accurate information to guardian to have on file in case the information is requested by someone outside of the agency. QP facilitate an In-Service with all staff on Documenting Behaviors for individual to ensure behaviors are being log with accurate information is being documented. QP will ensure that all discharge letters accurately reflect the recorded data for the individual. Compliance Specialist will monitor any discharge to ensure all guidelines are met before moving for with any discharge	11/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G227	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOWE DRIVE GROUP HOME	628 FLOWE DRIVE CHARLOTTE, NC 28213

(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 201	Continued From page 5 of the discharge notice revealed client #6 had become more challenging and aggressive over the past 6 months. Review of internal incident reports from 10/2019-5/2020 revealed no reports from 10/2019-1/2020. A review of incident reports from 2/2020-5/2020 revealed incident reports relative to client #6 on: 2/25/20, 3/13/20, 3/20/20, 3/22/20 and 4/2/20. Review of behavioral data related to the behaviors of client #6 revealed data was only available from 1/2020-2/2020. Review of a referral log relative to supporting client #6 with linkage to a new provider revealed various agencies were contacted from 3/12/20-4/13/20 with no ability to locate a new placement for client #6. A review of nursing notes from 12/31/19-5/2020 revealed various reports from staff regarding behaviors of client #6. Continued review of nursing notes revealed a note dated 3/3/20 that indicated the client was taken to the hospital for a psychological assessment due to staff reports of the client hitting, scratching, slapping others, throwing self to the floor and scratching herself (face and arms). Further review of nursing notes revealed 3/5/20 client #6 was discharged from the hospital back to the group home. Subsequent review of nursing notes revealed documented medical interventions for client #6 with psychiatric consults, medication changes and a hospital psychiatric assessment. Interview with the qualified intellectual disabilities professional (QIDP) on 11/10/20 verified client #6 was discharged to her guardian on 5/10/2020. Continued interview with the QIDP revealed he was unsure why self injurious behavior had not	W 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G227	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOWE DRIVE GROUP HOME	628 FLOWE DRIVE CHARLOTTE, NC 28213

(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 201	Continued From page 6 been identified as a target behavior of the behavior plan for client #6. Further interview with the QIDP revealed a team meeting relative to the behaviors of the client had not occurred with the guardian until 3/6/20. Subsequent interview with the QIDP verified he had no documentation relative to the 3/6/20 team meeting. The QIDP additionally revealed behavioral data for client #6 was not available for the 6 month period identified in the discharge notice to evidence client #6 had become more challenging or aggressive. Interview with the QIDP also verified he had no documented ability to have provided any additional provider behavior data for client #6 for the six month period referenced in the discharge notice to support alternative placement.	W 201		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure objectives in the individual habilitation plan (IHP) were implemented as prescribed for 1 of 3 sampled clients (#2) and 1 non-sampled client (#1) relative to behavior management. The findings are:	W 249	QP will facilitate an In-Service with staff on goal implementation, hygiene goals, meal goals for individual that has goal for meal time and how it should be ran. QP will facilitate an In-Service on the importance of individuals being provided choices during dinner time to ensure individuals enjoy there meal.	11/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G227	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOWE DRIVE GROUP HOME	628 FLOWE DRIVE CHARLOTTE, NC 28213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 7 A. The facility failed to ensure training objectives were implemented as prescribed relative to non-compliance and refusal behaviors for client #1. For example: Observations in the group home on 11/9/20 from 5:30 PM to 6:15 PM revealed client #1 to participate in the dinner meal with staff assistance. Dinner observations revealed client #1 to eat slowly and to take breaks between bites. Continued observations revealed staff B to grab client #1's fork and to attempt to feed the client at a faster pace. Client #1 was observed to refuse to eat and to push the staff's hands away and turn her head. Client #1 continued to refuse meal participation as staff B was observed to continue to grab client #1's spoon and attempt to feed her. Subsequent observations revealed staff B to instruct client #1 to put down her fork and to have a drink of juice. Observations revealed client #1 to ignore the staff's instruction and to push the staff's hand. Staff B was observed to place her hand at the bottom of client #1's cup and to push the cup towards the client's mouth to drink her juice. Review of records for client #1 revealed an IHP dated 3/19/20. Continued record review for client #1 revealed a behavior support plan dated (3/15/20) which indicated client #1 should be provided many choices and options so that she feels in control of her environment. Staff should word their requests to client #1 so that she can make decisions, allow her time to communicate her desires, be familiar with her non-verbal expressions and modified manual signs. Review of a daily living skills assessment for client #1 dated 3/18/20 indicated the client can use her spoon to scoop food with independence, drinks	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G227	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOWE DRIVE GROUP HOME	628 FLOWE DRIVE CHARLOTTE, NC 28213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 8 from a cup or glass with independence, drinks without spilling with independence, puts an appropriate amount of food in her mouth with supervision, and eats at an appropriate rate with supervision. Interview with the qualified intellectual disabilities professional (QIDP) on 11/10/20 verified that client #1 has a history of refusal and non-compliance behaviors and will attempt to hit or push staff in retaliation. Continued interview with the QIDP also verified that client #1 eats slowly and gets easily agitated during mealtimes. The QIDP also verified that staff should allow client #1 additional time to make decisions, options, and choices. Staff should also allow client #1 to finish her meals at her own pace. Further interview with the QIDP confirmed that client #1's objectives and interventions are current. The QIDP also confirmed during the interview that staff should follow objectives and interventions for client #1 relative to non-compliance behaviors and improving her level of independence. B. The facility failed to ensure training objectives were implemented as prescribed relative to toileting guidelines for client #2. For example: Observations in the group home on 11/10/20 at 8:25 AM revealed client #2 to transition to the bathroom. Further observations at 8:40 AM revealed staff D to enter the bathroom to offer client #2 assistance with toileting in which the client stated that she was doing fine and assistance wasn't needed. Continued observations at 9:10 AM revealed staff D to return to the bathroom to offer toileting assistance to client #2 in which she stated that she was doing	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G227	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOWE DRIVE GROUP HOME	628 FLOWE DRIVE CHARLOTTE, NC 28213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 9 fine. Subsequent observations at 9:17 AM revealed staff D to return to the bathroom to offer toileting assistance to client #2 in which she declined assistance. Observations revealed client #2 to transition from the bathroom to the next activity and to be in the bathroom a total of 47 minutes. Subsequent observation revealed the bathroom to smell of urine and evidence of urine was observed on the floor in front of the toilet. Review of the record for client #2 revealed an individual habilitation plan (IHP) dated 1/9/20. Continued review of the IHP revealed a daily living skills assessment dated 1/9/20 for client #2 which indicated that client #2 is independent, however, client #2 should thoroughly use the toilet without having accidents on the floor. Further review of the 1/2020 daily living skills assessment revealed client #2 has been known to use the bathroom on the floor before getting fully on the toilet and should not spend more than 20 minutes in the bathroom when toileting. Interview with staff D on 11/10/20 verified that client #2 spends a lot of time in the bathroom. Staff D also verified during the interview that all staff have been trained to allow client #2 extended time to use the bathroom independently. Interview with the qualified intellectual disabilities professional (QIDP) on 11/10/20 verified that client #2 spends a great length of time in the bathroom and can participate in toileting independently. Further interview with the QIDP confirmed that client #2's goals and interventions are current. Subsequent interview with the QIDP confirmed that staff should have followed client #2's bathroom guidelines as prescribed.	W 249	QP would make sure old goals are discontinued. QP entered all goals in Therap for staff to run properly. In-Service on the goal was conducted by QP. QP will monitor how the goal is ran daily by checking on Therap and getting feedback from the individual.	11/24/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G227	A. BUILDING _____ B. WING _____	C 11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOWE DRIVE GROUP HOME	628 FLOWE DRIVE CHARLOTTE, NC 28213

(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 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure the medication keys were not accessible to unauthorized individuals. The finding is: Observations in the group home on 11/10/20 from 6:30 AM to 9:20 AM revealed staff to place the keys to the medication room in a white plastic bowl in the kitchen area. Further observation revealed staff A to pick up the keys from the plastic bowl, open the medication cabinet, and return the keys to the plastic bowl in the kitchen. Subsequent observation revealed that the keys in the plastic bowl allowed clients and/or staff to have access to the medication room without staff supervision. Interview with the facility nurse on 11/10/20 verified that staff responsible for medication administration should keep the keys with them and to ensure that the medication room is secured and locked at all times. Interview with the qualified intellectual disabilities professional (QIDP) verified that all staff are certified to administer medications so there would be no need to lock or secure the medication keys. Further interview with the QIDP confirmed that the medication keys should not be accessible to clients and the medication room should remain locked and secured when not in use for medication administration.	W 383	QP facilitate an In-Service with all staff on making sure medication key must be in the possession of The Lead on shift or designated staff to prevent unauthorized use of the key and ensure that the medication is secured. GHM will check the medication checkout key list weekly to ensure the process is being follow. QP will also check the Medication Checkout list weekly.	11/17/20