STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G125	A. BUILDING _____ B. WING _____	C 07/07/2021

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CHANDLER ROAD	342 CHANDLER ROAD DURHAM, NC 27707

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W 000	INITIAL COMMENTS A recertification and complaint survey was conducted on 7/6/21-7/7/21. The complaint allegations were substantiated however, deficiencies were not cited as a result of the complaint survey for Intakes #NC00178779 and NC00178785. However, deficiencies were cited as a result of the recertiication survey.	W 000		
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 review and interviews, the facility failed to ensure privacy was maintained during personal care. This affected 1 audit clients (#2) and 1 non-audit client (#3). The finding is: During observations on 7/7/21 at 6:05am, audit client (#2) was observed with his bedroom door open standing in a T-shirt and his underwear. The residential manager (RM) walked by client #2's bedroom and told him to go ahead get dressed and make his bed. She walked to another client's bedroom to assist him. Client #2's bedroom door remained open and he dressed without any further reminders to close his door. There was one staff (residential manager) working in the facility. During observations on 7/7/21 at 7:20am, client #3 opened his bedroom door and when prompted to get his medications, he turned and walked to	W 130	The Habilitation Specialist will review client #2 and #3's ABI and implement programs addressing their privacy needs. The QP will in-service all staff on the needs of privacy for all people and incidental training on privacy. This will be monitoring through Interaction assessments two times per week for 4 weeks then on a routine basis thereafter. In the future, the QP will ensure person centered plans include intervention to address client needs. DHSR - Mental Health JUL 23 2021 Lic. & Cert. Section	9/7/21

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

Administrator 07.15.21

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 130	Continued From page 1 the bathroom to use the toilet. He toileted with the door open with no verbal cues to close the bathroom door. Staff B and the RM were working in the facility. Immediate interview on 7/7/21 with the RM revealed client #2 needs frequent reminders to shut his bedroom door and bathroom door to safeguard his privacy. Further interview revealed she did not think client #3 had any previous training in safeguarding his privacy. She stated client #3 also needs frequent prompts to close his bedroom door and the bathroom door during dressing and self- care. Review on 7/7/21 of client #2's individual program plan (IPP) dated 8/18/20 revealed an adaptive behavior inventory (ABI) that indicated client #2 has partial independence in protecting his privacy during dressing and self-care. Further review of the ABI did not indicate if client #2 had any previous training in the area of safeguarding his privacy. Review on 7/7/21 of client #3's IPP dated 1/5/21 revealed an ABI which indicated client #3 has no independence in the area of privacy. The ABI did not indicate if client #3 had any previous training in the area of safeguarding his privacy. Interview on 7/7/21 with the qualified intellectual disabilities professional (QIDP) revealed direct care staff should provide verbal cues and assist clients #2 and #3 with protecting their privacy.	W 130		9/7/21
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has	W 249		

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W 249	Continued From page 2 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 3 of 3 audit clients (#2, #5 and #6) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of objective implementation and leisure choices. The finding is: During observations in the facility on 7/6/21 from 2:15pm-4:50pm (140 minutes), clients #2, #5 and #6 sat in the living room area or spent time at the dining room table to color stenciled pictures on paper with colored pencils. Client #5 briefly worked on tracing his name at the dining room table. Client #6 assisted staff C in the kitchen making a sugar free beverage at 4:30pm. There were no other leisure supplies offered to clients #2, #5 and #6. There were limited color pencils available to clients #5 and #6. The television in the living room was on. During interview on 7/6/21 when staff B was asked about leisure supplies available to the clients, she stated the supplies were kept in the den area of the facility in a closet. When staff B walked down to the den area to the closet, she discovered the closet was locked. She attempted	W 249	The QP will inservice all staff on the importance of active tereatment and implementing formal and informal objective throughout the day. A work order will be completed for the door handle to the leisure closet to be replace with a non-locking handle so that access is not limited. The Habilitation Specialist and/or the Residential Team Leader will informally interview the clients to determine what leisure items they would enjoy and purchase those items with the people supported either in a store or online. This will be monitored through Interaction Assessesments two times a week for 4 weeks then on a routine basis thereafter. In the future, the QP will ensure active treatment is occurring in the home.	9/7/21

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W 249	Continued From page 3 several keys but was unable to to open the closet door. Further interview revealed the closet door had been locked for several days. Staff B stated she would leave a message for the maintenance person to unlock the door. Staff B confirmed as a result, there were limited supplies available to the clients for leisure. During interview on 7/6/21 with the habilitation specialist (HS) revealed she also attempted to open the closet but was unable to unlock the door with the keys she had available. Review on 7/6/21 of client #2's individual program plan (IPP) dated 8/18/20 revealed objectives to operate a food processor, tolerate staff brushing his teeth, shaving his face and using a picture communication book. Further review revealed the picture communication book is to assist client #2 in making choices throughout his daily routine. The picture communication book was not used during the observations on 7/6/21. Review on 7/6/21 of client #5's IPP dated 11/30/20 revealed objectives to tolerate wearing a mask, set his placesetting, trace his name and identify a penny. Review on 7/6/21 of client #6's IPP dated 5/19/21 revealed objectives to make sugar free beverage, match pictures of appropriate clothing to match the weather conditions and tolerate wearing a mask. Interviews on 7/7/21 with the residential manager (RM) revealed she was told the closet containing leisure supplies was locked but was unable to open the door. Further interview with the RM revealed the clients have been unable to attend	W 249	The QP will inservice all staff on the importance of active tereatment and implementing formal and informal objective throughout the day. A work order will be completed for the door handle to the leisure closet to be replace with a non-locking handle so that access is not limited. The Habilitation Specialist and/or the Residential Team Leader will informally interview the clients to determine what leisure items they would enjoy and purchase those items with the people supported either in a store or online. This will be monitored through Interaction Assessesments two times a week for 4 weeks then on a routine basis thereafter. In the future, the QP will ensure active treatment is occurring in the home.	9/7/21

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W 249	Continued From page 4 the vocational center for several months because of the current COVID-19 pandemic and have been receiving their programming and leisure at the facility. Additional interview revealed clients #2, #5 and #6 can make choices about choosing leisure activities and should have access to art supplies and board games in the closet downstairs. Interview on 7/7/21 with the qualified intellectual disabilities professional (QIDP) revealed the leisure supplies for the clients should be available for clients to make choices particularly since the clients have been receiving their programming and leisure at the facility due to the COVID-19 pandemic. Additional interview revealed direct care staff should use opportunities to implement formal objectives during their daily routines.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure data relative to the accomplishment of objectives specified in the individual program plan (IPP) was documented in measurable terms. This affected 1 non-audit client (#1). The finding is: During observations in the facility on 7/6/21, client #1 was sitting next to client #5 on the living room	W 252		

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W 252	Continued From page 5 couch. At 3:33pm. Client #1 reached over and hit client #5 on the back. Staff C assisted client #5 get up and move to another chair in the living room. Staff C remarked that she would record the incident in client #1's behavioral data. Staff C contacted the facility Nurse and communicated this incident. Interview with staff C on 7/6/21 regarding client #1's inappropriate behavior revealed staff #1 can have unprovoked aggression, "almost daily" and that they try to keep clients #1 and #5 separate when possible. Staff C stated that client #1 had a behavior support program to address physical aggression, self injury and property destruction. During observations on 7/7/21 at 7:55am at the facility client #5 sat down next to client #1 on the living room couch. Client #1 reached over and slapped client #5 on the back. The residential manager (RM) was working in the facility and immediately separated client #5 and had him sit in another chair. The RM immediately notified the facility Nurse and stated she was going to record this on an incident report and in client #1's behavioral data. Review on 7/7/21 of client #1's record revealed he has a behavioral support program (BSP) dated 7/1/20 that addresses physical aggression, property destruction, PICA and self-injurious behavior. Review on 7/7/21 of client #1's behavioral data revealed the following: July 1: 0 incidents July 2: 1 incident July 3: 1 incident	W 252	The Behavioral Specialist will in-service staff on the BSP for client #1, including appropriate documentation procedures. Also, the team will meet with the psychologist to discuss client #1's behavior rates. This will be monitored through Interaction Assessment twice a week for 4 weeks then on a routine basis thereafter. In the future the QP will ensure behaviors are documented as written in the BSP.	9/7/21

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W 252	Continued From page 6 July 4: 1 incident July 5: 1 incident July 6: 0 incidents recorded Interview on 7/7/21 with the qualified intellectual disabilities professional (QIDP) revealed he had not been contacted about the incident on 7/6/21 regarding client #1 exhibiting physical aggression. Further interview revealed direct care staff should be recording behavioral data for client #1 per his behavioral support program.	W 252		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on review of records and interview, the specially constituted committee, known as the Human Rights Committee (HRC), failed to review, approve and monitor internal investigations that posed risks for client protections for 1 audit client (#2) and 1 non-audit client (#1). The findings are: A. Review on 7/6/21 of an internal investigation dated 6/29/21 revealed there were allegations of physical abuse against a direct care staff. Former staff F which was reported from a new employee in the facility. The new employee witnessed a staff person hit client (#1) several times during third shift after she intervened with his behavior several times. The allegations also	W 262	The HRC has been notified of the previous investgations that took place. The Administrator will ensure that all internal investigation reports will be reviewed, approved and monitored by the HRC. This will be monitored by quarterly HRC minutes reviewed by internal QA as well as rountine reiviews of internal investigations. In the future, the Administrator will notify the HRC in a time manner.	9/7/21

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W 262	Continued From page 7 included former staff F pulling the covers off of client #2 and telling him to get moving and making him get out of bed. Further review of the investigation revealed these allegations were reported on that shift on 6/24/21 and that Former staff F was suspended during the investigation, Nursing was contacted to assess client #1 for injuries. It was determined after multiple interviews with direct care staff that the physical abuse was substantiated and also that two direct care staff had knowledge of reports of physical abuse and did not report these allegations. Additional review of the investigation revealed the decision to terminate former staff F and to also cite two direct care staff for not reporting possible allegations of abuse towards clients. Additional review of the facility's internal investigation dated 6/25/21 revealed all outside agencies, including health care personnel registry (HCPR), the department of social services (DSS), the police department and client #1's guardian were notified. However further review of the internal investigation revealed there was no signature by the human rights committee (HRC) representative. Interview with the facility administrator and the qualified intellectual disabilities professional (QIDP) revealed the human rights committee had not been notified of the facility's investigation into physical abuse of clients #1 and #2. B. Review on 7/6/21 of a second internal investigation dated 6/29/21 revealed there were additional allegations investigated against former staff G who allegedly held up her open hand against client #2. These allegations were reported by facility staff who were interviewed for example	W 262		

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W 262	Continued From page 8 A regarding physical abuse allegations against clients #1 and #2 by former staff F. Former staff G was suspended during the investigation. After collecting statements from several facility staff and investigating this incident, it was determined former staff G had intimidated client #2 by raising her open hand as if she were attempting to strike him. The facility made the decision to substantiate the allegations and terminated former staff G from the facility. Additional review of the facility's internal investigation dated 6/25/21 revealed all outside agencies including health care personnel registry (HCPR), the department of social services (DSS), the police department and client #2's guardian were notified. However further review of te internal investigation revealed there was no signature by the human rights committee (HRC) representative. Interview with the facility administrator and the qualified intellectual disabilities professional (QIDP) revealed the human rights committee had not been notified of the facility's investigation into physical abuse of client #2.	W 262		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all drugs were administered without error. This affected 2	W 369		

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W 369	Continued From page 9 of 3 audit clients observed to receive medications (#2, #5). The findings are: A. During observations of medication administration pass on 7/7/21 at 6:50am, client #2 received the following: Linzess 145mcg. (1), Apap/Codeine 30/60 mg. (1), Klonopin 1 mg. (1), Flomax 0.1 mg. (1), Omeprazole 20 mg. (1), Tegretol 100 mg. (3), Zyrtec 10 mg. (1), Abilify 5 mg. (1) and Singulair (1). Review on 7/7/21 of the physician orders dated 4/13/21 revealed the following: Linzess 145mcg. (1), Apap/Codeine 30/60 mg. (1), Klonopin 1 mg. (1), Flomax 0.1 mg. (1), Omeprazole 20 mg. (1), Tegretol 100 mg. (3), Zyrtec 10 mg. (1), Abilify 5 mg. (1) and Singulair (1). Deep sea Mist nasal spray 0.65% Apply 3-5 sprays each nostril, Fluticasone 50 mcg. Apply 1 spray to each nostril and Listerine swab 5 mls. swab mouth BID. B. During observations of the medication administration pass on 7/7/21 at 7am revealed client #5 received the following: Depakote Sprinkles 125 mg. (1) Tamulosin 0.4 mg. (1), Zoloft 25 mg. (1), Multivitamin (1), Vitamin D3 (1), Aricept 5 mg. (1), Claritin 10 mg. (1) and Proscar 5 mg. (1). Review on 7/7/21 of the physician orders dated 4/13/21 revealed the following: Depakote Sprinkles 125 mg. (1) Tamulosin 0.4 mg. (1), Zoloft 25 mg. (1), Multivitamin (1), Vitamin D3 (1), Aricept 5 mg. (1), Claritin 10 mg. (1) and Proscar 5 mg. (1) Fluticasone 50 mcg. (1) spray to each nostril and Listerine swab 5 ml, swab mouth BID. Interview on 7/7/21 with the facility nurse revealed the physician orders for clients #2 and #5 are	W 369	The nurse will inservice staff on proper medication administration protocols to ensure all medications and resource supplement are administered at the time prescribed. This will be monitored through medication observation twice a week for 4 weeks then on a rountine basis thereafter. In the future, the nurse will ensure staff are properly trained to administer medication as prescribed.	9/7/21

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W 369	Continued From page 10 current and should be followed. Further interview with the Nurse revealed these treatments for nasal sprays and mouth swabs were inadvertently omitted per staff working in the home.	W 369		
W 435	SPACE AND EQUIPMENT CFR(s): 483.470(g)(1) The facility must provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this subpart and as identified in each client's individual program plan. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a variety of leisure supplies for 3 of 3 sampled clients (#2, #5 and #6). The finding is: During observations in the facility on 7/6/21 from 2:15pm-4:50pm (140 minutes), clients #2, #5 and #6 sat in the living room area or spent time at the dining room table to color stenciled pictures on paper with colored pencils. There were no other leisure supplies offered to clients #2, #5 and #6. There were limited color pencils available to clients #5 and #6. The television in the living room was on. During interview on 7/6/21 when staff B was asked about leisure supplies available to the clients, she stated the supplies were kept in the den area of the facility in a closet. When staff B	W 435	The QP will inservice all staff on the importance of active tereatment and implementing formal and informal objective throughout the day. A work order will be completed for the door handle to the leisure closet to be replace with a non-locking handle so that access is not limited. The Habilitation Specialist and/or the Residential Team Leader will informally interview the clients to determine what leisure items they would enjoy and purchase those items with the people supported either in a store or online. This will be monitored through Interaction Assessesments two times a week for 4 weeks then on a routine basis thereafter. In the future, the QP will ensure active treatment is occurring in the home.	9/7/21

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W 435	Continued From page 11 walked down to the den area to the closet, she discovered the closet was locked. She attempted several keys but was unable to to open the closet door. Further interview revealed the closet door had been locked for several days. Staff B stated she would leave a message for the maintenance person to unlock the door. Staff B confirmed as a result, there were limited supplies available to the clients for leisure. During interview on 7/6/21 with the habilitation specialist (HS) revealed she also attempted to open the closet but was unable to unlock the door with the keys she had available. Interviews on 7/7/21 with the residential manager (RM) revealed she was told the closet containing leisure supplies was locked but was unable to open the door. Further interview with the RM revealed the clients have been unable to attend the vocational center for several months because of the current COVID-19 pandemic and have been receiving their programming and leisure at the facility. Additional interview revealed clients #2, #5 and #6 can make choices about choosing leisure activities and should have access to art supplies and board games in the closet downstairs.	W 435		

RHA
HEALTH SERVICES, LLC

July 15, 2021

Mrs. Kimberly C. McCaskill, MSW/FCCI
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

RE: Recertification Survey Completed on 07/07/21
Chandler Road, 342 Chandler Rd Durham, NC 27707
Provider Number: 34G125
MHL Number: MHL: 032-043

Dear Mrs. McCaskill

Thank you for your recent survey of Chandler Road 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

DHSR - Mental Health
JUL 23 2021
Lic. & Cert. Section

To:	Kimberly McCaskill	**Fax:**	919-715-8078
From:	Morris Thomas	**Date:**	07/15/21
Re:	Chandler Road Survey	**Pages:**	14 (Including Cover)
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DHSR - Mental Health

JUL 23 2021

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Form #: 2011-RTP

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DURATION	00:05:14
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RESULT	OK
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