STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G217	A. BUILDING _____ B. WING _____	06/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATES STREET ICF/MR	306 CATES STREET ROXBORO, NC 27573

(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 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 staff were sufficiently trained in the area of safety for 2 of 4 (#2 and #6) audit clients. The finding is: During morning observations at the home on 6/8/21 at 9:47am, Staff A was observed exiting the rear of the van on the wheelchair lift. The surveyor introduced themselves and explained to Staff A they were there for the annual recertification for the home. Staff A stated she would need to call the manager to let them know the surveyor was there. At 9:49am, Staff A went into the home, while a client was left on the van sitting in their wheelchair. At 9:50am, a female client exited the home and said "Hi" to the surveyor while she opened the van door and sat in the front seat. Additional observations revealed the key was in the ignition of the van and the van was running. At 9:51am, Staff A exited the home and told the surveyor the manager is coming. During immediate Staff A explained to the surveyor that she had been trained not to leave any of the clients unattended. Further interview revealed the client in the wheelchair was client #6 and the client sitting in the front seat of the van was client #2.	W 189		

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

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W 189	Continued From page 1 Review on 6/8/21 of client #2's direct care evaluation dated 10/10/20 stated she lacks the skills for knowing/following the laws; call police; call fire department and perform first aid on others. Review on 6/8/21 of client #6's direct care evaluation dated 10/27/20 stated he lacks the skills for knowing/following the laws; call police; call fire department and perform first aid on others. During an interview on 6/8/21, the management staff revealed all staff been trained not to leave any of the clients unattended.	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 each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of medication administration. This affected 1 of 4 audit clients (#4). The finding is:	W 249		

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W 249	Continued From page 2 During evening medication administration in the home on 6/8/21 at 5:04pm, Staff B poured liquid for client #4. At no time was client #4 prompted to participate in medication administration. During an interview on 6/8/21, Staff B stated she has always poured client #4's liquids during the medication administration. Staff B also stated that each client including client #4 have instructions in the medication administration record (MAR), which inform staff on what each client is able to do during medication administration. Review on 6/9/21 of client nursing evaluation dated 1/15/21 stated, "assist with or pours fluids." Review on 6/8/21 of the instructions in the MAR for client #4 stated, "[Client #4] can pour liquid from a small pitcher...." During an interview on 6/8/21, management staff revealed client #4 should have been given the opportunity to pour her fluids.	W 249		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure medications were administered in compliance with physician's orders. This affected 1 of 4 clients (#1). The finding is:	W 368		

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W 368	Continued From page 3 During morning medication administration in the home on 6/9/21 at 6:32am, client #1 consumed five pills, including Levothyroxine 75mcg. Review on 6/9/21 of client #1's physician orders stated, "Levothyroxine 75mcg 8am". During an interview on 6/9/21, Staff C (the medication technician) stated she knew client #1's Levothyroxine was ordered for 8am; she even told the nurse during her medication administration training, but the nurse told her to just continue giving client #1 all her morning medications at the same time. Further interview revealed Staff C understood about how medications can be given one hour before or one hour after the ordered time. During an interview on 6/9/21, the management staff revealed they were not aware client #1 was not getting her Levothyroxine at the correct time.	W 368		
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 ensure training in the area of medication administration for 1 of 4 audit clients (#2). The finding is:	W 371		

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W 371	Continued From page 4 During evening medication administration in the home on 6/8/21 at 5:01pm, Staff B punched out five pills from five bubble packs into a medication cup, which was for client #2. Further observations revealed client #4 was not in the medication area when then five pills were punched by Staff B. Staff B also poured client #2's fluid. At no time was client #2 prompted to participate. During an interview on 6/8/21, Staff B revealed she has always punched all of client #2's pills and pours her fluids. Staff B also stated that each client including client #2 have instructions in the medication administration record (MAR), which inform staff on what each client is able to do during medication administration. Review on 6/8/21 of the instructions in the MAR for client #2 did not stated if she can punch her own pills. Review on 6/9/21 of client #2's nursing evaluation dated 9/20 stated, "Med Pass: [Client #2] can pour her own drink if given a cup with the proper measurement (limited to 4 oz fluid restrictions)... [Client #2] is able to pop her own pills out if the bubble packs and put then in a med cup...." During an interview on 6/8/21, the management staff revealed client #2 has never had a goal to particiapte in medication administration.	W 371		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection	W 455		

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W 455	Continued From page 5 and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of possible infections and prevent possible cross-contamination. This potentially affected all the clients (#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: During morning observations in the home on 6/9/21 at 7:15am, client #4 put her bare hand inside of a glass with several ice cubes. Further observations revealed client #4 took out one ice cube and placed it in her coffee cup. Additional observations revealed another client placed their bare hand into the same glass with the ice cubes; took out one ice cube and placed it in their coffee cup. During an interview on 6/9/21, Staff B revealed the clients should not have placed their bare hands into the glass with the ice cubes. During an interview on 6/9/21, the qualified intellectual disabilities professional (QIDP) confirmed neither client should have placed their bare hands into the glass with the ice cubes.	W 455		