STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G144	A. BUILDING ______ B. WING ______	C 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDCAT GROUP HOME	**208 WILDCAT ROAD DEEP GAP, NC 28618**

(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 000	INITIAL COMMENTS A complaint survey was conducted on 3/22/21-3/23/21. Deficiencies were not cited as a result of the complaint survey for Intake #NC00174125.	W 000		
W 285	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the team failed to assure interventions to manage the behavior of 1 of 4 sampled clients (#11) was employed with sufficient safeguards and supervision to assure the welfare of the client was protected. The finding is: Observation in the facility throughout the 3/22-23/21 survey revealed client #11 to ambulate in a wheelchair with a pin release seat belt. Continued observation on 3/23/21 at 7:15 AM revealed client #11 to sit in her wheelchair in the common area of suite A and to verbalize "I want to go to bed". Staff A was observed to acknowledge client #11 and encourage the client to stay in her wheelchair due to the need to sit up with having ate breakfast. Further observation revealed client #11 to ambulate into her bedroom next to her bed, to utilize a clothing hanger under her bedding and to unfasten the wheelchair seatbelt. Subsequent observation at 7:18 AM	W 285	W285 – ID Team met and mini-team was completed. QIDP will in-service staff on proper safeguards for supervision to ensure safety, especially during times of inappropriate client behavior. The clinical team will complete weekly interaction assessments or a period of one month, then on a routine basis to ensure that proper safety is being followed. In the future, QIDP will ensure all staff are trained properly on client safety and rights.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lucay Rominger | TITLE: Regional Administrator | (X6) DATE: 4/7/21

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.

DHSR - Mental Health
APR 14 2021
Lic. & Cert. Section

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W 285	Continued From page 1 revealed staff A to monitor the common area of suite A while client #11 stood up from her wheelchair and stood at her bed. Additional observation at 7:19 AM revealed staff B to observe client #11 standing at her bed and to enter the clients room to provide assistance to client #11 with transferring into her bed. Observation of staff C revealed the staff to also enter client #11's room, to talk to client #11 and assist with transferring the client into her bed. Interview with staff A on 3/23/21 at 7:17 AM revealed when client #11 is in her wheelchair and goes to her room he does not provide close supervision as the client is unable to get out of her wheelchair with the seat belt secured. Interview with staff C on 3/23/21 at 7:21 AM revealed client #11 verified she had released the pin on the seatbelt. Continued interview with staff C revealed client #11 can unfasten her seatbelt if she is not closely monitored. Review of records for client #11 on 3/23/21 revealed an individual program plan (IPP) dated 6/25/20. Review of the IPP revealed adaptive equipment to include a wheelchair with a pin release seatbelt. Continued review of records for client #11 revealed a physical therapy assessment dated 6/11/20 that revealed the need for assistance and contact support for stand pivot transfers. Further record review for client #11 revealed a nursing evaluation dated 6/5/20 that reflected with mobility, client ambulates with assistance and requires monitoring to help prevent falls. Interview with the facility qualified intellectual disabilities professional (QIDP) on 3/23/21 verified client #11 has osteoporosis and is a fall	W 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G144	A. BUILDING ______ B. WING ______	C 03/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDCAT GROUP HOME	**208 WILDCAT ROAD DEEP GAP, NC 28618**

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W 285	Continued From page 2 risk. Continued interview with the QIDP revealed the pin release latch was added to client #11's wheelchair to prevent falls as the client was unlatching her seat belt and falling. Further interview with the QIDP revealed she was unaware the client had been unlatching her seatbelt and the restrictive latch implemented should not allow staff to negate proper supervision of the client.	W 285		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to keep prescription medication and topicals locked for 7 of 15 clients residing in the facility (#1, #2, #3, #9, #10, #11 and #12). The findings are: A. The facility failed to ensure topicals were kept locked for clients #1, #2, #3, #9, #10 and #12. For example: Observations throughout the morning of 3/23/21 from 6:45 until 9:15 AM of the facility's two shower rooms located on the back hallway of the facility revealed various shower baskets of multiple clients (#1, #2, #3, #9, #10 and #12) to sit in unlocked wall cabinets. Continued observation of the shower baskets for clients #1, #2, #3, #9, #10 and #12 revealed various topicals and hygiene items with pharmacy labels. Further observation of the shower rooms	W 382	W382 – All topical medications have been relocated and stored properly in the locked med carts. The QIDP and Nursing will in-service staff regarding proper storage of medications. The clinical team will complete weekly nursing assessments for a period of one month, then on a routine basis to ensure medications remain stored properly. In the future, nursing will ensure all staff are trained to store medication properly in a locked area when not being administered.	

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W 382	Continued From page 3 revealed a cart in each room, one of which was locked and the other unlocked with additional prescribed topicals. Interview conducted on 3/23/21 with the facility nurse revealed the treatment carts in the shower rooms should contain all prescribed topical medications for each client and should remain locked at all times when not in use. Continued interview with the facility nurse verified prescribed topicals should not be kept in the unlocked wall cabinets B. The facility failed to ensure medication was kept locked for client #11. For example: Observation in the facility on 3/23/21 in suite A at 8:05 AM revealed staff D to prepare client #11's morning medications for administration at a medication cart in the common area of suite A. Staff D was observed to access client #11's medications, to lock the cart and take medications to the client in her room. Continued observation revealed staff D to leave a opened bottle labeled as Haloperidol on top of the medication cart, unattended, while in client #11's room. Subsequent observation at 8:08 AM revealed staff D to return to the medication cart, place a secured cap on the bottle of Haloperidol and place the bottle in the medication cart. Interview with staff D on 3/23/21 revealed she was unsure if medication for client #11 should be left on top of the medication cart, unattended, as the bottle cap was used with administration in the client's room. Interview conducted with the facility nurse on 3/23/21 verified medication should not be left unattended and unlocked.	W 382		

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

April 1, 2021

Ms. Luray Rominger, Facility Administrator
RHA Health Services, Inc
176 Wildcat Road
Deep Gap, NC 28618

Re: Recertification and Complaint Survey Completed March 23, 2021
Wildcat Group Home
Provider Number #34G144
MHL# 095-011
E-mail Address: lrominger@rhanet.org
Intake #NC00174125

Dear Ms. Rominger:

Thank you for the cooperation and courtesy extended during the recertification survey and complaint survey completed March 23, 2021. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is May 23, 2021.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.

- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call me at (828) 750-2664.

Sincerely,

Kaila Mitchell
Facility Compliance Consultant II
Mental Health Licensure & Certification Section

Enclosures

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Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO