STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
34G175	A. BUILDING _____ B. WING _____	C 05/18/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHWAY 117 GROUP HOME	3801 US 117 NORTH GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed during the recertification survey for intakes #NC00176901 and #NC00176906. There were no deficiencies cited as a result of the complaint investigation; however, deficiencies were cited during the recertification survey.	W 000		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #5 had the right to access items which meet his needs, interests and choices. This affected 1 of 5 audit clients. The finding is: During observations in the home throughout the survey on 5/17 - 5/18/21, a broom closet in the home was kept locked. Various staff utilized a key to access the closet and retrieve items to be utilized by clients for cleaning. On 5/18/21, staff unlocked the closet to obtain a broom for client #5 sweep the floors. Later, the closet was again unlocked by staff as client #5 retrieved a mop and proceeded to mop the dining room and kitchen areas. Closer observation of the closet revealed several brooms, dust pans, mop and wet floor signs. Interview on 5/18/21 with the Home Supervisor revealed the closet was kept locked after an	W 137	Consumer #5 will have access to the broom closet by requesting a key from Staff. He will be observed using the key to the broom closet to determine if he requires training regarding key use. Once Consumer #5 obtains the cleaning items necessary to perform his chore assignment he will lock the closet and return the key to Staff. Upon finishing the assigned chores Consumer #5 will request the key from Staff, open the closet, return the cleaning items to the closet, lock the closet, then return the key to Staff. In this way, Consumer #5 can exercise maximum independence, while ensuring the safety of other Consumers. A Core Team meeting will be conducted to arrange implementation of this protocol.	07-16-2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Co-Executive Director	05-27-2021

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W 137	Continued From page 1 incident involving a client who no longer lives at the home. Additional interview indicated this area was now being locked because those items (mops, brooms, etc.) could potentially be used as a weapon. Review on 5/18/21 of client #5's Comprehensive Functional Assessment (CFA) dated 6/24/20 revealed he is relatively independent with domestic skills such as cleaning and requires various forms of monitoring and prompts to complete household maintenance tasks. Additional review noted the client works on the janitorial crew several days a week at the day program. Interview on 5/18/21 with the Co-Executive Director confirmed the broom closet remains locked because the enclosed items could be used as a weapon.	W 137		
W 231	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(iii) The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #2's behavior plan included an objective statement which provided measurable indices of performance. This affected 1 of 5 audit clients. The finding is: Review on 5/18/21 of client #2's Mental Health Plan (MHP) dated 4/8/21 revealed a behavior plan to address target behaviors of	W 231	All NOVA QP/IID Staff will review Mental Health Plan to assure that each plan contains one or more goal statement that are expressed in behavioral terms and are measurable. The Records Manager will audit all records to assure that each Mental Health Plan is in compliance.	07-16-2021

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Ann D Tsad	Co-Executive Director	05-27-2021

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W 231	Continued From page 2 non-compliance, property damage, elopement and threats. Additional review of the plan indicated no specific objective statement. Interview on 5/18/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the MHP did not include a formal objective statement.	W 231		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 5 audit clients (#3 and #6). The finding is: A. Review on 5/18/21 of client #3's Mental Health Plan (MHP) dated 10/28/20 revealed the objective, "Across all settings, [Client #3] will have anxiety free days related to symptoms of his DSM-5 Primary Psychiatric diagnosis, ADHD combined presentation, specifically non-compliance for 30 of 35 days." The MHP incorporated the use psychiatric medications to address client #3's inappropriate behaviors. Additional review of the record did not reveal a current consent for the MHP. Interview on 5/18/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no current consent had been obtained from client	W 263	At the time of admission and annually the Parent/Guardian signs a Consent Form for the use of restrictive interventions and a Consent Form for the use of psychoactive medications. In that Consents have already been obtained and placed in the Consumer Record, it would be redundant to require a " Consent " for the Mental Health Plan. The Consent section on the MHP will be deleted and the applicable Consents will be obtained in the Consumer Records.	07-16-2021

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W 263	Continued From page 3 #3's guardian. B. Review on 5/18/21 of client #6's Mental Health Plan (MHP) dated 6/30/20 revealed the objective, "Across all settings, [Client #6] will have incident free days related to symptoms of his DSM-5 Primary Psychiatric Diagnosis of Schizoaffective Disorder, Bipolar type, specifically for aggression for 80 of 85 days." The MHP incorporated the use psychiatric medications to address client #3's inappropriate behaviors. Additional review of the record did not reveal a current consent for the MHP. Interview on 5/18/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no current consent had been obtained from client #6's guardian.	W 263		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all staff were sufficiently trained regarding proper latex glove use and implementation of physician's orders. This specifically affected client #5 and potentially affected all clients residing in the home (#1, #2, #3, #4, #5 and #6). The findings are:	W 340	A. The Nursing Supervisor will develop a protocol for latex glove use. Nursing Staff will provide training to all facility Staff regarding the protocol and document the training on NOVA ' s Inservice Training Form. The QP/IID and other program staff will monitor facility operations to assure that the glove protocol is followed. Monitoring will be documented on the facility monitoring form. B. The Medical Director will modify the Order for Consumers BP and Pulse to weekly at 10:00am. This will permit action to the be carried out and documented by Nursing Staff to assure compliance.	07-16-2021

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Cam D Ford	Co-Executive Director	05-27-2021

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W 340	Continued From page 4 A. During observations throughout the survey in the home on 5/17 - 5/18/21, various staff wore latex gloves during interactions with clients and during general work tasks in the home. For example, several staff were noted to wear a single pair of gloves while continuously touching various surfaces in the home (i.e. tables, chairs, cabinet knobs, refrigerator door handle, objects, etc.), and handling keys, pens and cell phones. The staff were not observed to consistently change their gloves in a manner to reduce the potential for cross-contamination. Interview on 5/18/21 with Staff C revealed he had worked at the home for approximately one month and was trained to wear latex gloves "all the time" due to COVID-19 in order to protect himself and clients. When asked at what point the gloves would be considered contaminated, the staff indicated he did not know. Interview on 5/18/21 with Staff D revealed she had worked at the home for about 2 months and had been trained to wear latex gloves during the shift while interacting with clients. Review on 5/18/21 of staff training regarding bloodborne pathogens and latex glove use indicated staff have been trained to avoid touching other surfaces unnecessarily while wearing disposable gloves, to change gloves after providing care for one person and before providing care for the next and to wash their hands after removing the gloves. Additional review of the training noted, "The most effective measure to prevent the spread of infection is hand washing." Interview on 5/18/21 with the Clinical Nurse	W 340		

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Laura H Ford	Co-Executive Director	05-27-2021

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W 340	Continued From page 5 Supervisor confirmed all staff have been trained regarding the appropriate use of gloves during CPR/First Aid/AED training via video. Additional interview indicated staff should be washing and/or disinfecting their hands consistently and glove use should only be required during potential exposure to blood or other bodily fluids. B. During observations of medication administration in the home on 5/18/21 at 7:19am, client #5 indicated to the Registered Nurse (RN) that the staff who conducted the 8:00am med pass on 5/17/21 (Monday) did not take his blood pressure. Immediate observation of the Medication Administration Record (MAR) by the RN revealed no documentation of client #5's blood pressure on 5/17/21 at 8:00am. Immediate interview on 5/18/21 with the RN indicated client #5 has a physician's order to have his blood pressure taken once per week on Mondays at 8:00am. Review on 5/18/21 of client #5's physician's orders dated 5/1 - 5/31/21 revealed an order to "Check blood pressure every week on Mondays...check pulse every week on Mondays...8am" Interview on 5/18/21 with the Clinical Nurse Supervisor confirmed client #5 should have had his blood pressure take on 5/17/21 at 8:00am as indicated on his current physician's orders.	W 340		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are	W 369	Since Liquid Tears is an over-the-counter solution an ample supply of Liquid Tears will be maintained by the facility. When the final bottle is opened the facility Staff will inform the Nursing Staff to replenish the supply. Nursing Staff will provide training regarding the procedure and document the training regarding this procedure and document the training on the Inservice Training Form. Nursing Staff and Residential Supervisors will monitor the Medication Cabinet weekly to assure compliance.	07-16-2021

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sam D Ford	Co-Executive Director	05-27-2021

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W 369	Continued From page 6 self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered without error. This affected 1 of 3 clients observed receiving medications (#1). The finding is: During observations of medication administration in the home on 5/17/21 at 11:29am, the Registered Nurse (RN) obtained a bottle of Artificial Tears 1.4% and prepared to administer the drops into client #1's eyes. The bottle was empty. Client #1 did not receive eye drops during the observation. Immediate interview with the RN revealed nursing staff should have been notified that the client's eye drops were low prior to completely running out of the drops. Additional interview indicated a system is in place to ensure medications are replenished in the home in a timely manner. Review on 5/18/21 of client #1's physician's orders dated 5/1 - 5/31/21 revealed an order for Liquid Tears (Artificial Tears) 1.4%, instill one drop in each eye four times a day at 8a, 12n, 5p and 8p. Review of Medication Administration Audit sheets revealed staff are trained on when to request refills and to call the nurse for refills prior to the last dose being utilized. Interview on 5/18/21 with the Clinical Nurse Supervisor confirmed staff had not followed the procedure to ensure medications remain	W 369		

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W 369	Continued From page 7 available in the home. Additional interview confirmed the unavailability of the medication during the med pass constituted a medication error.	W 369		

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Lauren S Ford	Co-Executive Director	05-27-2021