| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G080 | A. BUILDING _____ B. WING _____ | 03/17/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOSS I GROUP HOME | 1617 MOSS SPRINGS ROAD ALBEMARLE, NC 28001 |

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|---|---|---|---|---|
| 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 person centered plan (PCP) failed to have sufficient training objectives to meet identified client needs for 2 of 5 sampled clients (#2 and #3). The findings are:<br><br>A. The PCP for client #2 failed to have programming to address needs relative to rate of eating. For example:<br><br>Observation in the group home on 3/16/21 at 5:42 PM revealed client #2 to participate in the dinner meal consisting of baked chicken, cabbage and mashed potatoes. Continued observation of client #2 at the dinner meal revealed staff A to sit next to client #2 and to verbally and physically prompt the client to slow her rate of eating throughout the meal. Staff A was observed to verbally prompt client #2 with "take a drink" and "take smaller bites" consistently throughout the dinner meal. Staff A was further observed at various times to push the client's plate away from the client until the client had swallowed bites in her mouth and for staff A to physically touch client #2's hand to slow the client's rate of eating. Subsequent observation revealed client #2 to eat quickly and require assistance to slow her rate of eating. | W 227 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G080 | A. BUILDING _____ B. WING _____ | 03/17/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| W 227 | Continued From page 1<br>Observation in the group home on 3/17/21 at 7:28 AM revealed client #2 to participate in the breakfast meal. Continued observation revealed staff C to monitor client #2 during the breakfast meal and to provide ongoing verbal prompts to slow client #2's rate of eating. Staff C was observed to repeat the prompt "wait" to client #2 at various times and to physically push the client's plate away from the client until the client had swallowed bites of food, then allowing the client further access to her plate.<br><br>Review of records for client #2 on 3/17/21 revealed a PCP dated 3/1/20. Review of client #2's PCP revealed training objectives relative to set place setting, make coffee, to place clothes in her dresser, to put dirty dishes in the dishwasher and oral hygiene. Continued review of records for client #2 revealed a nutritional assessment dated 6/5/20. Review of the 6/2020 nutritional evaluation revealed client #2 feeds self; staff encourage the client to slow down. Subsequent review of records for client #2 revealed a life skills assessment dated 2/10/21 that indicated client #2 requires extensive assistance for all meals.<br><br>Interview with the qualified intellectual disabilities professional (QIDP) on 3/17/21 verified client #2 eats quickly and requires supervision and prompts to slow down. Continued interview with the QIDP revealed client #2 did not have a current training objective or program relative to rate of eating. Further interview with the QIDP verified client #2 could benefit from a formal program to support rate of eating to ensure consistency with supporting client #2 at meals.<br><br>B. The PCP for client #3 failed to have programming to address ambulation needs. For | W 227 | | |

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|---|---|---|---|
| | 34G080 | A. BUILDING _____ B. WING _____ | 03/17/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| W 227 | Continued From page 2<br>example:<br><br>Observation in the group home throughout the 3/16 and 3/17/21 survey observations revealed client #3 to ambulate throughout the group home at various times to participate in various activities. Continued observation of client #3's ambulation revealed the client to ambulate with and without staff assistance, to utilize no adaptive equipment during ambulation and to bump into walls and doorways as the client entered and exited various rooms of the group home. Observation on 3/16/21 at 4:55 PM revealed client #3 to ambulate independently to the bathroom and to bump into a wall exiting the living room. Continued observation at 5:21 PM revealed client #3 to ambulate into the kitchen and to hit her hand on a kitchen wall. Staff D was then observed to physically redirect client #3 to the living room couch by holding the clients arm. Additional observation on 3/16/21 at 6:20 PM revealed client #3 to ambulate to the living room from the dining room and to walk into client #4, knocking client #4 down to the floor. Client #4 was then assisted up by staff C as client #3 proceeded to the living room independently.<br><br>Review of records for client #3 on 3/17/21 revealed a PCP dated 3/1/21. Review of the 3/2021 PCP for client #3 revealed current training objectives relative to communication, placing dishes in the dishwasher, oral hygiene, placing condiments on the table and dresser organization. Continued review of records for client #3 revealed a physical therapy (PT) assessment dated 2/26/21 that indicated client #3 to be a fall risk with a diagnosis of cerebral palsy, autism and lumbar spondylosis. Continued review of the PT assessment revealed | W 227 | | |

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|---|---|---|---|
| | 34G080 | A. BUILDING _____ B. WING _____ | 03/17/2021 |

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|---|---|---|---|---|
| W 227 | Continued From page 3<br>gait/balance deviations and client does not watch where she is going. Subsequent review of records for client #3 revealed a life skills assessment dated 2/8/21 that indicated client #3 ambulates with assistance.<br><br>Interview with staff D on 3/16/21 revealed client #3 does have ambulation difficulties and often bumps into things while walking. Interview with the QIDP on 3/17/21 verified client #3 had no ambulation guidelines to ensure consistency with how to support client #3 while ambulating. Further interview with the QIDP and home manager on 3/17/21 verified client #3 could benefit from ambulation guidelines to increase client safety. | W 227 | | |
| W 242 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(6)(iii)<br><br>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to assure the person center plan (PCP) for 1 of 5 sampled clients (#3) included training in personal skills related to privacy. The finding is:<br><br>Observations in the group home on 3/17/21 at | W 242 | | |

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|---|---|---|---|
| | 34G080 | A. BUILDING _____ B. WING _____ | 03/17/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MOSS I GROUP HOME | 1617 MOSS SPRINGS ROAD ALBEMARLE, NC 28001 |

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|---|---|---|---|---|
| W 242 | Continued From page 4<br>8:18 AM revealed client #3 to walk the back hallway of the group home and to enter client #1's bedroom. Continued observation revealed client #3 to access a pillow from client #1's bed and to attempt to exit the bedroom. Further observation revealed staff C to redirect client #3 to replace the pillow on client #1's bed and to exit client #1's bedroom. It should be noted during this observation client #1 was not in her bedroom.<br><br>Review of the record for client #3 on 3/17/21 revealed a PCP dated 3/1/21. Continued review of the PCP revealed training objectives for communication, to place dishes in dishwasher, oral hygiene, to place condiments on table and to organize dresser drawer. The PCP did not contain any programing or guidelines related to privacy with entering the bedrooms of others without permission.<br><br>Interview with staff C on 3/17/21 revealed client #3 will often enter the bedrooms of others without permission. Interview with Qualified Intellectual Disabilities Professional (QIDP) on 3/17/21 confirmed client #3 does enter other client's bedrooms and had no programming to address the privacy need. Continued interview with QIDP revealed client #3 would benefit from programming related to privacy. | W 242 | | |
| W 369 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(2)<br><br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.<br><br>This STANDARD is not met as evidenced by: | W 369 | | |

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|---|---|---|---|
| | 34G080 | A. BUILDING _____ B. WING _____ | 03/17/2021 |

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|---|---|---|---|---|
| W 369 | Continued From page 5 | W 369 | | |

Based on observation, record review and interview, the facility failed to assure all drugs were administered without error for 2 of 5 sampled clients (#1) and (#2). The findings are:

Observation in the group home on 3/17/21 at 9:01 AM revealed client #2 to enter the medication room, to participate in medication administration and exit the medication area at 9:05 AM. Client #2 was observed to be administered medications of: Docusate Calcium 240mg, Fluvoxamine 100mg, Lorazepam 1mg and a nasal spray of Fluticasone 50mcg.

Continued observation in the group home on 3/17/21 at 9:07 AM revealed client #1 to enter the medication room, to participate in medication administration and exit the medication area at 9:15 AM. Client #1 was observed to be administered medications of: Benefiber, Certavite tablet, Gabapentin 300mg, Levetiraceta 500mg, Metformin 500mg, Calcium D3 600-10mcg, Vimpat 250mg and Lactulose 10gm/15.

Review of the internal medication administration record revealed morning medication orders for client #1 and #2 to reflect an 8:00 AM physician order. Review of an internal medication variance report generated on 3/17/21 revealed medications ordered at 8:00 AM for client #1 were administered at 9:14 AM. Continued review of the internal medication variance report revealed medications ordered at 8:00 AM for client #2 were administered at 9:04 AM.

Interview with the facility nurse on 3/17/21 revealed medication can be given up to one hour before and one hour after the time they are ordered. Continued interview with the facility

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G080 | A. BUILDING _____ B. WING _____ | 03/17/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOSS I GROUP HOME | 1617 MOSS SPRINGS ROAD ALBEMARLE, NC 28001 |

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|---|---|---|---|---|
| W 369 | Continued From page 6<br>nurse verified medication ordered for 8:00 AM should not be given out after 9:00 AM without contacting the nurse so the physician could be contacted for authorization of late administration. Subsequent interview with the facility nurse verified she had not been contacted regarding the late administration of medications for clients #1 or #2 on 3/17/21. Additional interview with the facility nurse verified all medications ordered at 8:00 AM and administered after 9:00 AM on 3/17/21 were considered a medication error. | W 369 | | |
| W 474 | MEAL SERVICES<br>CFR(s): 483.480(b)(2)(iii)<br><br>Food must be served in a form consistent with the developmental level of the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, record review, and interview, the facility failed to assure food was served in a form consistent with the developmental level of 3 of 5 sampled clients (#1, #2 and #3). The findings are:<br><br>A. The facility failed to serve food in a form consistent with the developmental needs for client #1. For example:<br><br>Observation in the group home on 3/16/21 at 5:46 PM revealed client #1 to participate in the dinner meal that included baked chicken, cabbage and mashed potatoes. Continued observation of client #1's dinner meal revealed client #1 to be served a large piece of uncut chicken that client #1 was able to pick up with her hands and take bites of until staff could get to client #1 to offer and support hand over hand cutting. | W 474 | | |

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|---|---|---|---|
| | 34G080 | A. BUILDING _____ B. WING _____ | 03/17/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOSS I GROUP HOME | 1617 MOSS SPRINGS ROAD ALBEMARLE, NC 28001 |

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|---|---|---|---|---|
| W 474 | Continued From page 7<br><br>Observation in the group home on 3/17/21 at 7:28 AM revealed client #1 to participate in the breakfast meal that included pancakes and sausage. Continued observation of client #1's breakfast meal revealed the client to be served whole pancakes and whole sausage until staff was able to assist client #1 with hand over hand cutting of both food items. Prior to staff assistance with supporting client #1 with hand over hand cutting client #1 was observed to take large bites of her pancake using her hands.<br><br>Review of records for client #1 on 3/17/21 revealed a nutritional assessment dated 2/10/21. Review of the 2/2021 nutritional assessment revealed food items should be cut into small pieces as needed.<br><br>Interview with the facility qualified intellectual disabilities professional (QIDP) verified client #1 should be served a food consistency in accordance with the current nutritional assessment.<br><br>B. The facility failed to serve food in a form consistent with the developmental needs for client #2. For example:<br><br>Observation in the group home on 3/16/21 at 5:42 PM revealed client #2 to participate in the dinner meal that included baked chicken, cabbage and mashed potatoes. Continued observation of client #2's dinner meal revealed client #2 to be served a large piece of uncut chicken. Further observation revealed client #2 to tear the chicken serving with her hands and to eat large bites with her hands. Subsequent observation revealed no assistance offered to client #1 to cut the chicken | W 474 | | |

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|---|---|---|---|
| | 34G080 | A. BUILDING _____ B. WING _____ | 03/17/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| W 474 | Continued From page 8 | W 474 | | |

serving into small pieces.

Observation in the group home on 3/17/21 at 7:28 AM revealed client #2 to participate in the breakfast meal that included pancakes and sausage. Continued observation of client #2's breakfast meal revealed the client to be served whole pancakes and whole sausage until staff was able to assist client #2 with hand over hand cutting of both food items. Subsequent observation revealed client #2 to take large bites of food and to stuff her mouth until redirected by staff to "wait".

Review of records for client #2 on 3/17/21 revealed a nutritional assessment dated 6/5/20. Review of the 6/2020 nutritional assessment revealed all food items should be cut into small pieces.

Interview with the facility QIDP verified client #2 eats quickly, requires monitoring and should be served a food consistency in accordance with the current nutritional assessment.

C. The facility failed to serve food in a form consistent with the developmental needs for client #3. For example:

Observation in the group home on 3/16/21 at 5:42 PM revealed client #3 to participate in the dinner meal that included baked chicken, cabbage and mashed potatoes. Continued observation of client #3's dinner meal revealed client #3 to be served a large piece of uncut chicken that client #3 ate bites of with her hands until staff assisted the client with cutting.

Observation in the group home on 3/17/21 at 7:28

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|---|---|---|---|
| | 34G080 | A. BUILDING _____ B. WING _____ | 03/17/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOSS I GROUP HOME | 1617 MOSS SPRINGS ROAD ALBEMARLE, NC 28001 |

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|---|---|---|---|---|
| W 474 | Continued From page 9<br>AM revealed client #3 to participate in the breakfast meal that included pancakes and sausage. Continued observation of client #3's breakfast meal revealed the client to be served whole pancakes and whole sausage until staff was able to assist client #3 with hand over hand cutting of both food items.<br><br>Review of records for client #3 on 3/17/21 revealed a nutritional assessment dated 6/9/20. Review of the 6/2020 nutritional assessment for client #3 revealed a prescribed mechanical soft diet.<br><br>Interview with the facility home manager (HM) on 3/17/21 revealed she was unaware the 6/2020 nutritional assessment for client #3 indicated the need for a mechanical soft diet. Continued interview with the HM revealed she thought there had been a mistake in the nutritional assessment for client #3. The HM further verified client #3 had never been provided a mechanical soft diet.<br><br>Interview with the QIDP on 3/17/21 verified client #3's current diet on nutritional orders is for a mechanical soft diet. Continued interview with the QIDP verified the facility had no additional documentation to support a different diet consistency for client #3. Additional interview with the HM and QIDP verified client #3's diet orders needed to be verified with the nutritionist to ensure client #3 is provided the correct diet consistency. | W 474 | | |
| W 475 | MEAL SERVICES<br>CFR(s): 483.480(b)(2)(iv)<br><br>Food must be served with appropriate utensils. | W 475 | | |

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|---|---|---|---|
| | 34G080 | A. BUILDING _____ B. WING _____ | 03/17/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MOSS I GROUP HOME | 1617 MOSS SPRINGS ROAD ALBEMARLE, NC 28001 |

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|---|---|---|---|---|
| W 475 | Continued From page 10<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, review of records and interviews, the team failed to ensure adaptive equipment was used for 1 of 5 sampled clients (#3). The finding is:<br><br>Observation in the group home on 3/16/21 at 5:42 PM revealed client #3 to participate in the dinner meal that included baked chicken, cabbage and mashed potatoes. Continued observation of client #3's dinner meal revealed client #3's place setting to include regular utensils, regular cups and a regular dinner plate.<br><br>Observation in the group home on 3/17/21 at 7:28 AM revealed client #3 to participate in the breakfast meal that included pancakes and sausage. Continued observation of client #3's breakfast meal revealed the place setting to include regular utensils, regular cups and a regular plate. Further observation of client #3's breakfast meal revealed no use of adaptive equipment and for the client to continuously spill milk with attempting to drink her beverage.<br><br>Review of records for client #3 on 3/17/21 revealed a life skills assessment dated 2/8/21 that indicated client #3 feeds self with moderate assistance; is messy. Continued review of records for client #3 revealed a nutritional assessment dated 6/9/20. Review of the 6/2020 nutritional assessment for client #3 revealed a prescribed mechanical soft diet. Further review of client #3's nutritional assessment revealed adaptive equipment to include a plate guard or high sided dish, adaptive spoon, scoop bowl bib and 4 oz cups. | W 475 | | |

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|---|---|---|---|---|
| W 475 | Continued From page 11<br>Interview with the facility home manager (HM) on 3/17/21 revealed she was unaware the 6/2020 nutritional assessment for client #3 indicated the need for adaptive equipment at meals. Continued interview with the HM revealed she thought there had been a mistake in the nutritional assessment for client #3. The HM further verified client #3 had never been provided adaptive equipment at meals.<br><br>Interview with the QIDP on 3/17/21 verified client #3's current nutritional orders reflected the need for adaptive equipment at meals. Continued interview with the QIDP verified the facility had no additional documentation to support client #3 did not need adaptive equipment at meals. Additional interview with the HM and QIDP verified client #3's adaptive equipment recommendations needed to be verified with the nutritionist to ensure client #3 is provided the correct dining equipment and utensils. | W 475 | | |