STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G151	A. BUILDING _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NO PLACE LIKE HOME	4309 NC HWY 87 SOUTH FAYETTEVILLE, NC 28306

(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 assure the consistent implementation of the individual program plans (IPPs) in the areas of dining and toothbrushing for 2 of 3 audit clients (#1 and #4). The findings are: A. During observations of the dinner meal on 4/5/2021, client #4 was not prompted to utilize his fork and/or knife to eat his salmon filet. When the meal began at 4:37pm, he picked up his Salmon and took a bite out of it. He consumed the entire fish in this manner. Client #4 did not receive any prompting despite staff being present and talking with him. Note: this was the only meal observed requiring a knife and fork. Review of client #4's IPP dated 10/18/2020 revealed an adaptive behavior inventory not dated which indicated he knows how to use utensils including alternating utensils (ie. fork, chopsticks etc.). This was indicated as "4". Interview with the qualified intellectual disability professional (QIDP) on 4/6/2021 revealed staff	W 249		

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

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W 249	Continued From page 1	W 249		

should prompt individuals to use their forks and knives and physically assist when needed. She confirmed that client #4 would have needed staff assistance to cut the fish.

B. During observations in the home on 4/5/21 at 4:45pm, client #1 was served salmon filets and spinach. He initially attempted to cut up his fish with a fork, but stopped after one two attempts. Staff B observed that client #1 was using his fork and encouraged him to cut up fish. Next client #1 was observed to pick up the piece of fish and to tear it into small pieces with his fingers and proceeded to eat it that way. Staff A and Staff B were at the dinner table but were not observed to redirect client #1 to use his utensils.

Review on 4/5/21 of client #1's annual comprehensive functional assessment dated 3/31/20, it stated that he could not use a knife or fork for cutting.

Interview on 4/6/21 with the QIDP revealed, client #1 needed some assistance with cutting meats.

During morning observations in the home on 4/6/21 at 7:03am, client #1 was accompanied in the bathroom by Staff A to assist with brushing teeth after breakfast. Staff A gave client #1 verbal cues on where to place the toothbrush in mouth, to make contact with teeth. Staff A was not observed giving client #1instructions to brush along his gum lines, which were not touched. Afterwards, client #1 went back to his room, carrying his toothbrush and toothpaste and Staff A went to assist client #5. Client #1 was observed standing in his doorway with a piece of floss. No staff was present to ensure that he flossed properly.

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W 249	Continued From page 2 Client #1 was then observed removing his mouthwash from his oral hygiene kit and swallow a capful of mouthwash. Review on 4/5/21 of client #1's dental exam dated 1/5/21 revealed that client #1 had heavy plaque build up, inflamed gums and gingivitis. It was recommended that staff assist with brushing along gum line twice a day, and to floss daily. Interview on 4/6/21 with the QIDP revealed staff should be present at toothbrushing to make sure that client #1 was demonstrating correct technique and receive assistance if needed.	W 249		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure training in the area of medication administration for 2 of 3 audit clients (#4 and #5). The findings are: During a medication administration pass on 4/6/2021, Client #5 received his medications at 7:50am. The group home manager punched the medications out while telling him the name of some of them. He independently took the medications. At 8am, Client #4 received his	W 371		

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W 371	Continued From page 3 medications after the group home manager punched them out for him. Interview with the group home manager after the observation revealed she did not think the guys could punch the medications out and stated they have tried. Review of the records on 4/5/2021 and 4/6/2021, revealed no information assessing the medication administration skills for clients #4 and #5. Review of client #4's individual program plan (IPP) dated 10/18/2020 revealed no indication that he can self-administer his medications and no goals in medication administration. Review of client #5's IPP dated 12/9/2020 revealed no indication he can self-administer his medications and no goals in medication administration. Interview with the qualified intellectual disability professional (QIDP) on 4/6/2021 confirmed there are no training goals for client #4 or #5 in self-medication administration.	W 371		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #1	W 436		

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W 436	Continued From page 4	W 436		

was taught to use and make informed choices about the use of his eyeglasses. This effected 1 of 3 clients. The finding is:

During observations in the day program on 4/5/21 from 11:45am-12:30pm, client #1 did not wear eyeglasses. Client #1 was observed practicing writing his name on paper and setting the tables at lunch. An additional observation on 4/5/21 from 3:30pm-5:30pm in the home, client #1 did not wear his eyeglasses. Staff were not observed reminding client #1 to put on his eyeglasses. On 4/6/21 at 7:00am, client #1 was observed at the breakfast table not wearing his eyeglasses.

During medication administration on 4/6/21 at 7:30am, staff B was observed telling client #1 to go to his room and put on his eyeglasses. Staff B did not accompany client #1 to his room to ensure that he wore his eyeglasses. An additional observation at 7:45am, revealed a case of eyeglasses on the stand in client #1's bedroom. The eyeglasses were in the case. At 9:00am, client #1 was observed sitting on the van, leaving for the day program and still was not wearing his eyeglasses.

Review on 4/5/21 of client #1's vision exam dated 1/28/21 revealed that he had astigmatism, hyperopia OU and early cataracts. It was noted that he wore eyeglasses; there was no documentation of restrictions of use.

Interview on 4/6/21 with the qualified intellectual disabilities professional (QIDP) revealed that after receiving a verbal prompt to put on his eyeglasses, staff should accompany client #1 to his room, to make sure that he put them on.