STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G037	A. BUILDING _____ B. WING _____	01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALLARD LANE CENTER	142 MALLARD LANE ROCKINGHAM, NC 28379

(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	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 reviews and interviews, the facility failed to ensure 1 of 3 audit clients (#1) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plans (IPP) in the area of dining. The findings are: 1. During breakfast observations in the home on 1/20/21 at 7:15am, client #1 did not have a non-slip mat under his plate while he ate. At no time did staff provide client #1 with the non-slip mat. Further observations revealed a staff person using their hand to keep the plate from sliding when they assisted client #1 with scooping his food. Review on 1/19/21 of client #1's IPP dated 4/24/20 revealed, "[Client #1] uses...non-slip mat..." 2. During breakfast observations in the home on 1/20/21 at 7:15am, client #1 did not have his mini pitcher at his place setting. Further observations revealed staff bringing the jug of milk to the table	W 249	Program Implementation CFR(s): 483.440(d)(1) 1. By March 21,2021 all staff will Be re-inserviced on all person's Supported Adaptive equipment Needs and when the adaptive Equipment should be used. 2. Residential Team Leader or Designee will complete Bi-weekly meal observations To ensure all adaptive equipment is being used during All meals for any person supported that requires it. Responsible person: Residential Team Leader or designee Target Date: March 21,2021 DHSR - Mental Health FEB 11 2021 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Beth Tyler, RTL, QP, mPA	Residential Team Leader	1-28-21

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 249	Continued From page 1 and assisting him with pouring. At no time was client #1 provided with his mini pitcher. Review on 1/19/21 of client #1's IPP dated 4/24/20 revealed, "[Client #1] uses...a mini pitcher to pour his liquids from into his cup ..." During an interview on 1/20/21, the qualified intellectual disabilities professional (QIDP) confirmed client #1 should have had both his non-slip mat and his mini pitcher. Further interview revealed the non-slip mat is used to keep client #1's plate from sliding and the mini pitcher is used to assist him to be more independent with pouring.	W 249		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the nursing services failed to ensure that staff were sufficiently trained in taking the temperature and asking required questions in regards to COVID-19 protocol. This potentially effected all the clients in the home. The finding is: During an observation in the home on 1/19/21 at 10:15am, the surveyor entered the home. Further observations revealed the facilty nurse answered the door and let the surveyor into the	W 340	Nursing Services CFR(s): 483.460(c)(5)(i) 1. By March 21,2021 all staff will be re-inserviced on Monarch's Covid-19 Pandemic plan, specifically, screening all visitors essential workers, staff and the people we support. 2. Residential Team Leader or designee will collect screenings of visitors and essential workers and file in Covid 19 Screening notebook on site. Responsible person: Residential Team Leader or designee Target Date: March 21,2021	

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W 340	Continued From page 2 house. At no time did the nurse take the temperature or ask questions of the surveyor regarding COVID-19 protocol. Review on 1/20/21 of the facilty's COVID-19 Pandemic Preparedness Plan dated 5/13/20 revealed, "Any essential vendors entering residential facilities will be screened for COVID-19 risk level utilizing the tool prior to being granted entry." During an interview on 1/19/21, Staff C revealed anyone entering the home, including the surveyor should have their temperature taken and questions asked regarding the COVID-19 protocol. During an interview on 1/20/21, the facility's nurse confirmed she should have taken the temperature and asked questions of the surveyor, prior to having the surveyor enter the home.	W 340		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications remained locked. The finding is: During observations in the home on 1/19/21 at 7:53pm, Staff A walked out of client #1's bedroom to get him something to drink, so he could consume his medications. Further observations	W 382	Drug Storage and Record Keeping CFR(s): 483.460(l)(2) 1. By March 21,2021 all staff will be re-inserviced on Monarch's Medication Administration policy 2. Residential Team Leader or designee will complete bi-weekly medication administration observations to ensure all medications are kept secured and supervised during all medication administration.	

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W 382	Continued From page 3 revealed a bottle of Miralax was left on the top of the medication cart, while the surveyor and client #1 remained in his bedroom. During an interview on 1/19/21, Staff A confirmed she had been trained to ensure all medications are kept locked when not being administered. Review on 1/20/21 of the facility's medication policy dated 11/22/20 stated, "staff shall ensure that the medication area is secure before leaving the area." During an interview on 1/20/21, the facilty's confirmed staff have been trained to ensure all medications are kept locked when not in use.	W 382		
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 and #4 diets were provided as prescribed. This affected 2 of 3 clients. The findings are: A. During breakfast observations in the home on 1/20/21 at 7:35am, client #1 consumed one glass of regular milk. Further observations revealed client #1 began coughing fifteen times. Additional observations revealed client #1 consumed a second glass of milk and coughed an additional ten times. Further observations revealed Staff A person sitting next to him, who made no	W 460	Food and Nutrition Services CFR(s): 483.480(a)(1) 1. By March 21,2021 all staff will be re-inserviced on all people supported diet orders 2. Residential Team Leader or designee will complete bi-weekly meal observations to ensure all diet orders are being followed. Responsible person: Residential Team Leader or designee Target Date: March 21,2021	

	Responsible person: Residential Team Leader or designee Target Date: March 21,2021	

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

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W 460	Continued From page 4 modifications to his milk. During an interview on 1/20/21, Staff A revealed client #1 should have had thickener added to his milk. During an interview on 1/20/21, Staff B revealed client #1 should have had thickener added to his milk. Review on 1/19/21 of client #1's individual program plan (IPP) dated 4/24/20 revealed, "...nectar thick liquids... " Review on 1/20/21 of diet order sheet dated 8/20/19 revealed, "nectar thick liquids only ..." During an interview on 1/20/21, the facility's nurse confirmed client #1 milk should have had thickener added to it. Further interview revealed if thickener is not added client #1 will cough excessively, due to the fact he has been diagnosed with dysphasia. B. During breakfast observations in the home on 1/20/21 at 8:02am, client #4 consumed one round turkey sausage in three bites. The only utensil at client #4's place setting was a spoon. At no time was client #4 prompted to cut his turkey sausage. Review on 1/20/21 of client #4's IPP dated 2/28/20 revealed, "[Client #4's] foods be cut into bite size." During an interview on 1/20/21, the qualified intellectual disabilities professional (QIDP) stated client #4's food should be bite size, because he at times will eat in a fast pace.	W 460		