STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G308	A. BUILDING _____ B. WING _____	03/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHCROFT	3046 HEATHCROFT COURT CHARLOTTE, NC 28269

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W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on facility record/document review and interviews, the facility failed to ensure an injury and investigation relative possible abuse and/or neglect was reported to external officials in accordance with state law for 1 of 1 investigation reviewed. The finding is: Review of facility investigations on 3/3/21 revealed an investigation started on 1/12/21 and ending on 2/1/21. The original scope of the investigation was to rule out abuse and/or neglect. Continued review of the facility investigation revealed on 1/12/21 client #2 was observed by staff A sitting on the living room floor. Subsequent review of the 1/12/21 investigation revealed client #2 was reported to state to staff A "leg hurt" and was unable to stand. Staff A was documented to then call 911 and client #2 was transported to the local hospital for evaluation. Further review of the internal investigation revealed x-rays at the hospital indicated client #2 had a right hip fracture. The facility nurse, program manager, executive director and client #2's guardian were documented to have been notified 1/12/21. Continued review of notifications revealed the department of social services was notified	W 153		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 153	Continued From page 1 1/13/21. Further investigation review revealed no evidence of a Incident Response Improvement System (IRIS) report. A review of the conclusion from the 1/12/21 investigation revealed an unsubstantiated finding of abuse and/or neglect. Continued review of the conclusion revealed after a review of the evidence and factual findings it is plausible that client #2 fell while walking to the living room, however no one witnessed the fall. Client #2 did say "fall down, hurt leg" to the investigator. Further review of the investigation conclusion revealed staff A followed protocol and obtained medical treatment timely. Interview with the facility program manager (PM) on 3/3/21 verified an unsubstantiated finding of abuse and/or neglect with the 1/12/21 internal investigation. Continued interview with the facility PM revealed an IRIS report had not been completed with client #2's incident on 1/12/21 and a report should have been completed.	W 153		
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 observation, review of records and interview, the individual service plan (ISP) failed to have sufficient training objectives to meet identified client needs for 2 of 3 sampled clients	W 227		

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W 227	Continued From page 2	W 227		

(#2 and #5). The findings are:

Observation at the group home on 3/2/21 at 5:55 PM revealed all residents of the group home to begin loading the facility van for a community outing. Continued observation revealed client #5 to sit in the front passenger seat and to utilize the seat belt, buckling the lap belt and placing the shoulder strap behind her back. Further observation revealed client #2 to sit in the back seat of the facility van and to utilize the seat belt, buckling the lap belt and placing the shoulder strap behind her back.

Review of records for client #5 on 3/3/21 revealed an ISP dated 2/3/20. Continued review of the 2/2020 ISP revealed current training objectives relative to oral hygiene, laundry, use of deodorant, household task, napkin use at meals and exercise. Further review of records for client #5 revealed a behavior support plan (BSP) dated 2/2/21. Review of the 2/2021 BSP revealed target behaviors of non-compliance and self-injurious behavior.

Review of records for client #2 on 3/3/21 revealed revealed an ISP dated 10/6/20. Continued review of the 10/2020 ISP revealed current training objectives relative to communication, household task completion, meal preparation and money management. Further review of records for client #2 revealed a behavior support plan (BSP) dated 10/6/20. Review of the 10/2020 BSP revealed target behaviors of client #2 of: physical aggression, disruptive behavior and non-compliance.

Interview with staff on 3/2/21 revealed client's #2 and #5 refuse to wear the shoulder strap of their

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W 227	Continued From page 3 seatbelt. Continued interview with staff revealed to her knowledge, client's #2 and #5 have always refused to wear their shoulder strap during transport. Interview with the facility qualified intellectual disabilities professional (QIDP) and home manager (HM) on 3/2/21 revealed they were unaware of the refusal of client's #2 and #5 to wear their seat belt correctly with utilizing the shoulder strap. Continued interview with the facility QIDP on 3/3/21 verified client #2 or #5 did not have current programming to address proper wear of their seat belt during transport. The QIDP further revealed he was unaware of any past programming of either client (#2 or #5) relative to proper seat belt use. Subsequent interview with the QIDP confirmed the identified need of supporting both client #2 and #5 with proper wear of their seatbelt was needed.	W 227		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure all drugs were administered without error for 1 of 3 sampled clients (#4) and 1 non-sampled client (#3). The findings are: Observation in the group on 3/3/21 at 7:00 AM revealed all clients in the group home to be up, dressed and engaged in various activities in the	W 369		

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group home. Observation at 7:05 AM revealed client #5 to enter and participate in her morning medication administration. Continued observation of client #5 revealed the client to exit the medication administration area at 7:16 AM.

Observation at 7:19 AM revealed client #6 to enter the medication administration area of the group home and participate in the morning medication pass, exiting the medication administration area at 7:28 AM. Further observation revealed staff to lock up the medication administration area and inform the surveyor all medication had been administered for the morning.

A review of physician orders on 3/3/21 for clients #3 and #4 revealed multiple medications ordered at 8:00 AM. A review of the facility's internal medication administration record (MAR) for 3/3/21 revealed medication for client #3 ordered at 8:00 AM included Fluticasone Propionate 50mcg. Continued review of the internal MAR for 3/3/21 revealed client #3 was administered Fluticasone Propionate 50mcg on 3/3/21 at 6:54 AM.

Further review of the internal facility MAR for 3/3/21 revealed medications ordered at 8:00 AM for client #4 included: Culturelle capsule, Fluticasone spray 50mcg, GNP gas relied chew 125mg, GNP Vitamin D3 1000iu, Lorazepam 1mg, L-Theanine 100mg, Nystatin 50000, One-A-Day Womens Tablet, Super B-Comp Tablet, Tri-Lo- Tab Sprintec and Vitamin C 500mg. Subsequent review of the MAR for 3/3/21 revealed client #4's medications ordered for 8:00 AM were administered at 6:31 AM.

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W 369	Continued From page 5 Interview with the facility nurse on 3/3/21 revealed medication can be given up to one hour before and one hour after the time they are ordered. Continued interview with the facility nurse verified medication ordered for 8:00 AM should not be given out before 7:00 AM. Subsequent interview with the facility nurse verified all medications ordered at 8:00 AM and administered before 7:00 AM on 3/3/21 were considered a medication error.	W 369		