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	W 189 - Direct Support Staff will be trained by Residential Coordinator in the area of safety to include supervision of residents and vehicle safety. This will be done during orientation and bi-annually at staff meetings for June & December. On-going monitoring for safety compliance will be done by the Residential Coordinator and the QP. Training will be monitored by the QP bi-annually. DHSR - Mental Health JUN 23 2021 Lic. & Cert. Section	6/30/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Benita Purcell Director of Services		6/8/21

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.

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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	W 249 – Direct Support Staff will receive training regarding active treatment during medication administration. This training will include following Individual Medication Administration Participation Guidelines or goals developed by the team to promote independence during medication administration. The QP or Residential Coordinator will monitor medication administration at least monthly to ensure compliance.	7/30/21

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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	W 368 - The Registered Nurse will receive training from the Director of Services regarding the MAR, QMR and medication orders to ensure medications are delivered according to physician's orders including times of administration. The RN will do quality checks twice per month on MAR to ensure it matches the QMR and orders. The Director of Services will perform quarterly checks on QMR's and MAR's to ensure accuracy.	6/30/21

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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 371 The Director of Services will train the RN on ensuring information on the nursing evaluation regarding individual medication administration participation abilities are incorporated into guidelines on the Individual Medication Administration Participation Form. These guidelines will be updated and trained annually for each client at the time of the IPP and any time the guidelines are revised. The form will be signed and dated by the RN and placed in the MAR book. The QP will ensure that information regarding individual participation in medication administration is incorporated into the IPP through Health Considerations and any needed training is addressed through goal training. The Director of Services will monitor guidelines and Health Considerations quarterly to ensure inclusion of all information and training regarding individual medication administration participation.	6/30/21
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	W 455 - Staff will be trained to ensure a sanitary environment is promoted to avoid transmission of possible infections and prevent possible cross-contamination. This will be done by the Residential Coordinator bi-annually in staff meeting for June and December. The QP will monitor to ensure training bi-annually and the QP and Residential Coordinator will monitor continually to ensure staff follow sanitation guidelines.	6/30/21

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

June 11, 2021

Benita Purell, Director of Services
Person County Group Homes, Inc.
PO Box 721
Roxboro, NC 27573

Re: Recertification Survey June 8 - 9, 2021
Cates Street ICF/MR, 306 Cates Street, Roxboro, NC 27573
Provider Number 34G 217
MHL# 073-005
E-mail Address: Benita.purcell@pcghinc.org

Dear Ms. Purcell:

Thank you for the cooperation and courtesy extended during the recertification survey completed on June 8 - 9, 2021.

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 **August 8, 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

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Eugina Barnes at 919-819-8182.

Sincerely,

Eugina Barnes

Eugina Barnes, BSW, QIDP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: qmemail@cardinalinnovations.org
DHSR@Alliancebhc.org
File