DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G013	A. BUILDING _____ B. WING _____	04/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANVILLE ICF/MR GROUP HOME	5509 DORSEY ROAD OXFORD, NC 27565

(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 observations, record reviews and interviews, the facility did not provide privacy for 3 of 5 individuals living in the home. This affected clients #2, #3 and #5. The finding is: During observations on 4/27/2021 in the home at 6:10am, client #5 was being bathed in bed by Staff A with the door open. Additionally, Client #3 took his pants on and off several times in the room next door. He was making his bed while periodically undressing and re-dressing with the door wide open. Staff B walked back and forth occasionally checking on client #3's bed making progress without prompting either staff A or any clients to close the doors of either room. At 7am, client #2 came to down the hall and went into the bathroom. He left the door wide open and used the toilet. After a couple of minutes, staff B came down the hall and saw client #2 in the bathroom with the door open. She praised client #2 for using the bathroom and closed the door for him. she did not prompt staff A to close the door while she bathed client #5 and was unaware client #3 was dressing and undressing with his door open. Interview with staff A on 4/27/2021 revealed she was new and has been trained on privacy. However, she indicated it was fine to leave the door open while bathing client #5 because she needed to help keep an eye on the other	W 130	The Habiliation Specialist will implement a formal program for Client #2, 3, and 5 in regards to closing the doors for privacy. All staff will be in-service by the Habilitation Specialist on all clients privacy program. The Clinical team will monitor to ensure client, 2, 3 and 5 privacy program is implemented through 2 interaction assessment a week for a month and than on routine basis. In future, QP will ensure staff are trained to ensure clients rights to privacy during toileting, undressing and dressing.	06/24/21

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 130	Continued From page 1 individuals. Staff B stated in an interview on the same date that the doors should be closed when clients are dressing or bathing and they should knock to honor privacy. Review on 4/27/2021 of client #5's individual program plan (IPP) dated 6/3/2020 indicated he is profoundly intellectually disabled with a legal guardian and staff who help him exercise his rights. Review on 4/27/2021 of client #3's IPP revealed a plan dated 11/11/2020 which indicated he has a diagnosis of moderate/severe and "likes" his privacy. It further included a rights assessment dated 11/11/2020 which noted he requires full assistance to support the right to privacy. Review on 4/27/2021 of the IPP dated 3/10/2021 for client #2 revealed he has a legal guardian to assist him in exercising and protecting his rights. His record also included an assessment dated 3/10/2021 which stated he is independent in privacy for personal care. Interview on 4/27/2021 with management confirmed staff should afford all individuals assistance with privacy.	W 130		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observations, record reviews and	W 192		

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W 192	Continued From page 2 interviews, the facility failed to assure all employees who work with clients displayed skills and competencies toward client's health needs by reporting vomiting to the nurse. This affected one non audit client (#2). The finding is: During observations on 4/27/2021 at 7:10a m, client #2 was assisted by staff C into the bathroom because he had vomited into his hand and on his clothing. Interview on 4/27/2021 with staff C revealed he has been vomiting and they report it to nursing. He stated that client #2 has been vomiting like this for a while now. He indicated he does it when he drinks his boost and they report and nothing has been done. Further interview with staff B indicated this is the first time she has seen him vomit this much. He usually just regurgitates it and that is a behavior he expresses. Staff B indicated he had a recent addition of a protein powder that would more likely be the cause because he has been on boost longer than staff C had been working with him. Review on 4/27/2021 of client #2's individual program plan (IPP) dated 3/10/21 indicated he has a history of regurgitation and further review of the nursing notes did not reveal recent vomiting. Interview with the nurse on 4/27/2021 revealed no staff had contacted her about client #2 vomiting this morning. She was not aware of any vomiting with client #2 and stated direct care staff had not reported this to her. She indicated she would have him checked soon.	W 192	The QP and the responsiblie nurse will in-service staff on the importance of reporting through and accurate health concerns for person supported in a timely manner. The QP and Home Manager will monitor documentation through a communication log book for on call nursing daily.The Home Manager and QP will be notified of all call to nursing pertaining health issues. In the future, QP will ensure all staff are trained on reporting information relevant to the person we supported health.	06/24/21
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i)	W 240		

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W 240	Continued From page 3 The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the individual program plan (IPP) for client #5 included relevant and specific directions for him to eat safely. The finding is: During observations of lunch and dinner on 4/26/2021, client #5 was fed by staff by giving him 4-6 bites of food and then a drink. During further observations of breakfast on 4/27/2021, client #5 was fed by staff giving him 2-4 bites and then a drink. Review on 4/26/2021 of client #5's IPP dated 6/3/2020 revealed he is fed a pureed diet "alternating solids and liquids." Interview on 4/27/2021 with all staff confirmed the observations is how they feed client #5. Further interview with all staff on 4/28/2021 revealed they feed the individual 2-4 bites and then offer liquids. Interview with nursing on 4/27/2021 confirmed the IPP does not specify exactly how many bites of solids to liquids client #5 should take.	W 240	The OT will evaluate client #5 specificially on how many bites he should take between liquids. The QP will revise the PCP to include information into client PCP, implementation and inservicing staff. The clinical team will monitor the bites through meal assessement 2x per week for one month and than on a routine basis. In the future, QP will ensure all person supported PCP describe relevant intervention to support the individual toward independence.	06/24/21
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	W 249		

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W 249	Continued From page 4 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 (IPP) for client #2 and client #5. The finding is: A. Throughout observations on 4/26-4/27/2021, client #5 did not have a lap tray with an attached communication board and was never presented a "communication board." He further did not wear palm protectors or have rolled wash clothes in his contracted hands. Review on 4/26/2021 of client #5's IPP dated 6/3/2020 revealed he should have a rolled wash cloth in his palms throughout the day. Further review revealed he has a communication board which is attached to his laptray at all times. The plan indicated he communicates through smiles, eye contact and the communication board. Interview with staff B on 4/27/2021 indicated client #5 should have wash clothes in his hands at all times. B. During observations on 4/27/2021 at 7:10am, client #2 was assisted by staff C into the bathroom because he vomited into his hand and on his clothing.	W 249	W 249-A,B The PT will evaluate client #5 need for lap tray and SLP will evaluate client #5 for a communication board. The Habiliation Specialist will do and OSG for palm protectors and in service staff. The OT and SLP will do a swallow evaluate for client #2 do to requrgitation. The QP will revise the PCP to add result from all evaluation. The Habilitation Specialist and QP will train staff on evaluation recomendation. The Clinical Team will montior through interaction assessment 2X a week for one month and than on routine basis to ensure staff are following orders for client #5 & #2. In the future, QP will ensure all staff are trained and implement order for adapative equipment.	06/24/21

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W 249	Continued From page 5 Interview on 4/27/2021 with staff C revealed he has been vomiting and they report it to nursing. He stated that client #2 has been vomiting like this for a while now. He indicated he does it when he drinks his boost and they report and nothing has been done. Further interview with staff B indicated this is the first time she has seen him vomit this much. He usually just regurgitates it and that is a behavior he expresses. Staff B indicated he had a recent addition of a protein powder that would more likely be the cause because he has been on boost longer than staff C had been working with him. Review on 4/27/2021 of client #2's individual program plan (IPP) dated 3/10/21 indicated he has a history of regurgitation and further review of the nursing notes did not reveal recent vomiting. Review on 4/27/2021 of client #2's IPP dated 3/10/2021 revealed he should be monitored for choking. Further review revealed Boost was ordered 1/7/2021 and on 9/28/2020 the doctor ordered a swallowing study and specified this was to be "OT/Speech" swallow evaluation not a Modified Swallow Study (MBSS). A 2014 note indicated he refused a MBSS. Interview with the nurse on 4/27/2021 revealed the study was not conducted. She called the doctor after being asked about the study and he indicated on this date that could be discarded due to his 2014 refusal. She was told in the interview the doctor had specified that it be a speech/OT evaluation for which she had no reply. She indicated she will revisit it with the doctor.	W 249		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)	W 436		

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W 436	Continued From page 6 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 reviews and interviews, the facility failed to assure the provision of adaptive equipment in good repair for 2 clients (#1 and #5). The findings are: A. Throughout observations on 4/26 and 4/27/2021, client #1's anti-tip poles were on his wheelchair backwards (they were under his chair in a fashion that would assist the wheelchair tipping backwards not prevent it.) There was no strap only a seatbelt. Review of client #1's individual program plan (IPP) dated 12/15/2020 revealed no information about his wheelchair and how it should be equiped. Interview with staff B on 4/26/2021, when asked about the anti-tips on client #1's wheelchair, stated they did not look correct to her but she did not know what was wrong. Interview with management on 4/27/2021 revealed a strap harness for client #1's wheelchair was needed and had been ordered but he was unaware of the anti-tips being turned around.	W 436	W436 A The Habilitation Specialist will in-service staff on clients #2 anti-tip poles on his wheelchair. When client #2 is in his wheelchair his anti-tip poles should be on wheelchair correcltly. The clinical team will monitor client #2 anti-tip poles are on correcltly through interaction 2x a week and than on a routine basis. In the future, the QP will ensure staff are trained on adapative equipment and the proper position for said equipment.	06/24/21

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W 436	Continued From page 7 B. Throughout observations on 4/26-4/27/2021 client #5's armrest was missing off of the left arm to his wheelchair and he did not have a lap tray. Interview with staff B on 4/27/2021 revealed his armrest was in need of repair and she thought they had ordered it. Staff C indicated it had been broken a long time. Review on 4/26/2021 of client #5's IPP included a physical therapy evaluation dated 2/3/2021 which indicated his wheelchair was in good condition. Interview with management on 4/27/2021 confirmed client #1's wheelchair was in need of repair and that they had begun that process. After the survey exit, an email dated April 2?, 2021 was presented stating that insurance was reviewing the order for "client #1's wheelchair" and they were waiting on approval.	W 436	W 436 B The QP will in-service staff on the adapative equipment for person supported maintaining in good repair. The Clinical team will monitor correct placement/function of adaptive equipment through monthly interaction/enviromental assessments. In the future, the QP will ensure adapative equipment has been repair as needed and in good condition.	06/24/21

RHA HEALTH SERVICES, LLC

RHA Health Services, LLC
2527 E. Lyon Station Rd
Creedmoor, NC 27522
Phone: 919-528-2558
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FAX TRANSMISSION

CONFIDENTIAL HEALTH INFORMATION ENCLOSED

To:	Joy Alford, QIDP/SW Mental Health Licensure & Certification Section	Fax:	919 715-8078
From:	RHA Health Service, LLC Delphia Easter, QP	Date:	5/06/2021
Re:		Pages:	10 (Including Cover)
CC:			

Urgent	For Review	As Requested	Please Reply	Please Recycle

Additional Comments: Plan of Correction - Oxford (Granville ICF/MR Group home)

RHA
HEALTH SERVICES, LLC

May 6, 2021

Mrs. Joy Alford, QIDP/SW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

RE: Recertification Survey Completed on 04/27/21
Granville ICF/MR Group Home, 5509 Dorsey Road Oxford, NC 27565
Provider Number: 34G013
MHL Number: MHL039-041

Dear Mrs. Alford

Thank you for your recent survey of Granville ICF/MR Group Home. It was a pleasure working with you and we look forward to your follow up and return to ensure all deficiencies have been corrected.

Enclosed you will find the plan of correction for all deficiencies cited. If anything was missed please let me know and I will make the proper corrections.

Sincerely

Morris Thomas
Administrator