| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G350 | A. BUILDING _____ B. WING _____ | 02/05/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CAROLINA FARMS GROUP HOME #3 | 31713 HERB FARM CIRCLE ALBEMARLE, NC 28001 |

| (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 104 | GOVERNING BODY<br>CFR(s): 483.410(a)(1)<br><br>The governing body must exercise general policy, budget, and operating direction over the facility.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to ensure environmental cleanliness. The finding is:<br><br>Observations in the group home on 2/4/21 revealed dining chairs at the dining table to have dried food debris on the frames of all chairs before and after the dinner meal. Continued observation on 2/4/21 revealed the lid of the kitchen trashcan to hang on a wall outside the kitchen throughout the evening observation period and to have food debris and dried meal spillage visible on the lid. Subsequent observation revealed the kitchen trashcan to have dried spillage. Observation of the wall behind the kitchen trashcan revealed a plexiglass covering that also had food debris and dried spillage.<br><br>Observation in the group home on 2/5/21 from 7:15 AM until 8:30 AM revealed observations consistent with observations on 2/4/21 relative to the condition of dining chairs, the lid to the kitchen trashcan hanging on the wall and the condition of the kitchen trashcan and wall behind the trashcan. Additional observation on 2/5/21 revealed a plexiglass cover on the wall under the bar of the kitchen that was covered in debris and various marks of dirt. | W 104 | W104<br><br>The staff will be trained to ensure environmental cleanliness of the individual home. Staff will be trained to ensure areas of the home are clean to include the dining areas/kitchen. All dining and kitchen areas should be thoroughly cleaned after each used as part of the inservice with staff. Chief Regulatory Officer will train the manager/QP on the expectations of the cleanliness of the home. The team will monitor by conducting assessments weekly for 1 month. If areas are noted not clean during the completion of the assessment the manager and/ or QP will document inservicing staff of areas noted on the assessment of concern with a training sheet. Ongoing monitoring will occur by the team to ensure the home environment is clean.<br><br>DHSR - Mental Health<br>Lic. & Cert. Section | 4/5/2021 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Chief Regulatory Officer — (X6) DATE: 2/19/2021

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 104 | Continued From page 1<br>Interview with the home manager (HM) on 2/5/21 revealed the kitchen trashcan lid was hung on the wall to prevent residents of the home from touching the lid as trash was placed in the trash can. Continued interview with the HM verified, with observation, the lid of the trashcan was not clean and the kitchen trashcan also was not clean.<br><br>Interview with the facility qualified intellectual disabilities professional (QIDP) verified the dining chairs of the facility should be cleaned after each meal and dining chairs were not clean with dried debris and spillage. Continued interview with the QIDP verified the plexiglass wall covering under the kitchen bar and behind the kitchen trashcan was not clean and needed to be wiped down by staff. | W 104 | | |
| W 227 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(4)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, review of records and interview the individual support plan (ISP) failed to have sufficient training objectives or interventions relative to dining behavior for 1 of 3 sampled clients (#5). The finding is:<br><br>Observation in the group home on 2/4/21 at 5:43 PM revealed client #5 to sit in a dining chair and participate in the dinner meal. Continued | W 227 | | |

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| W 227 | Continued From page 2<br>observation revealed client #5 to utilize his hands to touch items on his dinner plate and to finger foods then place various bites of food in his mouth using his fingers. Subsequent observation of client #5 during the dinner meal revealed client #5 to spit multiple bites of food out onto the floor after placing food in his mouth. Additional observation revealed staff to visually monitor client #5 throughout the dinner meal with no verbal redirection regarding the use of fingers to eat or spitting food into the floor.<br><br>Observation in the group home on 2/5/21 at 8:05 AM revealed client #5 to participate in the breakfast meal. Continued observation revealed client #5 to utilize his hands at various times to touch items on his breakfast plate and to place food in his mouth that he intermittently spit in the floor. Additional observation revealed staff to monitor client #5 during the breakfast meal with no redirection or prompting relative to spitting food in the floor.<br><br>Interview with the facility qualified intellectual disabilities professional (QIDP) verified client #5 at times spits food in the floor and has no programming or training objective to address the behavior. Continued interview with the QIDP revealed it is not known why client #5 spits food in the floor during meals and indicated the action might be due to a possible sensory reaction of client #5 to various foods. Further interview with the QIDP verified client #5 could benefit from a program to address spitting food into the floor during meals. | W 227 | W227<br><br>4-5-2021<br><br>The team will meet, to include the dietician, to establish a mealtime recommendations/plan for Client #5. The team will follow up with the dietician a plan to address eating with his fingers and spitting food on the floor. Staff will be inserviced on the plan developed by the team to assist Client #5 in the area of dining. The QP will monitor by conducting mealtime assessment on any plan/ recommendations from dietary/team for Client #5.<br><br>The QP will review all individuals who have programs in the area of dining and make changes as warranted and document in Q note. During observations conducted by the team, if other dining issues are noted for any individual a plan will be developed as warranted. The Chief Regulatory Officer will inserviced QP/Manager and/or other team members to complete a Mealtime Assessment during all dining opportunities. Monitoring will occur by mealtime assessments completed weekly by the team for 2 months or until the issue is resolved. | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1) | W 249 | | |

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| W 249 | Continued From page 3<br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to ensure 1 of 3 sampled clients (#5) received a continuous active treatment program consisting of needed interventions as identified in the individual support plan (ISP) relative to dining. The findings are:<br><br>A. The team failed to ensure a program objective relative to utensil use at meals was implemented in sufficient frequency to support the need of client #5. The finding is:<br><br>Observation in the group home on 2/4/21 at 5:43 PM revealed client #5 to sit in a dining chair and participate in the dinner meal. Continued observation revealed client #5 to utilize his hands at various times to touch items on his dinner plate and to finger foods then place various bites of food in his mouth using his fingers. Additional observation revealed staff to visually monitor client #5 throughout the dinner meal with no verbal redirection regarding the use of fingers to eat.<br><br>Observation in the group home on 2/5/21 at 8:05 AM revealed client #5 to participate in the breakfast meal. Continued observation revealed | W 249 | W249<br><br>The team will meet to discuss current training programs in place for Client #5 in the area of dining to include use of utensils and family style dining. The team will consult with the dietician on recommendations to support Client #5 in the area of dining. Staff will be trained on the plan developed by the team to assist Client #5 in the area of dining. The QP will monitor by conducting mealtime assessment on implementation of any recommendations from dietary/team in the area of program implementation for Client #5.<br><br>more on next page | 4-5-2021 |

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| W 249 | Continued From page 4<br>client #5 to utilize his hands at various times to touch items on his breakfast plate and to place food in his mouth. Additional observation revealed staff to monitor client #5 during the breakfast meal with no redirection or prompting relative to the use of utensils.<br><br>Review of records for client #5 on 2/5/21 revealed a individual support plan (ISP) dated 10/10/20. Review of the 10/2020 ISP revealed a training objective implemented 4/30/20 that client #5 will use his utensils while eating with 4 or less prompts for 6 consecutive months. A review of the training method relative to the training objective to address utensil use at meals revealed staff will prompt client #5 as required to use his utensils while eating.<br><br>Interview with the qualified intellectual disabilities professional (QIDP) verified client #5's program objective for utensil use at meals is a current training objective. Continued interview with the QIDP verified client #5's program for utensil use should have been implemented as written with verbal redirection from staff when the client used his hands to eat.<br><br>B. The team failed to ensure a program objective relative to participation in family style dining at meals was implemented in sufficient frequency to support the need of client #5. The finding is:<br><br>Observation in the group home on 2/5/21 at 8:05 AM revealed client #5 to participate in the breakfast meal. Continued observation during the meal revealed client #5 to get out of his dining chair, to sit on the floor near staff and drink a cup of juice. Further observation revealed staff to ask client #5 "Would you like to go back to the table | W 249 | The QP will review all individuals who have programs in the area of family style dining and/or any specific identified areas the individuals need to work on across the board and make changes as warranted. This will be documented in Q note.<br>During observations conducted by the team, if other dining issues noted for any individual a plan will be developed as warranted.<br>The Chief Regulatory Officer will inservice QP/Manager and/or other team members to complete a Mealtime Assessment during all dining opportunities.<br>Monitoring will occur by the team conducting mealtime assessments weekly by the team for 2 months or until the issue is resolved. | 4-5-2021 |

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| W 249 | Continued From page 5<br>with your juice?" to which the client refused. Subsequent observation revealed client #5 to remain in the floor and to ambulate near his dining room chair with no further redirection from staff to return to his dining chair. Additional observation revealed client #5 to return to his room and leave his breakfast dishes on the table that staff took to the kitchen.<br><br>Review of records for client #5 on 2/5/21 revealed a individual support plan (ISP) dated 10/10/20. Review of the 10/2020 ISP revealed a training objective implemented 4/30/20 that client #5 will participate in family style dining with assistance from staff as needed with 5 or less prompts for 6 consecutive months. A review of the training method relative to the family style meal participation objective revealed when prompted client #5 will sit at the table. Continued review of the training method for client #5's family style meal participation objective revealed the client will remain in his chair while eating; if client #5 gets up to leave the table before he is finished eating staff will prompt the client to return to the table to finish.<br><br>Interview with the QIDP verified client #5's program objective for participation in family style dining is a current training objective. Continued interview with the QIDP verified client #5's program for family style meal participation should have been implemented as written with verbal redirection from staff, in the frequency indicated in the objective to address client #5 with returning to the table to finish his meal. | W 249 | | |

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

February 17, 2021

Melissa Rivera
GHA Autism Supports
PO Box 2487
Albemarle, NC 28001

Re: Recertification Completed February 5, 2021
Carolina Farms Group Home #3
Provider Number #34G350
MHL# 084-061
E-mail Address: MelissaRivera@ghainc.org

Dear Ms. Rivera:

Thank you for the cooperation and courtesy extended during the recertification survey completed February 5, 2021. 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 April 5, 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

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) 750-2664.

Sincerely,

Kaila Mitchell, MSW
Facility Compliance Consultant II
Mental Health Licensure & Certification Section

Enclosures

Cc: qmemail@cardinalinnovations.org
DHSR@Alliancebhc.org
dhhs@vayahealth.com
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO