STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G137	A. BUILDING _____ B. WING _____	04/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERLYN	6113 BLUE LANTERN ROAD GIBSONVILLE, NC 27249

(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 review, and interview the interdisciplinary team failed to assure that consistent interventions in the behavior support plan (BSP) were implemented to support the needs of 1 non-sampled client (#1). The finding is: Observations in the group home on 4/12/21 at 5:39 PM revealed client #1 to disrobe his t-shirt in the living room, enter the personal space of the surveyor and bite the corner of the surveyor's notebook. Continued observation revealed client #1 to be directed to his bedroom with staff and return with his shirt on. Further observation on 4/12/21 at 5:41pm revealed client #1 to enter the personal space of the surveyor with no redirection from staff. Observations in the group home on 4/13/21 from 8:30 AM to 8:50 AM revealed client #1 to walk around and hit his head with an open hand. Continued observation revealed client #1 to bite his arm. Further observation revealed no redirection from staff towards client #1 relative to self-injurious behavior (SIB).	W 249		

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
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W 249	Continued From page 1 Review of the records for client #1 on 4/13/21 revealed an ISP dated 8/26/20. Review of the ISP revealed a behavior support plan (BSP) dated 10/27/19. Review of client #1's BSP revealed target behaviors to include: Self Injury (SIB) consisting of head banging, hitting or other self-performed action which may injure or cause tissue damage and aggression consisting of hitting, kicking, grabbing, biting, scratching, or other actions directed toward others which may cause harm or produce injury. Further review of the 10/27/19 BSP for client #1 revealed an intervention that when client #1 attempts to hit or bite himself or engage in any form of SIB, the behavior will be blocked if possible. Subsequent review of BSP interventions revealed the need for client #1 to be redirected to an activity or task, preferably one involving appropriate use of hands. Interview with the qualified intellectual disabilities professional (QIDP) verified the 10/2019 BSP for client #1 was current. Continued interview with the QIDP verified interventions of client #1's BSP should have been implemented as prescribed.	W 249		
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	W 369		

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	34G137	A. BUILDING _____ B. WING _____	04/13/2021

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SUMMERLYN	6113 BLUE LANTERN ROAD GIBSONVILLE, NC 27249

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W 369	Continued From page 2	W 369		

were administered without error for 2 of 3 sampled clients (#4, #5). The findings are:

A. Medications were not administered as prescribed per physician order for client #5.

Observation in the group on 4/13/21 at 7:00 AM revealed all clients in the group home to be awake, dressed and engaged in various activities in the group home. Observation at 9:04 AM revealed client #5 to enter and participate in his morning medication administration. Continued observation of client #5 revealed the client to exit the medication administration area at 9:08 AM.

A review of physician orders dated 4/1/21 for client #5 revealed multiple medications ordered at 8:00 AM that included: DOK 100mg, hydrochlorothiazide 25mg, lisinopril 20mg,vitamin D3 50 MCG (2000 IU), divalproex sprinkle 125mg.

Interview with the facility nurse on 4/13/21 revealed medication can be administered up to one hour before and one hour after the time prescribed. Continued interview with the facility nurse verified she was not contacted by the group home staff to indicate medications were administered after 9:00 AM on 4/13/21. Interview with the qualified intellectual disability professional (QIDP) verified medications were not administered as prescribed and should have been reported to the facility nurse and QIDP.

B. Medications were not administered as prescribed per physician order for client #4.

Observation in the group home on 4/13/21 at 9:10 AM revealed client #4 to enter the medication

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W 369	Continued From page 3 administration area of the group home and participate in the morning medication pass, exiting the medication administration area at 9:14 AM. Further observation revealed staff to lock up the medication administration area and inform the surveyor all medications had been administered for the morning. Review of the physician orders dated 4/1/21 for client #4 revealed multiple medications ordered at 8:00 AM that included: calcitriol 0.25 mcg, ferrous sulfate 325mg, hydrochlorothiazide 25mg, potassium ER 10 meq, Senexon-s 8.6-50mg and Chlorhexidine gloc 0.12% solution. Interview with the facility nurse on 4/13/21 revealed medication can be given up to one hour before and one hour after the time prescribed. Continued interview with the facility nurse verified she was not contacted by the group home staff to indicate medications were administered after 9:00 AM on 4/13/21. Interview with the QIDP verified medications were not administered as prescribed and should have been reported to the facilty nurse and QIDP.	W 369		