STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G168	A. BUILDING _____ B. WING _____	06/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBAY GROUP HOME	1907 NORTHBAY DRIVE BROWN SUMMIT, NC 27214

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure privacy was maintained for 1 of 4 sampled clients (#2) during toileting. The finding is: Observations in the group home on 6/9/21 at 7:46 AM revealed client #2 to get up from a living room chair and go to the back-hall bathroom leaving a small opening in the door. Continued observation at 7:50 AM revealed client #1 to get up from the living room couch, walk to the back hallway and to push the back-hall bathroom door open while client #2 was occupying the bathroom. Further observation revealed staff to follow behind client #1 and to re-direct the client to another bathroom. Subsequent observation revealed while exiting the bathroom with client #1 staff did not secure the bathroom door to provide privacy for client #2. The bathroom door was observed to remain opened from 7:50 AM to 7:54 AM and revealed client #2 to stand in the bathroom, undressed, holding his brief while preparing to put it on and no staff during this time intervening to close the bathroom door. Review of the records for client #2 revealed a habilitation plan dated 7/9/20. Review of the 7/9/20 plan revealed training objectives relative to meal prep, medication administration, toothbrushing, coin identification, and practical living (shopping skills). Further review of the	W 130		

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

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W 130	Continued From page 1 records for client #2 revealed an Adaptive Behavior Inventory (ABI) dated 1/15/19 which indicated client #2 has partial independence to urinate (daytime) and no independence to defecate (daytime) requiring staff assistance. Additionally, the ABI assessment indicated partial independence for client #2 to close the bathroom door before using the toilet which requires staff assistance. Interview with the qualified intellectual disabilities professional (QIDP) confirmed that staff should follow all interventions for client #2 relative to providing privacy during toileting. Continued interview with the QIDP confirmed that staff should have closed the bathroom door for client #2 to maintain privacy.	W 130		
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) 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. This STANDARD is not met as evidenced by: Based on observations, interviews, and record reviews, the facility to ensure the habilitation plan for 1 of 4 sampled clients (#1) included objective training to address observed needs relative to privacy. The finding is:	W 242		

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W 242	Continued From page 2 Observations in the group home on 6/9/21 at 7:46 AM revealed client #2 to get up from a living room chair and go to the back-hall bathroom leaving a small opening in the door. Continued observation at 7:50 AM revealed client #1 to get up from the living room couch and to push the back-hall bathroom door open without knocking while client #2 was occupying the bathroom with his pants off and holding his brief. Further observation revealed staff to follow behind client #1 and redirect him to another bathroom. Review of records for client #1 on 6/9/21 revealed a habilitation plan dated 8/11/20. Review of the 8/11/20 plan for client #1 revealed objectives relative to bathing, wash hands, medication administration, toileting, and shopping. Further review of training objectives for client #1 revealed no training objectives relative to privacy. Interview with the qualified intellectual disabilities professional (QIDP) confirmed that client #1 will walk in on clients while they are in the bathroom. Continued interview with the QIDP confirmed that client #1 has history of entering the bathroom without knocking on doors and does not have a goal in the area of privacy. Further interview with the QIDP revealed that client #1 would benefit from a privacy goal.	W 242		
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	W 371		

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W 371	Continued From page 3	W 371		

does not specify otherwise.

This STANDARD is not met as evidenced by:
Based on observations, record review and interviews, the system for drug administration failed to assure 2 of 4 sampled clients (#3 and #4) observed during the medication pass were provided teaching related to name, purpose and side effects of medications administered. The findings are:

A. The system for drug administration failed to assure client #4 was provided teaching related to the name, purpose or possible side effects of medications received. For example:

Observations in the group home on 6/9/21 at 7:45 AM during medication administration revealed client #4 to receive medications that included: gavilax powder, furosemide 20mg, meloxicam 15mg, metoprolol ER, minocycline 100mg, and vitamin D3. Continued observations revealed client #4 to take medications followed by a cup of water. At no point during observations did staff A provide client #4 with teaching related to the name, purpose or possible side effects of medications administered.

Review of medical record for client #4 on 6/9/21 revealed a habilitation plan dated 7/7/20. Continued review of the plan revealed an adaptive behavior inventory (ABI) dated 1/15/19. Further review of the ABI revealed with self administration of medications client #4 cannot perform any portion of the tasks listed independently relative to knowing what kind and amount of medication taken.

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W 371	Continued From page 4	W 371		

Interview with the qualified intellectual disability professional (QIDP) on 6/9/21 verified client #4 should have been provided education during his medication pass with the identification of at least one medication, purpose and side effect. Continued interview with the facility nurse (RN)confirmed staff has been trained to provide education while administering medications. The RN further confirmed staff should provide client #4 with teachings related to the name, purpose and side effects of all medications administered.

B. The system for drug administration failed to assure client #3 was provided teaching related to the name, purpose or possible side effects of medications received. For example:

Observations in the group home on 6/9/21 at 8:00 AM during medication administration revealed client #3 to receive medications that included: benefiber, gavilax powder, oxcarbazepine 300mg, docusate calcium 240mg, doxycycline 100mg, fluvoxamine 100mg, vitamin D 400IU and diazepam 10mg. Continued observations revealed client #3 to take medications followed by a cup of water. At no point during observations did staff A provide client #3 with teaching related to the name, purpose or possible side effects of medications administered.

Review of records for client #3 on 6/9/21 revealed a habiliation plan dated 6/25/20. Continued review of the plan revealed an adaptive behavior inventory (ABI) dated 1/15/19. Further review of the ABI revealed with self administration of medication client #3 can not perform any portion of the tasks listed independently relative to knowing what kind of medication taken or the amount of medication taken.

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W 371	Continued From page 5 Interview with the qualified intellectual disability professional (QIDP) on 6/9/21 verified client #3 should have been provided education during his medication pass with the identification of at least one medication, purpose and side effect. Continued interview with the facility nurse confirmed staff has been trained to provide education while administering medications and should provide teachings to all clients related to the name, purpose and side effects of all medications.	W 371		