STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G307	A. BUILDING _____ B. WING _____	11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERLEA GROUP HOME	5691 MACK LINEBERRY ROAD CLIMAX, NC 27233

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that privacy was provided for 2 of 3 (#1 and #6) sampled clients during medication administration. The findings are: A. The facility failed to assure that privacy was maintained for client #6 while receiving morning medications. For example: Morning observations in the group home on 11/6/20 at 7:40 AM revealed client #6 to be verbally prompted by staff G to the med closet to get his meds. Further oberservation revealed staff G to leave the med closet door open then pour mediccations for client #6 into a med cup. Continued observations revealed another client to stand in the middle of the open med door and to watch staff G prompt client #6 to take his medications followed by a cup of water. At no time was client #6 provided privacy during medication administration. Interview with facility nurse on 11/6/20 confirmed staff had been trained on ensuring the med room door is closed when all clients are receiving medications. The facility nurse further confirmed client #6 should have received privacy during medication administration. B. The facility failed to assure that privacy was maintained for client #1 while receiving morning	W 130	**W130** The facility will ensure the rights of all Clients. Staff will be in serviced on privacy during medication administration. 1/5/21 The nurse will in service all staff on privacy during all medication passes. This will be monitored by program manager weekly, Nursing monthly and QP monthly DHSR - Mental Health Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara Williams — TITLE: Clinical Supervisor — (X6) DATE: 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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W 130	Continued From page 1 medications. For example: Morning observations in the group home on 11/6/20 at 7:55 AM revealed client #1 was verbally prompted by staff G to the med closet to get his meds. Further oberservation revealed staff G to leave the med closet door open then pour medications for client #1 into a med cup. Continued observation revealed other clients and staff to walk by the open door of the medication closet. At no time was client #1 provided privacy during medication administration. Interview with facility nurse on 11/6/20 confirmed staff had been trained on ensuring the med room door was closed when all clients are receiving medications. The Facility nurse further confirmed all clients should have received privacy during medication administration.	W 130		
W 226	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) 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 implement a habilitation treatment plan within 30 days of admission for 1 of 3 sampled clients (#1). The finding is: Review of record for client #1 on 11/6/20 revealed an admission date of 3/6/20 and an ABI (adaptive behavioral inventory) completed on 5/27/20. Continued review revealed training	W 226	**W226** 1/5/21 The facility will ensure for any newly admitted client, an initial team meeting 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 #1 training objectives are in place and the typed IPP document will be filed in the client's record.	

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W 226	Continued From page 2 objectives implemented on 6/1/20 relative to grooming, chores, medication administration and meal preparation. Further review revealed a habilitation treatment plan meeting held on 6/23/20 awaiting to be typed and sent out for signatures. Interview with the qualified intellectual disabilities professional (QIDP) on 11/6/20 confirmed the habilitation treatment plan meeting for client #1 was held on 6/23/20. Further interview with QIDP confirmed the habilitation plan for client #1 needed to be typed and sent out for signatures. The QIDP additionally confirmed client #1's habilitation treatment plan should have been completed within thirty days of the client's admission.	W 226	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.	
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to implement objective training to address identified needs relative to maladaptive behavior for 1 of 3 sampled clients (#1). The finding is: Review of records for client #1 on 11/6/20 revealed an admission date 3/6/20. A treatment habilitation plan meeting held on 6/23/20 indicated: currently collecting data to develop	W 227	**W227** The facility will ensure that specific objectives necessary to meet the client's needs through a comprehensive assessment will be completed. 1/5/21 The Psychologist will complete a behavior plan based off of need and documentation within the first 30 days of admission. The QP will review all cleints records to ensure development of behavior support plan by a psychologist when applicable.	

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W 227	Continued From page 3 behavior support plan. Continued review of records for client #1 revealed a psychological evaluation dated 1/23/20. Review of the psychological evaluation revealed diagnosis to include: A diagnosis of bipolar disorder, unspecified attention deficit/hyperactivity, mild IDD, schizophrenia and other problems related to psychosocial circumstance. Further review of records for client #1 revealed a psychological evaluation dated 6/5/20 that revealed: "the psychological consultant agreed with general findings and recommendations from psychological evaluation completed on 1/23/20. A behavior support plan will be developed for client #1 and baseline behavior data collection will be used to identify behaviors of concern in this setting. Behavior Support Plan will be developed and monitored by this psychologist". Further review of records for client #1 revealed a quarterly medication review dated 7/31/20 that reflected a need to develop a behavior plan, continue present regime and drug change considered by prescribing physician. A review of incident reports since client #1's admission on 3/6/20 revealed three hospitalizations for suicidal ideation on 4/14/20, 10/3/20, and 10/30/20. Behavior data reviewed for 9/2020 and 10/2020 revealed several behavioral incidents of client #1 relative to maladaptive behaviors relative to biting holes in his shirt, chewing on his shirt, mocking others and suicidal threats. Interview with the qualified intellectual disabilities professional (QIDP) on 11/6/20 revealed client #1 had no current training objectives relative to maladaptive behaviors. Further interview with the QIDP revealed behaviors were not accurately	W 227		

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W 227	Continued From page 4 documented in 6/20, 7/20, and 8/20 nor forwarded to the psychologist for review to initiate the development of a behavior plan. The QIDP further verified behavior data for 9/2020 and 10/2020 had not been forwarded to the psychologist and a behavioral support plan was currently being developed.	W 227		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the system for drug administration failed to assure 2 of 3 clients (#1 and #6) observed during medication administration were provided the opportunity to participate in medication self-administration. The findings are: A. The system for drug administration failed to assure client #6 was provided the opportunity to participate in medication self-administration. For example: Observations conducted on 11/6/20 at 7:40 AM revealed client #6 to enter the medication administration area and receive medications as ordered per the current administration record.	W 371	**W371** The facility will ensure that the system for drug administration is followed to assure that clients are taught to administer their won medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective and if the physician does not specify otherwise. The habilitation specialist will develop a goal for individual based on their ability to assist in administering medications. The habilitation specialist will in-service staff on the goals steps. The nurse will in service staff on the appropriate way to follow goal as outlined and ensure staff is adhering to medication administration guidelines. This will be monitored weekly by manager and habilitation specialist, monthly by Nurse and QP	1/5/21

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W 371	Continued From page 5 Continued observation conducted during the medication administration for client #6 revealed staff G to retrieve client #6's medications from a closet, tear open pre-packed medications and transfer the medications to a medication cup. Staff G was then observed to hand medications to client #6 in the medication cup. Client #6 was observed to take all medications followed by water in a cup that was poured by staff. Review of records for client #6 on 11/6/20 revealed training objectives implemented 6/1/20 to include client #6 is to identify medications. Interview with the facility nurse on 11/6/20 verified client #6 should have been offered and encouraged to participate during medication administration with staff assistance. B. The system for drug administration failed to assure client #1 was provided the opportunity to participate in medication self-administration. For example: Observation conducted on 10/7/20 at 7:55 AM revealed client #1 to enter the medication administration area and receive medications relative to the client's morning medication orders. Continued observation conducted during the medication administration for client #1 revealed staff G to retrieve client #1's medications from a closet, tear open pre-packed medications and transfer medications to a medication cup. Staff G was then observed to hand medications to client #1 in the medication cup. Client #1 was observed to take all medications followed by water in a cup that was poured by staff. Review of records for client #1 on 11/6/20 revealed training objectives implemented 6/1/20 relative to medication administration to include client #1 is to identify	W 371		

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W 371	Continued From page 6 medications. Interview with the facility nurse on 11/6/20 verified client #1 should have been offered and encouraged to participate during medication administration with staff assistance.	W 371		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

November 17, 2020

Melissa Bryant Facility Administrator
Community Innovations
80 Alliance Drive
Whiteville, NC 28472

Re: Recertification Completed November 6, 2020
Timberlea Group Home 5691 Mack Lineberry Road Climax, NC 27233
Provider Number 34G307
MHL# 076-023
E-mail Address: mbryant@communityinnovations.com

Dear Ms. Bryant:

Thank you for the cooperation and courtesy extended during the recertification survey completed November 6, 2020. This survey was required for continued participation in the Medicaid program.

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 Jan 5, 2021.

1. **What to include in the Plan of Correction**
2. 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.).
3. Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
4. Indicate ***who will monitor*** the situation to ensure it will not occur again.
5. 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

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call me at (828) 750-2702.

Sincerely,

Shyluer Holder-Hansen
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc:

DHSRreports@eastpointe.net
_DHSR_Letters@sandhillscenter.org