| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G085 | A. BUILDING _____ B. WING _____ | 09/08/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OAKDALE GROUP HOME | 436 MOCKSVILLE HWY STATESVILLE, NC 28625 |

| (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 130 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(7)<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure privacy was maintained for 6 of 6 clients (#1, #2, #3, #4, #5 and #6) during medication administration. The findings are:<br><br>Observations in the group home on 9/8/21 at 7:35 AM revealed client #4 to transition to the medication room to prepare for medication administration. Continued observations revealed staff F to offer medication education while having client #4 punch medications in a cup. Further observations revealed client #4 to take his medication as another client sat directly in front of the open door, and other clients sitting in the living room area. At no point during the observation was client #4 offered privacy during medication administration.<br><br>Observations in the group home at 8:00 AM revealed client #6 to transition to the medication room via wheelchair. Continued observations revealed staff F to offer medication education. Further observations revealed client #6 to take his medication as another client sat directly in front of the open door, and other clients sitting in the living room area. At no point during the observation was client #6 offered privacy during medication administration.<br><br>Observations in the group home at 8:15 AM revealed client #1 to transition to the medication | W 130 | | |

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

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|---|---|---|---|---|
| W 130 | Continued From page 1 | W 130 | | |

room. Continued observations revealed staff F to administer medications to client #1 with the door open and another client sitting directly in front of the door. Further observations revealed staff D to stand in the doorway facing the medication room while client #1 received his medication. At no point during the observation did staff F prompt the client to move away from the entryway nor did she offer privacy to client #1 by closing the door.

Observations at 8:20 AM revealed client #2 to transition to the medication room. Continued observations revealed staff F to administer client #2's medication while staff D was standing outside the doorway and clients were walking up and down the hallway. At no point during the observation did staff offer client #2 privacy during medication administration.

Observations at 8:40 AM revealed client #3 to enter the medication room. Continued observations revealed client #3 to take his medications which could be seen from the hallway. Further observations revealed client #3 to respond to another client sitting in the living room relative to what type of cereal he likes. Observations did not reveal client #3 to be offered privacy during medication administration.

Observations at 8:50 AM revealed client #5 to transition to the medication room with assistance. Continued observations revealed client #5 to exit the medication room on three different occasions and is redirected to return. Further observations revealed another client to stand in the doorway of the medication room and ask staff D if she was almost finished. Subsequent observations revealed staff D to respond while crushing client #5's medication then mixing it with applesauce.

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| | 34G085 | A. BUILDING _____ B. WING _____ | 09/08/2021 |

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|---|---|---|---|---|
| W 130 | Continued From page 2<br>Additional observations revealed client #5 to take his medications while standing. It is important to mention that at no point during the observation did staff F prompt the client to move away from the entryway nor did she offer privacy to client #5 by closing the door.<br><br>Interview with staff F on 9/8/21 at 9:00 AM revealed that privacy is offered primarily when staff are administering topicals or any other ointment. Continued interview with staff F confirmed if the door was closed, client #5 could not easily exit the medication room. Further interview with staff F confirmed that all clients should be offered privacy during medication administration.<br><br>Interview with the facility nurse on 9/8/21 verified that all clients have a choice to the right to privacy during medication administration and that should have occurred. | W 130 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interview, the facility failed to ensure 1 of 6 clients | W 249 | | |

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|---|---|---|---|---|
| W 249 | Continued From page 3 | W 249 | | |

(#5) received a continuous active treatment program consisting of needed interventions as identified in the person-centered plan relative to supervision and safety. The finding is:

Observation on 9/8/21 at 6:45 AM revealed client #5 to be sitting by himself in the living room. Continued observation at 7:00 AM revealed client #5 to walk into the hallway bathroom and use the restroom with the door open. Further observation revealed client #5 to exit the bathroom without flushing the toilet or washing his hands, and enter his bedroom. During the time client #5 used the restroom, observations revealed staff D, the only staff on duty, to be occupied with breakfast preparation in the kitchen.

Review of client #5's record on 9/8/21 revealed a person-centered plan (PCP) dated 3/30/21. Review of client #5's PCP indicated "while at home, a staff must remain within eyesight of client #5 to ensure his safety and those around him. When he uses the restroom, 1:1 support staff should remain within eyesight of the restroom to ensure client #5's safety." Continued review of client #5's record revealed a behavior support plan (BSP) dated 5/19/21. Review of the BSP indicated target behaviors of aggression and self-injury. Further review of the BSP revealed client #5 "requires one-on-one staffing" and "staff should monitor him while toileting and showering to notice if he has any injury from this behavior."

Interview with the qualified intellectual disabilities professional (QIDP) on 9/8/21 confirmed client #5 should be supervised by a 1:1 staff at all times, and staff should have monitored his toileting as specified in his PCP and BSP.