STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G222	A. BUILDING _____ B. WING _____	08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JADE TREE	6501 JADE TREE LANE RALEIGH, NC 27615

(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 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure drugs used to manage clients inappropriate behaviors were used only as an integral part of the individual program plan (IPP). This affected 5 of 5 audit clients (#1, #2, #3, #4 and #6). The findings are: A. Review on 8/3/21 of client #1's behavior support plan (BSP) consents did not include the name of her behavior medications. Further review revealed client #1's behavior medication is Luvox. B. Review on 8/2/21 of client #3's behavior support plan (BSP) consents did not include the name of his behavior medications. Further review revealed client #3's behavior medications are Abilify and Depakote. C. Review on 8/3/21 of client #4's behavior support plan (BSP) consents did not include the name of his behavior medication. Further review revealed client #4's behavior medication is Luvox. D. Review on 8/3/21 of client #6's behavior support plan (BSP) consents did not include the name of his behavior medication. Further review revealed client #6's behavior medication is	W 312	A review of systems revealed the need to revise our processes for BSP and medication consents. Although BSPs were signed and included in consumer charts, the BSP consents were not included with the BSP itself. We will review all BSPs to ensure that all plans include a signed and approved consent form the guardian. This process will be reviewed and updated immediately within the consumer record and at least annually moving forward.	Within 60 days

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

Tiffany S. Williams — Clinical Director/QP — 8/17/2021

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 312	Continued From page 1 Prozac. E. Review on 8/2/2021 of client #2's Behavior Support Plan (BSP) dated 4/1/2020 revealed target behaviors of property destruction, disruption, aggression, taking others belongings and stealing food. Medications used to manage behavior were listed as Depakote 250mg in the morning, Depakote 500mg in the evening and Abilify 25mg daily. Further review of client #2's quarterly psychiatric evaluation dated 1/11/2021 revealed Abilify dosage had been decreased to 20mg daily and Cogentin 1mg twice daily had been added due to side effects of previous Abilify dose. The BSP was not updated to include the changes to client #2's behavior medications. Interview on 8/3/2021 with the qualified intellectual disabilities professional (QIDP) stated she was unaware that a list of the behavior medications for clients #1, #2, #3, #4 and #5 needed to be in the charts, along with the signature of the guardians for the clients. The QIDP also confirmed client #2 ingests Abilify 20mg daily and Cogentin 1mg twice daily. QIDP confirmed the plan had not been updated to include the recent changes.	W 312		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the	W 323		

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W 323	Continued From page 2 facility failed to ensure client #2 received his annual visual and audiology exam. This affected 1 of 5 audit clients. The finding is: Review on 8/2/2021 of annual nursing evaluation dated 9/9/2020 revealed client #2 is due for a visual and audiology exam at this time. Further record review on 8/3/2021 revealed client #2 received last annual visual and audiology exams 9/2019. A phone interview conducted on 8/3/2021 with the facility's audiologist provider revealed the office has been seeing patients in person again since July 2020. A phone interview conducted on 8/3/2021 with the facility's eye care provider revealed they have been conducting in office visits since March 2020. During an interview on 8/3/2021, the qualified intellectual disabilities professional (QIDP) confirmed client #2 had not received a visual or audiology exam since 2019. The QIDP explained appointments had not been made due to providers not conducting in person appointments.	W 323	Following the completion of our annual survey, a review of systems revealed the need to review our practices related to consumer annual evaluations. Due to covid-19, some of these practices were challenged because of the initial stay-at-home order and other state and/or agency requirements. Our facilities were under a stay-at-home order issued by the State and then by our organization until April 2021 following several covid-19 outbreaks in our group homes. We have immediately began reviewing our annual appointments to ensure that we are in full compliance. Our nurse will provide each group home with an updated list for each consumer of dates for each annual evaluation which will be reviewed at least annually at each annual plan meeting. Group Home managers will be trained on the requirements for consumers to have annual exams completed.	Within 60 days
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on review of fire drill reports and interview, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients (#1, #2, #3, #4, $5 and #6) residing in the home. The finding is:	W 441		

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W 441	Continued From page 3 Review of fire drill reports on 8/2/21 revealed the following: Four drills were conducted on second shift: 8:31pm; 4:40pm; 4:30pm and 4:01pm. During an interview on 8/3/21 the qualified intellectual disabilities professional (QIDP) revealed three of the four fire drills were not conducted during varied times. The QIDP stated second shift hours are from 3pm until 11pm.	W 441	Although we have conducted drills on each shift, a systems review revealed that further training and review was required to fully satisfy the regulation requirements. While each home has been provided with a schedule of drills to be conducted and times to conduct the drill, the Health and Safety Officer will provide training to the Group Home Manager on this process. The HSO will provide monthly oversight over the fire drill process to ensure that drills are conducted as scheduled.	Within 60 days
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of possible infection and prevent possible cross-contamination. This potentially affected all clients (#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: During breakfast observations in the home on 8/3/21 at 7am, client #2 used his fork to get 3 sausage links from a serving plate. Further observations revealed Staff A told client #2 to get only two sausage links and client #2 used his right index finger to touch the third sausage link to put it back on the serving plate. Staff A then took the plate and covered it back up and placed it on the table. At 7:24am, client #4 removed the	W 455	Although staff have been trained on cross contamination, observations during the survey revealed a continued need for training in this area. As such, the agency RN and HSO will review infection control policies and procedures and provide training to staff. The Group Home Manager will provide daily oversight to ensure staff compliance with infection control policies and procedures. The Group Home Manager will be responsible for reporting any concerns to the QP for further review and follow-up.	Within 60 days

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W 455	Continued From page 4 sausage link which client #2 had previously touched. Further observations revealed client #4 consumed the sausage link. At no time was client #4 prompted not to eat the sausage link. During an interview on 8/3/21, Staff A revealed she did not see client #2 touch the sausage link with his finger. During an interview on 8/3/21, the qualified intellectual disabilities professional (QIDP) stated the sausage link should have been discarded.	W 455		