STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G236	A. BUILDING _____ B. WING _____	03/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINE VALLEY HOME	1519 ROBERT E LEE DRIVE WILMINGTON, NC 28412

(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 recertification survey and complaint survey was completed on March 24, 2021 for Intake #NC00175479. No deficiencies were cited for the complaint. However, deficiencies were cited as a result of the recertification survey.	W 000		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all staff were sufficiently trained to perform their duties efficiently. This affected all the clients residing in the home (#1, #2, #3, #4, #5 and #6). The findings are: A. During observations in the home on 3/23/21 from 3:15pm to 6:45pm, Staff E and Staff F were observed to repeatedly use their personal cell phones to text and/or make and receive phone calls in the presence of clients during leisure time, objective training and dining. Review on 3/24/21 of the facility's policy, Cell Phone Usage (dated 2/10/21) revealed "There should be no personal cell usage on the floor from 6am - 9pm...Use your personal cell phones on your break...If it's an emergency, please step outside to make/take your calls." Interview on 3/24/21 with Staff C revealed staff	W 189		

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

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W 189	Continued From page 1 are not supposed to have their cell phone out in the presence of clients. Staff C reported that staff are to use their phones on their breaks or in their cars, but never while working with clients. Interview on 3/24/21 with the facility's Quality Assurance/Quality Improvement (QA/QI) Coordinator revealed staff are not to use their personal cell phones on the floor and in the presence of clients. If there is a emergency, staff should go to the office or to their cars. Interview on 3/24/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should follow the facility's policy on cell phone use, and should not be on their personal phones while in the presence of clients. B. Upon arrival to the facility on 3/24/21 at 3:15pm, Staff F was observed standing on the front porch of the home, smoking a cigarette. During observations in the home on 3/24/21, Staff E and Staff F were observed standing outside on the back patio and standing at the swing in the backyard smoking a cigarette. During the observations, clients were in the presence of Staff E and Staff F while they were smoking. Review on 3/24/21 of the facility's policy, Smoking (dated 6/16/7 and updated 10/7/20) revealed "There is no smoking, e-cigarettes or smokeless tobacco use near doors of any of the facility's buildings...Staff should be at least 10 feet from a door of the facility's building while using these products...Staff should not be observing participants served from a distance while smoking."	W 189		

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W 189	Continued From page 2 Interview on 3/24/21 with Staff B revealed that although she does not smoke, she knows that staff are not supposed to smoke in the presence of the clients. Interview on 3/24/21 with the facility's QA/QI Coordinator revealed staff should not smoke near the door of the home, and should not be smoking in the presence of the clients. Interview on 3/24/21 with the QIDP revealed staff should follow the facility's policy, and should not be smoking near the home, within 10 feet of the door, and should not smoke in the presence of the clients.	W 189		
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 5 of 6 audit clients (#2, #3, #4, #5 and #6) received a continuous active treatment program consisting of needed interventions and services in the areas of behavior intervention program implementation, use of communication board, and use of adaptive equipment. The findings are:	W 249		

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W 249	Continued From page 3 A. During observations in the home on 3/23/21 from 10:55am to 12:05pm, client #3 was observed to make verbal threats of physical aggression towards the surveyor by stating "I'm going to hit him" or "Is it okay to hit him." During these observations, staff were observed to ignore the behavior and only redirected client #3 to go outside and swing. Additional observations in the home on 3/23/21 from 3:15pm to 6:45pm revealed client #3 making verbal threats to physically harm one of her peers by hitting him or throwing objects at him. During these observations, staff were observed to ignore client #3's threats to harm her peer. Review on 3/23/21 of client #3's Individual Program Plan (IPP) dated 3/17/20 revealed a training objective for client #3 to "display two or less noncompliant episodes per month." Additional review on 3/24/21 of client #3's IPP revealed a Behavior Intervention Program (BIP) dated 2/23/21 which identifies a target behavior of task avoidance. Review of the BIP defines task avoidance as "refusing to participate in any activity that is considered an essential part of her day and IPP objectives. Task avoidance also includes episodes of verbal aggression or cursing." Continued review of the BIP revealed procedures to task avoidance, which includes: - Use verbal/gestural cues to direct client #3 to scheduled task, activity, etc. - If task avoidance escalates into verbal aggression, client #3 should be separated from her peers to an area for exclusionary time away with verbal and physical prompts. Continue use of relaxation room until calm.	W 249		

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W 249	Continued From page 4 - Upon termination of relaxation room, use verbal and physical prompts to direct client #3 back to the original task or a new task. - Repeat procedures until client #3 is involved in the activity. Interview on 3/24/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff should have followed the BIP strategies and not ignored client #3's behaviors. B. During observations in the home on 3/23/21 through 3/24/21, staff were observed to give client #4 an item or activity during leisure times to participate in. Review on 3/23/21 of client #4's IPP dated 8/7/20 revealed an objective for staff to use a visual choice board with two pictures when providing choices to client #4 to ensure her opportunity for independence, to be trained four times a week on first and second shifts. Further review of client #4's objective revealed strategies that consist of: - Staff using a board with two choices to assist client #4 in making her choices known. - Activities will be activities she enjoys participating in. - Visual choice board should be provided during leisure time. Interview on 3/24/21 with the QIDP confirmed that staff should have been giving client #4 choices during her leisure time with the use of the visual choice board. C. During observations in the home on 3/23/21 at 11:19am, the client's were observed eating lunch. Lunch consisted of a sandwich, chips, and a fruit cup or cup of pudding. Each client was observed	W 249		

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W 249	Continued From page 5 to eat lunch with a white plastic spoon. Additional observations in the home on 3/23/21 at 3:41pm revealed the clients having a snack. The snack consisted of a fruit cup, cup of pudding or cup of applesauce. Each client was observed to eat their snack with a white plastic spoon. 1. Review on 3/23/21 of client #4's IPP dated 8/7/20 revealed client #4 uses adaptive equipment while dining which consists of a small maroon spoon "to help take small bites and slow rate of eating." Review on 3/24/21 of client #4's record revealed physician's orders dated 1/1/21 which states "use of small maroon spoon at all meals." 2. Review on 3/24/21 of client #5's IPP dated 6/30/20 revealed client #5 uses adaptive equipment which consists of a large maroon spoon when eating. Review on 3/24/21 of client #5's record revealed physician's orders dated 1/1/21 which states "use large maroon spoon for all meals." 3. Review on 3/24/21 of client #6's IPP dated 10/22/19 revealed client #6 uses adaptive equipment which consists of a maroon spoon when eating. Review of 3/24/21 of client #6's record revealed physician's orders dated 1/1/21 which states "use large maroon spoon for all meals." Interview on 3/24/21 with the QIDP and Home Manager (HM) confirmed that clients #4, #5 and #6 should always use their maroon spoon while	W 249		

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W 249	Continued From page 6 eating, unless it is finger foods such as chips. D. During observations in the home on 3/23/21 at 11:19am revealed the clients eating lunch. Staff B was observed to use a rocker knife to cut up client #3 and client #5's food. Client #3 and client #5 were prompted to assist with cutting their food. 1. Review on 3/23/21 of client #3's IPP dated 11/13/18 revealed client #3 should be encouraged to use a rocker knife to increase her mealtime independence. Review on 3/24/21 of client #4's Habilitation Evaluation dated 11/19/20 revealed client #3 cuts her food with a rocker knife with gestures or modeling. 2. Review on 3/24/21 of client #5's IPP dated 6/30/20 revealed client #5 should be encouraged to use a rocker knife to increase his mealtime independence. Review on 3/24/21 of client #5's Habilitation Evaluation dated 5/1/20 - 5/10/20 revealed client #3 cuts his food with a rocker knife with gestures or modeling. Interview on 3/24/21 with the QIDP and HM confirmed client #3 and client #5 should have been prompted to participate in cutting their food with the rocker knife, and staff should have used hand-over-hand assistance if needed.	W 249		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the	W 260		

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W 260	Continued From page 7 process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to update the individual program plans (IPP's) annually for 2 of 6 audit clients (#2 and #6). The findings are: A. Review on 3/21/21 of client #3's record revealed an IPP dated 11/13/18. Additional review of client #3's record revealed no updated IPP since 11/13/18. Interview on 3/23/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the facility had difficulty contacting client #3's legal guardian, and during the process, a new legal guardian was obtained. The QIDP revealed that client #3's IPP meeting was held in 12/20, but due to COVID, the updated IPP was not written. B. Review on 3/24/21 of client #6's record revealed an IPP dated 10/22/19. Additional review of client #6's record revealed no updated IPP since 10/22/19. Interview on 3/24/21 with the QIDP revealed revealed that client #6's IPP meeting was held on 11/5/20, but due to COVID, the updated IPP was not written.	W 260		
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	W 340		

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W 340	Continued From page 8 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 interviews, the facility failed to ensure all staff were sufficiently trained to implement the facility's current COVID-19 visitor screening process and to appropriately use a digital thermometer. The finding is: Upon arrival to the facility's office on 3/23/21, the surveyor was asked to take his temperature and sign in. The sign in sheet revealed a section which states "Did you answer yes or no to question #4 and #5." No questions were available for the surveyor to review and answer. Upon arrival to the home on 3/23/21 at 10:55am, the surveyor was not screened nor was his temperature taken. Upon arrival to the home on 3/23/21 at 3:15pm, the surveyor was not screened nor was his temperature taken. Upon arrival to the home on 3/24/21 at 6:15am, the surveyors temperature was taken by Staff G, but the surveyor was not screened. Upon arrival to the facility's office on 3/24/21 at 8:45am, the surveyor was asked to take his temperature and sign in. The sign in sheet revealed a section which states "Did you answer yes or no to question #4 and #5." No questions were available for the surveyor to review and answer.	W 340		

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W 340	Continued From page 9 Review on 3/24/21 of the facility's Emergency Plan Procedure for COVID-19 revised 3/1/21 revealed "All staff/visitors will be screened for fever and other COVID-19 symptoms upon entering any of the facility's offices or homes." Interview on 3/24/21 with the facility's Quality Assurance/Quality Improvement (QA/QI) Coordinator revealed that each time the surveyor entered the home or office, his temperature should have been taken and a screening of COVID-19 symptoms should have been asked. The QA/QI Coordinator revealed the questions should have been available for the surveyor to review and answer. Interview on 3/24/21 with the Qualified Intellectual Disabilities Professional (QIDP) and facility Nurse confirmed the surveyor's temperature should have been taken and screening for COVID-19 symptoms should have been completed. B. During observations in the home on 3/23/21 from 3:15pm to 6:45pm, staff were consistently observed to wear their face masks below their nose, mouth and chin during times of leisure activities, objective training and dining. Review on 3/24/21 of the facility's Emergency Plan Procedure for COVID-19 revised 3/1/21 revealed the facility follows guidelines that masks are required when in any common areas including hallways. Interview on 3/24/21 with Staff C revealed staff are to wear masks for their entire working shift, and masks should be worn to cover the nose, mouth and chin.	W 340		

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W 340	Continued From page 10 Interview on 3/24/21 with the facility Nurse revealed she and the QA/QI Coordinator are responsible for training staff on wearing Personal Protective Equipment (PPE), including masks. The facility Nurse revealed staff are trained to wear their face masks to ensure it covers their nose and mouth. Continued interview with the facility Nurse and QIDP confirmed staff should have been wearing their masks above the nose and below the mouth/chin.	W 340		