STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G120	A. BUILDING _____ B. WING _____	11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS FORK HOMES I AND II	1358 & 1388 LEWIS FORK BAPTIST CHURCH RD FERGUSON, NC 28624

(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 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 observation and interview, the facility failed to ensure privacy was maintained during medication administration for 6 of 11 clients (#8) at Lewis Fork I and clients (#1, #2, #4, #5, and #6) at Lewis Fork II. The findings are: A. The facility failed to ensure privacy was maintained during medication administration for client #8 at Lewis Fork I. For example: Observation on 11/23/21 at 8:15 AM revealed client #8 to sit at the dining room table. Continued observation at 8:16 AM revealed staff E to exit the medication room with a foam swab. Staff E was then observed to approach client #8 and to ask the client to open his mouth. Further observation revealed staff E to swab the teeth and gums of client #8 while the client sat at the table. Subsequent observation revealed three clients to sit at the table participating in decorating Christmas ornaments while staff E administered oral care with client #8. At no time during observations did staff offer client #8 privacy with administering a medicated oral treatment. Review of record for client #8 revealed a person centered plan dated 2/10/21. Continued review of 2/10/21 plan revealed client medications to include; Chlorhexidine gluc 0.12% to be administered to client's teeth and gums. Interview with the facility nurse on 11/23/21 confirmed staff have been trained with ensuring	W 130		

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

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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privacy while administering medications. Continued interview with the facility nurse confirmed all clients should be offered privacy during the administration of all medications.

B. The facility failed to ensure privacy was maintained during medication administration for client's (#1, #2, #4, #5, #6) at Lewis Fork II. For example:

Observation in the group home on 11/23/21 at 7:05 AM revealed client #4 to enter the medication room and staff J to conduct a blood pressure check prior to medication administration. Continued observation revealed the medication room door to remain open and client #6 to enter and exit multiple times. Further observation revealed staff J to redirect client #6 multiple times away from the medication room and subsequently miss client #4's first blood pressure reading.

Observation at 7:15 AM revealed client #5 to enter the medication room for medication administration. Continued observation revealed the medication room door to remain open during the medication pass and client #4 to stand right outside the door. Further observation at 7:24 AM revealed staff J to be on the phone with the nurse and client #6 to enter and exit the medication room multiple times.

Observation at 7:40 AM revealed client #6 to enter the medication room for medication administration. Continued observation revealed the medication room door to remain open during the medication pass. Further observation revealed client #6 to exit and enter the medication

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W 130	Continued From page 2 room multiple times during the medication pass. Observation at 7:57 AM revealed client #1 to enter the medication room for medication administration. Continued observation revealed the medication room door to remain open during the medication pass and client #4 to stand right outside the medication room door. Observation at 8:20 AM revealed client #2 to enter the medication room for medication administration. Continued observation revealed the medication room door to remain open during the medication pass and client #4 to stand right outside the medication room door. Further observation at 8:29 AM revealed client #1 to enter the medication room during the medication pass for client #2. Interview with staff J on 11/23/21 revealed there is a curtain in the medication room that can be closed for privacy, however, staff forgot to close the curtain. Continued interview with staff J confirmed she experienced distraction during the medication administration. Interview with the facility nurse on 11/23/21 confirmed client behavior of walking in and out of the medication room during the medication pass could cause distraction or medication errors. Continued interview with the facility nurse confirmed all clients should be offered privacy during medication administration.	W 130		
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	W 371		

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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 observation, record review and interview, the system for drug administration failed to assure 2 of 2 clients (#8 and #10) observed during medication administration were provided the opportunity to participate in medication self-administration at Lewis Fork I. The findings are:

A. The system for drug administration failed to assure client #8 was provided the opportunity to participate in medication self-administration. For example:

Observation in the group home on 11/23/21 at 7:15 AM revealed client #8 to enter the medication room and to sit in a chair while staff E prepared and administered medications to the client. Continued observation revealed staff E to reconcile medications from a bubble pack with the medication record, punch medications for client #8 into a medication cup and feed client #8 medications mixed with pudding. Staff E was further observed to provide no training to client #8 relative to medication names, purpose or side effects.

Review of records for client #8 on 11/23/21 revealed a person-centered plan (PCP) dated 2/10/21. Continued review of records for client #8 revealed a skills assessment with an annual date of 2020. Review of the 2020 skills assessment revealed client #8 to have independence with punching pills out of the medication cup.

Interview with the facility nurse on 11/23/21

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W 371	Continued From page 4 verified client #8 is capable of participating in various tasks involved in medication administration. Continued interview with the facility nurse revealed staff should have offered client #8 the opportunity to participate during his medication administration. B. The system for drug administration failed to assure client #10 was provided the opportunity to participate in medication self-administration. For example: Observation on 11/23/21 at 8:15 AM revealed client #10 to enter the medication room and to sit in a chair while staff E administered medication, that was already in a medication cup, to the client. Continued observation revealed staff E to feed client #10 medications mixed with pudding and for client #10 to exit the medication room. Staff E was further observed to provide no training to client #10 relative to medication names, purpose or side effects. Review of records for client #10 on 11/23/21 revealed a PCP dated 6/21/21. Continued review of records for client #10 revealed a skills assessment with an annual date of 2020. Review of the 2020 skills assessment revealed client #10 is able to participate in medication administration with verbal assistance from staff. Interview with the facility nurse on 11/23/21 verified client #10 is capable of participating in various tasks involved in medication administration. Continued interview revealed staff have been trained to ensure participation for all clients during medication administration. Further interview confirmed staff should have offered client #10 the opportunity to participate	W 371		

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W 371	Continued From page 5 during the medication administration.	W 371		