STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G305	A. BUILDING _____ B. WING _____	C 10/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKWOOD	313 EAST BROOKWOOD AVENUE LIBERTY, NC 27298

(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 Complaint Intake #: NC00181844, NC00182102 and NC00182143.	W 000		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure sufficient staff were available to manage and supervise 6 of 6 clients (#1, #2, #3, #4, #5, and #6) in accordance with their individual habilitation plans (IHPs). The finding is: Observations at the day program on 10/18/21 at 11:45 AM revealed client #4 to sit at her work station engaged in a coloring activity. Continued observations revealed client #4 to have bruises on her thighs and a swollen and slightly bruised left hand. Review of incident reports from 7/2021 through 10/2021 revealed the following; on 7/19/21 a bruise of unknown origin involving client #4, 7/20/21 a red scrape/bruise of unknown origin, 7/24/21 a client picking her fingers, 7/26/21 a client had a fall at the day program, 7/27/21 a bruise of unknown origin was discovered on client's right back shoulder, 8/2/21 a medication error, 8/6/21 a medication error and 9/17/21 involving client #4 to fall and awaken with a	W 186		

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

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W 186	Continued From page 1	W 186		

swollen foot.

Review of records for client #3 on 10/18/21 revealed an individual habilitation plan (IHP) dated 9/16/20. Review of records for client #4 revealed an IHP dated 9/15/20. Continued review of records for client #3 and #4 revealed the need for one on one staffing due to behavioral and medical challenges.

Review of the facility schedule for July 2021 through October 2021 revealed four staff scheduled on first and second shifts. Continued review of the schedule revealed openings for staff on first and second shifts. Subsequent review of facility schedules could not verify a time of one staff working on shift from July 2021 through October 2021.

Interview with staff A revealed she had worked alone in the group home on first shift. Continued interview revealed staff ratio in the group home is 4:6 with one on one staffing with clients #3 and #4 and two additional staff work with client #1, #2, #5 and #6.

Interview with the facility qualified intellectual disabilities professional (QIDP) on 10/18/21 could not verify that staff A had worked alone in the home. Continued interview with the QIDP verified staff ratio in the group home is one to one staffing for clients #3 and #4 due to medical and behavioral challenges and two additional staff are scheduled to support client #1, #2, #5 and #6. Further interview with the QIDP revealed during the incidents involving client #4, one on one staffing was available. The QIDP also verified the facility schedule was current and the group home was short staffed on first and second shifts.

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W 186	Continued From page 2 Subsequent interview with the QIDP revealed the group home is utilizing a newly assigned home manager and staff from other group homes to support staff shortage. The QIDP also verified the facility has currently hired three new employees who are scheduled for trainings. Additional interview with the QIDP confirmed three staff were scheduled to work on second shift on the current survey date (10/18/21) and the facility had failed to provide sufficient direct care staff consistently to manage and supervise clients according to their needs.	W 186		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, nursing services failed to follow up and monitor for documentation of body checks by staff. The finding is: Observations at the day program on 10/18/21 at 11:45 AM revealed client #4 to sit at her work station engaged in a coloring activity. Continued observations revealed client #4 to have bruises on her thighs and a swollen and slightly bruised left hand. Review of incident reports from 7/2021 through 10/2021 revealed the following; on 7/19/21 a bruise of unknown origin involving client #4,	W 340		

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W 340	Continued From page 3	W 340		

7/20/21 a red scrape/bruise of unknown origin, 7/24/21 a client picking her fingers, 7/26/21 a client had a fall at the day program, 7/27/21 a bruise of unknown origin was discovered on client's right back shoulder, 8/2/21 a medication error, 8/6/21 a medication error and 9/17/21 involving client #4 to fall and awaken with a swollen foot.

Interview with staff A on 10/18/21 at the day program revealed she had noticed the bruising on client #4 on the current day (10/18/21) and had left a message on the facility nurse's answering service to call her back. Subsequent interview with the day program staff revealed she was not aware of client #4's swollen hand.

Interview with the qualified intellectual disabilities professional (QIDP) on 10/18/21 revealed she was not made aware of client #4's swollen hand or bruises on her thighs. Continued interview with the QIDP revealed staff had been recently trained on 9/13/21 on how to complete body checks when finding a bruise, scratch or mark on an individual and following instructions given by the nurse and/or doctor's order. The QIDP also verified there were no body checks completed after 7/19/21 for this surveyor to review.

Interview with the facility nurse on 10/18/21 revealed she retrieved a voice message left on her voicemail at 10:30 AM with staff requesting to return her call. The facility nurse further confirmed she was not made aware of client #4's swollen hand and bruises until the QIDP informed her of the bruising on the current day (10/18/21). Subsequent interview with the facility nurse revealed she went over to the day program to assess client #4, then instructed staff to take her

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W 340	Continued From page 4 to urgent care for further medical attention. Additional interview with the facility nurse confirmed staff should have completed a body check and contacted the nurse leaving a detailed message on her voicemail which did not occur.	W 340		