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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 assure privacy was maintained for 3 of 6 clients (#8, #10 and #11) during personal hygiene at Rockwell II. The findings are: A. The facility failed to ensure privacy was maintained for client #8 during personal hygiene. For example: Observation in the group home on 11/30/21 at 5:45 AM revealed client #8 to sit on the toilet in the bathroom with the door open while client #5 was performing his personal hygiene with assistance from staff D. Continued observation at 6:05 AM revealed staff D and client #5 to exit the bathroom and leave the door open while client #8 remain sitting on the toilet. Interview with the qualified intellectual developmental disabilities (QIDP) and Quality Assurance Manager (QM) on 11/30/21 revealed the bathroom door should be closed at all times. Continued interview with the QIDP and QM confirmed staff should not have two clients in a bathroom at any given time especially while personal hygiene care is being provided. B. The facility failed to ensure privacy was maintained for client #11 during personal hygiene. For example: Observation in the group home on 11/30/21 at 7:00 AM revealed client #11 to exit the bathroom	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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W 130	Continued From page 1 and enter his bedroom leaving the door open. Continued observation revealed client #11 to stand in the middle of his bedroom and get dressed. Further observation revealed staff D to redirect client #11 from the laundry room to put his clothes on. Subsequent observations at 7:10 AM revealed client #11 to exit his bedroom. At no time during observations did staff prompt the client to close his door or close the door for him. Interview with the QIDP and QM confirmed staff should prompt client #11 to close the door or close the door for him. Continued interview revealed staff should offer and ensure privacy for all clients while in their bedrooms. C. The facility failed to ensure privacy was maintained for client #10 during personal hygiene. For example: Observation in the group home on 11/30/21 at 7:45 AM revealed client #10 to stand in the bathroom with staff D completing personal hygiene care with the door open. Continued observations revealed client #10 to wash his face, brush his teeth, put on deodorant and brush his hair with verbal and some physical prompts from staff D. Further observations revealed client #11 to walk by the open door and staff D to redirect him back to his room. Interview with the QIDP and QM confirmed staff should have closed the bathroom door to ensure privacy while assisting client #10 with his personal hygiene care. Continued interview revealed staff should also prompt clients to close the door while in the bathroom. Further interview revealed privacy should be provided at all times, while additional training was needed with staff.	W 130		

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W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on review of records and interview, the person-centered plan (PCP) failed to have sufficient training or interventions to meet identified needs for 1 of 3 sampled clients (#2) at Rockwell I. The finding is: Afternoon observations in the group home on 11/29/21 from 5:00 PM to 6:30 PM revealed client #2 to participate in an activity, participate in the dinner meal and to converse with staff. Further observations reveal client #2 to curse, call names and to verbalize inappropriate phrases to various staff. Continued observations at 5:30 PM revealed staff to mimic client #2's inappropriate phrases. At no point during the observation period did staff redirect client #2 to refrain from name calling and cursing. Morning observations in the group home on 11/30/21 from 7:00 AM to 10:00 AM revealed client #2 to participate in various activities such as grooming and participating in the breakfast meal. Further observations revealed client #2 to continue name calling and cursing toward staff. Observations at 9:30 AM revealed client #2 to call this surveyor "hey floozy" and "hey big head" without redirection from staff. Continued observations revealed staff to mimic client #2's phrases without prompting or redirection the client to refrain from inappropriate gestures. Review of records for client #2 on 11/30/21	W 227		

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revealed a person-centered plan (PCP) dated 7/22/21. Further review of the record revealed a behavior support plan (BSP) dated 4/5/18 included the client displaying aggressive behavior and refusing medical treatment. Continued review of the record indicated that client #2 would receive medical/dental sedation and wrap prior to medical and/or dental appointments. Review of the PCP and BSP for client #2 did not reveal target behaviors such as cursing, inappropriate phrases or gestures towards others. Review of the 11/23/21 mini-team report revealed that client #2 has met previous behavior plan criteria with a team recommendation to discontinue the client's BSP and implement an other service goal (OSG) moving forward.

Interview with the behavioral specialist on 11/30/21 at 2:00 PM verified that client #2 has not displayed any significant behaviors and the team decided that it was appropriate for the client to no longer have a formal behavior support plan.

Interview with the QA Manager and behavioral specialist verified that they were familiar with client #2 verbalizing certain phrases but did not believe that the words warranted the need for formal programming goals. Continued interview with the QA Manager verified that client #2 learned several of the phrases while attending family visits and thought that the phrases were friendly gestures to the client's family members. Interview with the QA Manager also revealed that client #2 has verbalized some of the same gestures for quite some time. Further interview with the QA Manager verified that although client #2 verbalizes inappropriate phrases at times, it would be more appropriate to educate staff on how to prompt and/or redirect the client to refrain

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W 227	Continued From page 4 from inappropriate gestures. Subsequent interview with the QA Manager and Qualified Intellectual Disabilities Professional (QIDP) on 11/30/21 at 3:20 PM confirmed that client #2 should be prompted to refrain from inappropriate phrases and gestures. Further interview with the QIDP and QA Manager also confirmed that client #2 could benefit from sufficient training to teach the client to refrain from inappropriate phrases towards others.	W 227		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 5 of 12 clients (#7) at Rockwell I and (#5, #8, #9, and #10) at Rockwell II received a continuous active treatment program consisting of needed interventions as identified in the person-centered plan (PCP). The findings are: A. The facility failed to follow client #5's training objective relative to privacy as prescribed. For example:	W 249		

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Morning observations in the group home on 11/29/21 from 5:45 AM - 6:05 AM revealed client #5 to stand near the bathroom sink while staff E completed his personal hygiene with the door open. Continued observation revealed another client to sit on the toilet in the same bathroom while client #5 get his teeth brushed and face washed. Further observation at 6:05 AM revealed staff E to ask client #5 to transfer to another bathroom to get his hair done. Subsequent observation revealed staff E and client #5 to enter another bathroom, sit on the toilet with the door open to get his hair done.

Review of the record for client #5 on 11/30/21 revealed a person centered plan (PCP) dated 3/5/21. Continue review of the PCP for client #5 revealed training objectives to include; tolerate oral hygiene, behavior, participate in daily activities, wash palms together, medication administration and close door for privacy. Further review revealed client #5 will learn how to close doors for privacy. This will occur during times privacy is required such as toileting, dressing, oral hygiene, medication administration and bathing. Staff should reinforce client #5 to close the door.

Interview with the qualified intellectual developmental professional (QIDP) and Quality Assurance Manager (QM) verified on 11/30/21 that client #5's training programs are current. Continued interview with the QIDP and QA Manager also confirmed that staff should utilize client #5's training objectives as prescribed to maintain structure and increase independence.

B. The facility failed to follow client #9's training objective relative to communication as prescribed. For example:

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Observations in the group home during 11/29-30/21 survey revealed client #9 to participate in leisure activities, dinner, take dishes to the kitchen, morning routine, medication administration and get on the school bus. Continued observations revealed staff to verbally prompt client to participate in each activity accordingly. At no time during survey observation did staff utilize the client's communication program.

Review of the record for client #9 on 11/30/21 revealed a PCP dated 3/26/21. Continue review of the PCP for client #9 revealed training objectives to include; behavior, tolerate oral hygiene, hand washing, privacy, table manners, personal space and privacy and pair sign Further review revealed; when asked the sign for a targeted word, client #9 will independently pair the sign with verbalization with 90% accuracy over three consecutive months. Subsequent review revealed this goal should be taught continuously and at naturally occurring times throughout client's day.

Interview with the QIDP and QM verified on 11/30/21 that client #9's training programs are current. Continued interview with the QIDP and QA Manager also confirmed that staff should utilize client #9's training objectives as prescribed to maintain structure and increase communication skills.

C. The facility failed to follow client #8's training objective relative to communication as prescribed. For example:

Observations in the group home during

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11/29-30/21 survey revealed client #8 to participate in leisure activities, dinner, take dishes to the kitchen, morning routine, medication administration and get on the school bus. Continued observations revealed staff to verbally prompt client to participate in each activity accordingly. At no time during survey observation did staff utilize the client's communication program.

Review of the record for client #8 on 11/30/21 revealed a PCP dated 2/25/21. Continue review of the PCP for client #8 revealed training objectives to include; behavior, toileting, hand sanitizer, eating skills, oral hygiene and communication. Further review revealed; during naturally occurring times (mealtimes) client will verbally indicate napkin and cup 90% of trials for two consecutive months.

Interview with the QIDP and QM verified on 11/30/21 that client #8's training programs are current. Continued interview with the QIDP and QA Manager also confirmed that staff should utilize client #8's training objectives as prescribed to maintain structure and increase communication skills.

D. The facility failed to follow client #10's training objective relative to communication as prescribed. For example:

Observations in the group home during 11/29-30/21 survey revealed client #10 to participate in leisure activities, dinner, take dishes to the kitchen, morning routine, medication administration and get on the school bus. Continued observations revealed staff to verbally prompt the client to participate in each activity

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accordingly. At no time during survey observation did staff utilize the client's communication program.

Review of the record for client #10 on 11/30/21 revealed a person centered plan (PCP) dated 9/8/21. Continue review of the PCP for client #10 revealed training objectives to include; hand washing, brush teeth, improve eating skills, behavior and a TEACCH schedule. Further review revealed during times of transition, staff will say go check your schedule. Client #10 will read the item, check it off and go to the location with 90% accuracy over two consecutive months.

Interview with the QIDP and QM verified on 11/30/21 that client #10's training programs are current. Continued interview with the QIDP and QA Manager also confirmed that staff should utilize client #10's training objectives as prescribed to maintain structure and increase communication skills.

E. The facility failed to follow client #7's training objectives as prescribed. For example:

Afternoon observations in the group home on 11/29/21 from 4:30 PM to 6:30 PM revealed client #7 to participate in various activities such as prepare for and participate in the dinner meal. Further observations revealed client #7 to leave out of her supervised area, to consistently pace around the group home. Continued observations revealed staff to attempt to keep the client out of the kitchen and seated in the living room area. At no point during the observation period was client #7 offered an opportunity to place her food in the food processor and turn it on according to her program goals.

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Morning observations in the group home on 11/30/21 from 7:30 AM to 10:00 AM revealed client #7 to participate in various activities such as grooming and to participate in the breakfast meal. Further observations revealed client #7 to leave her supervised area and pace around the group home. At no point during the observation period was client #7 offered the opportunity to assist with blending her food by turning on the food processor.

Review of the record for client #7 on 11/30/21 revealed a person-centered plan (PCP) dated 1/19/21 which included the following programs: to apply hand sanitizer during medication administration, choose clothing, tolerate oral hygiene care, and turn on the food processor.

Interview with the qualified intellectual disabilities professional (QIDP) and Quality Assurance Manager on 11/30/21 verified that staff should have offered client #7 to turn on the food processor during meal preparation. Further interview with the QIDP verified that all of client #7's programs are current. Continued interview with the QIDP confirmed that staff should use client #7's training objectives as prescribed to maintain structure.

F. The facility failed to utilize the behavior support plan (BSP) for client #7 as prescribed. For example:

Observations in the group home on 11/29/21 from 4:30 PM to 6:30 PM revealed client #7 to leave out of her supervised area and to consistently pace around the group home. Continued observation revealed staff C to attempt to keep

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client #7 out of the kitchen and to stand in front of the client to block the client from pacing around the group home. Further observation at 5:10 PM revealed staff C to pull client #7 from the back of her gait belt/vest and attempt to pull the client to the sofa. Observation revealed staff C to position client #7 in front of the sofa and to push the client onto the sofa with both hands placed on the client's shoulders. At no point during the observation period was client #7 offered alternative activities and attempt to help the client to refrain from excessive pacing around the group home.

Review of the record for client #7 on 11/30/21 revealed a PCP dated 1/19/21. Further review of the PCP for client #7 revealed a BSP dated 12/11/20 which included the following target behaviors: excessive pacing, activity refusal, stealing food, tantrum behaviors, self-injurious behaviors (SIBs), inappropriate clothing removal, property destruction, physical aggression, hair pulling, and inappropriate toileting. Continued review of the 12/11/20 BSP indicated that staff should offer alternative activities and attempt to help client #5 to concentrate on getting involved with preferred activities the client would enjoy.

Interview with the QIDP and Quality Assurance Manager verified on 11/30/21 that client #7 will constantly pace around the group home and needs structured activities to eliminate excessive pacing. Further interview with the QIDP and QA Manager confirmed that client #7's programs and interventions are current. Continued interview with the QIDP and QA Manager also confirmed that staff should utilize client #7's training objectives as prescribed to maintain structure and decrease target behaviors.

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W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide nursing services in accordance with the needs of 1 of 3 sampled clients (#1) by not ensuring appropriate monitoring and staff training after a change in client health status at Rockwell I. The finding is: Observations in the group home on 11/30/21 at 9:00 AM revealed client #1 to transition to the medication room with staff. Further observation revealed client #1 to be administered the following medications: Breviate 100 mg, Clonidine 0.1 mg, Fycompa 6 mg, Losartan Potassium 25 mg, Norethindrone Acetate & Ethynyl Estradiol, Oxcarbazepine 300 mg, Oyster Calcium/Vitamin D 500 mg/200 IU, Topiramate 200 mg, Vimpat 200 mg, Vitamin D3 50 mcg and Chlorhexidine Gluconate. Continued observations revealed client #1 to refuse Polyethylene Glycol Powder 3350 mixed with water. Staff was observed to record the medication refusal on the Medication Administration Record (MAR) form and escort client #1 to the living room area. Review of the record on 11/30/21 revealed a person-centered plan (PCP) dated 5/5/21 which indicates the following diagnoses: I/DD Profound, ADHD, right distal fibula fracture, constipation and tonic chronic seizures (vagal nerve stimulator - VNS implant). Review of the bowel movement (BM) log for 10/2021 and 11/2021 did not reveal client #1 going more than two days without having a bowel movement. Review of the MAR form for 11/2021 revealed that client #1 refused the	W 331		

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Polyethylene Glycol Powder 3350 for 25 out of 30 days.

Interview with staff D on 11/30/21 revealed that client #1 often refuses the Polyethylene Glycol Powder 3350 medication because the client does not like the taste of it. Further interview with staff D revealed that client #1 has refused the medication at least 20 days during the month of November 2021. Continued interview with staff D revealed that it is facility protocol to contact the nurse if there is a trend in clients refusing medications. Staff D also revealed during the interview that the facility nurse comes to the group home at least twice weekly to check on medications and MAR forms. Staff D confirmed during the interview that she should have contacted the nurse of client #1's continuous medication refusal.

Interview with the facility nurse on 11/30/21 verified that she was not aware that client #1 had been continuously refusing the Polyethylene Glycol Powder 3350 medication. The nurse also verified during the interview that it is facility protocol that staff contact nursing services if client #1 has no bowel movements within three days. Further interview with the nurse verified that she visits the group home weekly to check on the status of all clients' medications. Continued interview with the nurse confirmed that she will alert client #1's attending physician to report health changes relative to the client's medication refusal. The nurse confirmed that she will in-service facility staff on timely reporting of medication refusals and changes. The nurse also confirmed during the interview that she will recommend that client #1 receive a medication change from liquid to pill form to encourage the

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ROCKWELL 1 & 2	**HIGHWAY 152 EAST 6330 ROCKWELL, NC 28138**

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W 331	Continued From page 13 client to take her medication regularly to aid in relieving constipation.	W 331		
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 observation, record review and interview, the facility failed to assure all drugs were administered without error for 1 of 3 sampled clients (#3) at Rockwell I. The finding is: Observations in the group home on 3/24/21 at 8:20 AM revealed client #3 to enter the medication room and participate in medication administration. Further observations revealed staff to administer the following medications client #3: Levothyroxine 125 mcg, MAPA Arthritis 650 mg, Estradiol 1 mg, Oyster Calcium/Vitamin D 500 mg/200 IU, Thermaderm lotion, Vesicare 10 mg, Aripiprazole 2 mg, and Hydroxy HCL 25 mg. Continued observations reveal staff to administer client #3 Levothyroxine 125 mcg after the client participated in the breakfast meal at 7:30 AM. Continued observations revealed med tech staff to return the medication bottle to the medication cabinet and check off the medication as dispensed in the computer system. Review of the record for client #3 revealed a person-centered plan dated 3/5/21. Review of the medication administration record (MAR) dated 10/26/21 revealed the medication Levothyroxine 125 mcg to be administered to client #3 for thyroid hormone replacement. Further review of the 10/26/21 MAR form did not indicate that	W 369		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G048	A. BUILDING ______ B. WING ______	11/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKWELL 1 & 2	**HIGHWAY 152 EAST 6330** **ROCKWELL, NC 28138**

(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 369	Continued From page 14 Levothyroxine should be administered at least 30 minutes prior to a meal. Interview with the facility nurse on 11/30/21 revealed client #3 should have been given the Levothyroxine 125 mcg on an empty stomach to aid in absorption. Further interview with the facility nurse revealed that the MAR should have included medication instructions to include that Levothyroxine should be taken on an empty stomach at least 30 minutes prior to a meal. Continued interview with the facility nurse confirmed that she will contact the pharmacy to ensure that the medication bottles includes medication administration instructions for all medications for client #3. The facility nurse also confirmed that she will ensure that all staff performing medication administration will receive in-service training on any medication changes and instructions.	W 369		