08-26-'21 14:29 FROM-T-421

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

P0003/0014 F-341 PRINTED: VOLLIZUZI FORM APPROVED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING | (X3) DATE SURVEY COMPLETED | |
|---|---|------------------------------|---|---|
| | 34G292 | B. WING | | 08/10/2021 |
| NAME OF PROVIDER OR SUPPLIER ROCKWOOD | | 44 | TREET ADDRESS, CITY, STATE, ZIP CODE 189 ROCKWOOD DRIVE ALEIGH, NC 27612 | 1 VOTOLET |
| PREFIX (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION |
| This STANDARD is n Based on observatior interviews, the facility audit clients (#5) recei swallowing skills wher had a history of dysph pureed diet. The findi During observations o client #5 received a pu and potatoes with fruit There were no observe At dinner preparation a staff C stated, "I will si will probably grab." Sh fable where she was fe the meal (Turkey burge with crackers.) She we water. During this time burger from her peer a observed consequence then grabbed another i same peer and she che came toward her and p at which time the burge mouth onto her lap. Si | of met as evidenced by: not met as evidenced by: not met as evidenced by: not record reviews and failed to assure that 1 of 5 yed an assessment of her of the team noted that she agia and serving her a ng is: n 8/09/2021 at 12:00pm, nreed lunch of fishsticks She was fed her lunch ed issues with swallowing, at approximately 5:30pm, ther at the table but she e assisted client #5 to the ed a ground consistency of ers with cheese and soup as provided thickened , she grabbed a fourth of a nd ate it. There were no es or changes, Client#5 fourth of a burger from the oked. The home manager patted her hard on the back | W 217 | This deficiency will be correct the following actions: A. The Clinical supervisor ensure that each individual assessments are completed by the annidate. B. Client #5 will receive a assessment of her swallowing skills in ordetermine an appropridiet and consistency or and drinks at meal. C. The individual's ISP will updated to reflect the information in the assessment to ensure the information in the assessment to ensure the individual is receiving the services recommended. D. Staff will be in-serviced the update ISP's. E. RN will monitor and document on this mon. F. Site Supervisor will more and document on this time a week. G. Clinical Supervisor will. | will iduals e ual due nd der to iate f food I be current he he on thly nitor one |
| indicated she should go choke again. | et it so the client did not breakfast on 8/10/2021, at served a plate with | | monitor and document this one time a week | UIT |

Any deficiency statement along with an asterist (7) denotes a definite the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (He 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 44 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.

26-'21 14:29 FROM-P0004/0014 F-341 DEPARTMENT OF HEALTH AND HUMAN SERVICES PŘINTED: 08/11/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G292 B. WING 08/10/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4409 ROCKWOOD DRIVE ROCKWOOD RALEIGH, NC 27612 SUMMARY STATEMENT OF DEFICIENCIES (X4) JD PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE-COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 217 Continued From page 1 W 217 well as unmodified orange slices. This diet was not pureed and there was no concern by staff about serving her this diet. Client #5 immediately ate one of the whole muffins and the group home manager assisting her laughed. She stated she laughed because client #5 was so fast. She then cut the other whole muffin in half. When asked if her diet was appropriate she said, "Yes." Client #5 ate the whole half of the muffin in one bite and the other half in two bites. She ate the oranges (canned) as they were served (unmodified.) She was provided thickened water. During observations of the medication administration pass on 8/10/2021 at 6:30am. client #5 was given her medications in regular unthickened milk with strawberry flavoring. When the milk was finished she was given regular unthickened water for the rest of her medication. Review of client #5's diet order on 8/9/2021, revealed she should receive a pureed diet. Further review of client #5's individual program plan (IPP) dated 12/30/2020 revealed she should receive a pureed diet with nectar thick liquids. It noted she had a history of dysphasia. Further review revealed the current physician order which

noted client #5 is on a pureed diet with thickened liquids but also noted she may have "cheese puffs, cheerios, graham crackers, rice puffs, saltines, yogurt puffs or other approved items as per Speech." Further review of client #5's Nutritional evaluation dated 6/9/2020 revealed she needs a "puree diet for safe PO intake."

There was no modified barium swallow study (MBSS) or swallowing team assessment in client #5's record to clarify exactly what diet she should be on and if other non-pureed foods were

08-26-'21 14:29 FROM-

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES T-421 P0005/0014 F-341

PRINTED: 08/11/2021 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION | OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|-------------------------------|---|---|
| <u>.</u> | | 34G292 | 8. WING | | 08/10/2021 |
| NAME OF PROVIDER OR SUF | PLIERYA Mariana Maria | in the state of th | .0. | STREET ADDRESS, CITY, STATE, ZIP GOO 4469-ROCKWOOD DRIVE RALEIGH, NC 27612 | |
| PREFIX" (EACH) | DEFICIENCY ML | MENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) | ID PRÉFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS REFERENCED TO THE DEFICIENCY) | N SHOULD BE COMPLÉTION OF PATE OF STREET |
| professional client #5 had if she had recalled the nu knowledge, "evaluation." need for clier other foods so non-pureed cataff fed her the management | n the qualifie (QIDP) on 8 not received ceived a swarse who told She has nev The QIDP on t #5 becaus he is okay to consistency, cods not on seemed cei | d intellectual disability /10/2021 revealed that I a MBSS. When asked illowing evaluation, he him to the best of her er received a swallowing onfirmed this may be a e there is not a list of eat that are a He acknowledged that the list but no tain as to whether these | W 21 | W 227 This deficiency will be of the following actions: | corrected by |
| W 227 INDIVIDUAL CFR(s): 483. The individual objectives neas identified to | PROGRAM 440(c)(4) I program pl cessary to n by the compr | ed to be pureed. PLAN an states the specific seet the client's needs, when sive assessment (3) of this section. | W 227 | the Clinical Sup- address the cur and goals and s training objectiv to be put in place | updated by ervisor to rent needs specific ves that need ce to meet |
| Based on ob interviews, the clients (#5) had meet identified observed need inappropriate eating was not objective. The During observed in the client #5 receives | servations, referenced to specific to deeds. Specific to deeds. Specific to deed to not take diet texture at addressed to findings and ations on 8/4 ved a pureed | net as evidenced by: ecord reviews and d to assure 1 of 5 audit aining objectives to ecifically, client #5's e food that is an and to slow her rate of with a training e: 19/2021 at 12:00pm, d lunch of fishsticks he was fed her lunch. | | C. Clent #5 will ha training objective identified needs D. Clinical Supervises serviced all staff updated ISP's are documentation. E. Site Supervisor version and document of time a week. F. Clinical Supervisor monitor and document document of time a week. | ves to meet for will infonthe and proper will monitor on this one for will |

08-26-'21 14:30 FROM-T-421 P0006/0014 F-341 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/11/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER; COMPLETED A. BUILDING 34G292 08/10/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4409 ROCKWOOD DRIVE ROCKWOOD , well RALEIGH, NC 27612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION . LANCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX 12 1 AND A MEACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG " " CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 227 Continued From page 3 W 227 There were no observed issues with swallowing, At dinner preparation at approximately 5:30pm, staff C stated; "I will sit her at the table but she will probably grab." She assisted client #5 to the table where she was fed a ground consistency of the meal (Turkey burgers with cheese and soup with crackers.) She was provided thickened water. During this time, she grabbed a fourth of a burger from her peer and ate it. There were no observed consequences or changes. She then grabbed another fourth of a burger from the same peer and she choked. The home manager came toward her and patted her hard on the back at which time the burger projected out of her mouth onto her lap. Surveyor 2 told the manager the large piece of food remained on her lap and indicated she should get it so the client did not choke again. During observations of breakfast on 8/10/2021, at 7:00am, client #5 was served a plate with oatmeal and raisins and two whole muffins as well as unmodified orange slices. This diet was not pureed. Client #5 immediately ate one of the whole muffins and the group home manager assisting her laughed. She stated she laughed because client #5 was so fast. She then cut the other whole muffin in half. Client #5 ate the whole half of the muffin in one bite and the other half in

program plan (IPP) dated 12/30/2020 revealed she should receive a pureed diet with nectar thick liquids. It noted she had a history of dysphasia.

FORM CMS-2587(02-99) Previous Versions Obsolete

whole bottle of thickened water.

two bites. She ate the oranges (canned) as they were served (unmodified.) She was provided a

Review on 8/10/2021 of client #5's diet order on 8/9/2021, revealed she should receive a pureed diet. Further review of client #5's individual

Event ID; EW6P11

Facility ID: 955749

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08-26-³21 14:30 FROM-

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

T-421 P0007/0014 F-341

PRINTED: 08/11/2021 FORM APPROVED OMB NO: 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPE A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|-----------------------------|--|--|--|
| | 34G292 | B. WING | | 08/10/2021 | |
| NAME OF PROVIDER OR SUPPLIER ROCKWOOD | A Company of the Comp | | STREET ADDRESS, CITY, STATE, ZIP CODE 4409 ROCKWOOD DRIVE | en e | |
| PREFIX: CACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDE DEFICIENCY) | (XS) SE COMPLETION ATE DATE | |
| taking food (especially | s the fast pace of eating or | W 227 | | | |
| Review of the current I (BSP) dated 12/30/201 address hair pulling se | ion money and behavioral. pehavior support program 9 revealed a plan to If-injurious behaviors with | | | | |
| mittens. There were n listed. | o other target behaviors | * | | 7. X | |
| professional (QIDP) оп | M'PLAN | W 247 | W 247 This deficiency will be correcte the following actions: | d by 10.8.2021 | |
| meaningful activities as | t met as evidenced by: i, record review and alled to provide a choice of per the Individual 3 of 5 audit clients (#2; | | A. Clinical Supervisor will on that all ISPs are updated. B. All staff will be in-service the updated ISP's C. All staff will be in-service client rights and client of D. All clients will be given. | ed on choice | |
| sat by a felevision in the seemed interested in the the staff turned it onto a | es), the staff and clients e living room. No clients e television. At 11:00am, music channel and to dance. No choice was ervations on 8/10/2021 | | opportunity to choose meaningful daily activit E. Site Supervisor will more and document that this occurring one time a w. F. Clinical Supervisor will monitor and document this is occurring one time week. | itor is eek that | |

08-26-'21 14:31 FROM-P0008/0014 F-341 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTEU: 08/11/2021 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 34G292 08/10/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4409 ROCKWOOD DRIVE ROCKWOOD RALEIGH, NC 27612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID. PROVIDER'S PLAN OF CORRECTION D: (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX "PREFIX (EACH CORRECTIVE ACTION SHOULD BE: COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE : TAG : CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W:247 Continued From page 5 minutes), all clients sat by the television in the living room and were not provided any meaningful activity choices. Observation of the schedule on the wall indicated they should be provided opportunities to do chores. Review of the clients IPPs revealed they could all make choices. A. Review on 8/9/2021 of client #5's IPP dated 12/30/2020 revealed she can make choices and likes to play with string activities and do activities with house mats. B. Review on 8/9/2021 of client #3's IPP dated 11/11/2020 revealed that he can make choices. and has specific games he prefers. C. Review on 8/9/2021 of client #2's IPP dated 5/11/2021 revealed that she can make choices and prefers visually stimulating objects. Interview with Staff C on 8/10/2021, revealed clients can make choices if the choices are

presented to them. Further interview with the group home manager indicated there is no real structured schedule for the home time during COVID. She stated they just "do activities and games." When asked if they do goals she confirmed they do. The qualified intellectual disabilities professional (QIDP) confirmed that clients should be given choices throughout the day.

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

W 263 !

08-26-'21 14:31 FROM-

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

T-421 P0009/0014 F-341

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| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION . | | (X3) DATE SURVEY COMPLETED | |
|---------------|---|--|-----------------------------|--|---------------------------------|---------------------------------------|--|
| | | 34G292 | B. WING | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C | | 08/10/2021 | |
| · | gaga i sast gira sasa s | | 1 | 4409 ROCKWOOD DRIVE | ODE : | | |
| ROCKWO | OD | | | RALEIGH, NC 27612 | | | |
| (X4).iD. | SUMMARY STA | TEMENT OF DEFICIENCIES | | | <u> </u> | | |
| PREFIX TAG | . (EAGH DEFICIENC) | MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S REAN OF EACH CORRECTIVE ACT CROSS REFERENCED TO T DEFICIENCE | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| W 263 | Continued From page | 8 | W. 000 | W 263 | | | |
| | , , , , , , , , , , , , , , , , , , , | parents (if the client is a | VV 263 | This deficiency will be | corrected by | | |
| | minor) or legal guardia | an: | | the following actions: | | 10.8.2021 | |
| | | The same of the sa | | A: Clinical Supervi | | | |
| | | | | that current be | | | |
| | This STANDARD is n | ot met as evidenced by: | | support plans a | | | |
| | | is, record reviews and | | B. All behavioral s | | | |
| | | failed to ensure 1 of 5 audit | | will be reviewe | | 200 | |
| | clients (#5) received h | | • • • | C: All behavioral s | | 1 12 4 5 300 | |
| | prescribed. The finding | g is: facility failed to assure | | will address the | current | ٠ | |
| | the informed written of | of their behavior support | | needs and tech | niques to | | |
| | | affected 3 of 5 audits (#3, | | manage inappr | opriate | | |
| , | #4, #5). The findings a | | | behaviors | | | |
| ` | | | i | D. All proper techr | niques will be | | |
| | A. Review on 8/9/2021 | revealed client #3 had a | | used to manage | | | |
| | BSP dated 12/4/2019. | The plan addressed | | E. Psychologist wil | | ; | |
| : | agitation, physical agg | | ; | plans | 3 1 C A1 C AA Citi | : | |
| ; | | d to be a restrictive plan as | | • | nd the acaded | 3 | |
| | it included medications | | | F. HRC approval a | | | |
| | Risperidone. There wa | sine HCL, Minazapine and | | consents will be | | · · · · · · · · · · · · · · · · · · · | |
| | consent in the record. | as not a current BSF | | all behaviöral su | | | |
| | Concort in the record, | | | G. Clinical Supervis | | . | |
| | B. Review on 8/9/2021 | revealed client #4 had a | | and obtain guar | | | |
| | BSP dated 5/1/2020: 7 | The plan addressed | | consents for all i | | | |
| | inappropriate verbaliza | tions; noncompliance, | | specifically #3, # | 4, and #5 | | |
| | physical aggression, pr | operty destruction and | | whose consents | were | | |
| | false accusations. It was | is noted to be a restrictive | | missing | | | |
| · | plan as it included med | ications such as Lexapro, | | H. All staff will be in | -serviced on | | |
| | Olanzapine and Indera | al to aid in behavioral a current BSP consent in | i i | update behavior | | | |
| | the record. | a current por Consent in | | plans | | | |
| 1. | प्यत्र र ज्या विकास विकास सम्बद्धाः । १ | | | I. Site Supervisor w | /ill monitor | | |
| . 1 | C. Review on 8/9/2021 | revealed client #5 had a | h - 1 | and document t | | | |
| ì, | B\$P dated 12/30/2019. | The plan addressed SIB | 4.0 | | | | |
| | of hair pulling. It was n | | | occurring one tir | | | |
| | plan as it included the u | | , | J. Clinical will mon | ' | | |
| ; i | medications such as Be | enztropine, Ziprasidone, | 10 | document that ti | | | |
| ; · | Civinipramine, Gabape | ntin and Baclofen. There | | Occurring one tire | ne a week | | |

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08-26-'21 14:31 FROM-T-421 P0010/0014 F-341 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/11/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 34G292 B. WING 08/10/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ROCKWOOD 4409 ROCKWOOD DRIVE RALEIGH, NC 27612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX MEACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG: CROSS REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 263 Continued From page 7 W 263 was not a current BSP consent in the record. Interview with the qualified intellectual disability professional (QIDP) on 8/10/2021 revealed none of the current required behavioral consents are in place. This deficiency will be corrected by the W 288 MGMT OF INAPPROPRIATE CLIENT W 288 following actions: BEHAVIOR A Clinical Supervisor will review all CFR(s): 483.450(b)(3) ISP's Clinical Supervisor will update all Techniques to manage inappropriate client behavior must never be used as a substitute for ISP' to include any specific an active treatment program. techniques that need to be utilized or goals that need to be put in place to manage client This STANDARD is not met as evidenced by: behavior Based on observations, record review and C. Clinical Supervisor will update interview, the facility failed to assure specific the ISP for client #2 to include techniques to manage client #2's rapid eating were included in a formal active treatment specific techniques that can be program. This effected 1 of 5 audit clients (client used to address rapid eating #2). The finding is: D. Clinical Supervisor will review all BSP's to ensure that any Based on observations, during dinner on techniques that are to be 8/9/2021 staff C was assisiting client #2 with her utilized are include in there as meal. During this time, when client #2 beganeating too quickly, staff C held client #2's arm still well approximately 35 seconds until she swallowed E. Clinical Supervisor will in-service what was in her mouth. During further stall on the updated ISP and BSP

observation on 8/10/2021 of breakfast, staff B

was assisting client #2 with her meal. When client

#2 began to eat too quickly, staff B would pulled client #2's tray out of her reach until she had

swallowed what was in her mouth. Staff B did this

Review on 8/10/2021 of client #2's occupational therapy quarterly update (dated 7/12/2021)

several times throughout the meal.

F. Site Supervisor will monitor

G. Clinical will monitor and

document that this is

and document that this is

occurring one time a week

occurring one time a week

08-26-121 14:32 FROM-

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

T-421 P0011/0014 F-341

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| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | | CONSTRUCTION | (X3) DAT | E SURVEY | |
|----------------|--|--|---------------------|----------|---|---|-----------------|--------------------------------|
| 34G292 | | 8. WINC | 8. WING | | | 3/10/2021 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | . s | TREET ADDRESS, CITY, STATE, ZIP CODE | (2.77) | Torner. | |
| ROCKWO | OD | | | ı | 409 ROCKWOOD DRIVE LALEIGH, NC 27612 | *** | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | يئين بسنون | | | المساسرة والمساسرة | | 20100 VIV |
| PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PRE | FIX | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | OULD BE | COMPLETION DATE | |
| W 288 | Continued From page | ± 8 | 1/0 | / 288 | | | | I MAU H T X |
| ا به بین | revealed "staff should | | V.V. | / 200 | | | | |
| | themselves close to c | client #2 during meals. If | | | | | | |
| | client #2 starts to eat | at a fast pace, overload her | | ás n | | | | $g_{13} \stackrel{G_2}{=} g_3$ |
| | | respond to verbal prompts to | | ! | | · , · · · · · · · · · · · · · · · · · · | | 15.50 |
| | slow down, staff is nea | larey to offer physical lown". The type of physical | | : | | | | |
| | prompts to be used w | | | : 4 | | | | 10.00 10.000 (1) |
| | | | |] | | • | | <i>:</i> : |
| | Interview on 8/10/202 | 1 with the home manager | | . ! | | | | |
| | | y aware of a need to slow began to eat too quickly but | * . | į | | ÷, | | |
| ļ | were unsure of proper | | | | • • | | | ļ |
| W 325 | PHYSICIAN SERVICE | ES | w | / 325 | * | | | |
| • | CFR(s): 483.460(a)(3) |)(iii) | | į | | | • | , |
| . ; | | ide or obtain annual physical | ! | : | W 325 | | 1 45 4 | |
| į | examinations of each | client that at a minimum | | | This deficiency will be correct | ed by the | 10.8.2021 | |
| | includes routine scree | | . ! | | following actions: | - | | |
| i Tanana da | examinations as deter physician, | rmined necessary by the | the state of | المراجعة | A. The Site Supervisor w | ' ' | 14 1 11 114 | |
| | A Section of the Control of the Cont | | S MARK | | that all clients medica | 1 | | Vingerape — — Territoria |
| | | 1 · · · · · · · · · · · · · · · · · · · | | . : | appointments are cor ordered | npleted as | | |
| ! | This STANDARD is no | ot met as evidenced by: | | , ; | B. Client #2 will obtain to | La labe | | |
| , | based on record revie | ew and interview, the facility is determined necessary by | : | : | work that was ordere | | | |
| | | ined for 1 of 5 audit clients | : | . : | | | | 1. 1. 1. |
| | (#2), The finding is: | 11 m at 1 m / A m v = | • | | compliance | IIL HOTE | . [| 1 . 4 |
| | ~ | | | : | C The Site Supervisor wi | iii | | |
| | | of client #2's consultation isit on 7/13/2021 revealed | | | document on this we | | | ' ' |
| | | ended "lab work today." | | i | D. The Clinical Superviso | | | |
| 1 | Further review of client | it #2's record revealed no | • | | monitor and documer | | | |
| 1 | lab work was obtained | I on that day and has not | | : | 🖖 🐣 this monthly | · | | , |
| | been rescheduled. | • | | • | E. The Nurse will monito | - 1 | | , |
| | During an interview on | 8/10/2021 the house | : | | document on this mor | nthly | | ٠, |
| | | nt #2 was uncooperative | | 1 | • | ₹, | | |
| | | awn on that day and no | | ; | | | | |
| | | | | | | * | 1 | |

08-26-'21 14:32 FROM-T-421 P0012/0014 F-341 PRINTED: 08/11/2021 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 34G292 08/10/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4409 ROCKWOOD DRIVE ROCKWOOD RALEIGH, NC 27612 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO ID: PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL 🦠 PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 325 Continued From page 9 W 325 follow up appointment has been scheduled W 436 SPACE AND EQUIPMENT W 436 CFR(s): 483.470(g)(2) This deficiency will be corrected by the following actions: The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, 10.8.2021 hearing and other communications aids, braces, A. Staff will be in-serviced on and other devices identified by the all ISP's and adaptive interdisciplinary team as needed by the client, equipment used by each client will be identified B. The Site Supervisor will be This STANDARD is not met as evidenced by: Based on observation, record review and responsible for ensuring interview, the facility failed to assure client #1 was that all adaptive furnished adaptive equipment that was equipment is furnished maintained in good repair. This affected 1 of 2 audited clients who were prescribed glasses. and in good repair C. Client #1 will have her During observations in the home throughout the adaptive equipment survey on 8/9-10/2021, client #1 did not wear leyeglasses) repaired and eyeglasses. The client was not prompted or assisted to wear eyeglasses. available for her use D. The Site Supervisor will Review on 8/9/2021 of client #1's Individual monitor and document on Program Plan dated 4/14/2021 revealed glasses as adaptive equipment needed. Further review this weekly

utilized by client #1. W-460 FOOD AND NUTRITION SERVICES

FORM CMS-2567(02-99) Previous Versions Obsolete

revealed a visual examination on 1/14/2021. The

Interview on 8/10/2021 with the home manager indicated she was not aware that client #1

currently had or needed glasses. After looking in

client #1's room, the home manager found eye

glasses that were broken and unable to be

report noted client #1 needs glasses.

Facility IO: 955749

E. The Area Supervisor will

F: The Clinical Supervisor will

monitor and document

this monthly

on this weekly

monitor and document on

08-26-'21 14:33 FROM-DEPARTMENT OF HEALTH AND HUMAN SERVICES T-421

P0013/0014 F-341 FRINTED: 08/11/2021 FORM APPROVED OMB NO. 0938-0391

| CENTER | RS FOR MEDICARE & | MEDICAID SERVICES | | - | OMB NO. 0938-0391 |
|---------------------------|--|--|-----------------------------|--|--|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | LE CONSTRUCTION : | (X3) DATE SURVEY COMPLETED |
| | | 34G292 | B. WING | | 08/10/2021 |
| NAME OF F | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | - 100/10/2021 |
| ROCKWO | T-1 | | | 4409 ROCKWOOD DRIVE RALEIGH, NC 27612 | the many of the state |
| (X4) ID PREFIX- YAG | (EACH DEFICIENC | NYEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE COMPLETION |
| W 460 | Continued From page | 10 | W 460 |) | |
| | CFR(s): 483;480(a)(1 | | 1117100 | | |
| Nr | | • | | 411.440 | 10.8.2021 |
| 5, . | Each client must rece | ive a nourishing | | W 460 This deficiency will be corrected | |
| , | well-balanced diet inc | luding modified and | | following actions: | Toy are |
| | specially-prescribed d | iets. | | TOROWING REGOLD, | |
| | | | in the second | A. All Individual Support F | olans will |
| | | ersker i de de 🖆 🕆 e e e e e | | be updated to include: | |
| " | This STANDARD is n | of met as evidenced by: | | recommended diet for | |
| | Based on observation | | | client | |
| | | iled to ensure 1 of 5 audit | ,• | B. The Clinical Supervisor | will |
| | clients (#5) received h | | | review each ISP | |
| | prescribed. The finding | g is: | į | . C. The Clinical Supervisor | will in- |
| | | | 1 | service staff on the upo | lated ISP |
| , | | n 8/09/2021 at 12:00pm, | | to ensure the proper d | |
| | | reed lunch of fishsticks | ř r | guidelines are being fo | |
| | | . She was fed her lunch. | † | D. Staff will ensure that cli | |
| | I nere were no observ | ed issues with swallowing. | | modified diet is being f | |
| ! | At dinner preparation | at approximately 5:30pm, | 1 | E. The Site Supervisor will | |
| · | | ther at the table but she | | and document on this | |
| | | e assisted client #5 to the | | F. The Clinical Supervisor | |
| · · ·) | table where she was n | ed a ground consistency of | · | monitor and documen | tion this |
| | | ers with cheese and soup | | weekly | |
| i | with crackers.) She water During this time | s provided inickened , she grabbed a fourth of a | | G. The Area Supervisor w | ill monitor |
| | | nd ate it. There were no | | and document on this | montrily [|
| ; | | es or changes. She then | | | |
| ; | | of a burger from the same | | | |
| į | | The home manager came | | | |
| 1 | | her hard on the back at | | | 1 |
| | | projected out of her mouth | | and the control of the state of the control of the | () |
| ; | | 2 told the manager the | | | |
| 1 | large piece of food rem | | : | han see | |
| | | et it so the client did not | <u>.</u> | | |
| | choke again. | | | | |
| | | • | | Service of the servic | 150 |
| | | breakfast on 8/10/2021, at | · . | | |
| | 7:00am, client #5 was : | | | | |
| | oatmeal and raisins an | | | the second | and the state of t |
| | well as unmodified orai | nge slices. This diet was | | • | 1 |

26—"21 14:33 FROM— P0014/0014 F-341 PŘINTED: 08/11/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 34G292 B. WING 08/10/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP.CODE 4409 ROCKWOOD DRIVE RALEIGH, NC 27612 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL IEACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETION REGULATORY OR USCHDENTIFYING INFORMATION TAG" CROSS REFERENCED TO THE APPROPRIATE DATE. TAG · DEFICIENCY) W 460 Continued From page 11 W 460 not pureed. Client #5 immediately ate one of the whole muffins and the group home manager assisting her laughed. She stated she laughed because client #5 was so fast. She then cut the other whole muffin in half. Client #5 ate the whole half of the muffin in one bite and the other half in two bites. She ate the oranges (canned) as they were served (unmodified.) She was provided thickened water. During observations of the medication administration pass on 8/10/2021 at 6:30am. client #5 was given her medications in regular unthickened milk with strawberry flavoring. When the milk was finished she was given regular unthickened water for the rest of her medication. Review of client #5's diet order on 8/9/2021, revealed she should receive a pureed diet. Further review of client #5's individual program plan (IPP) dated 12/30/2020 revealed she should receive a pureed diet with nectar thick liquids. It noted she had a history of dysphasia. Further review revealed the current physician order which noted she is on a pureed diet with thickened

Interview with the group home manager on 8/9/2021 revealed that client #5 should receive a pureed diet with thickened liquids.

liquids but also noted she may have "cheese puffs, cheerios, graham crackers, rice puffs, saltines; yogurt puffs or other approved items as per Speech." Further review of client #5's Nutritional evaluation dated 6/9/2020 revealed she needs a "puree diet for safe PO intake."