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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 observations and interviews, the facility failed to ensure privacy for 2 of 3 sampled clients (#2, #3) and 1 non-sampled client (#5). The findings are: A. The facility failed to ensure privacy for client #3 during medication administration. For example: Observations in the group home on 1/31/22 at 6:08 PM revealed client #3 to sit in her wheelchair outside of the medication room to prepare for medication administration. Continued observation revealed staff to enter the medication room and punch several pills in a cup for client #3. Further observation revealed staff to enter the kitchen and place a tablespoon of yogurt in the medication cup. Additional observation revealed staff to provide medication administration to client #3 in the dining area as other clients and staff walked by. At no point during the observation was client #3 offered privacy during medication administration. Interview with the qualified intellectual disabilities professional (QIDP) on 2/1/22 verified that all clients should receive medication administration in the medication room and not in the dining area. Continued interview with the QIDP verified that client #2 should have been placed in the medication room with the door closed for medication administration. The facility nurse was not available for the interview. Further interview	W 130		

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

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with the QIDP confirmed that staff would receive in-service training on respecting the privacy of clients at all times.

B. The facility failed to ensure the privacy of client #3 during toileting. For example:

Observations in the group home on 1/31/22 at 4:38 PM revealed client #3 to be assisted to the bathroom in her wheelchair by staff. Continued observation revealed staff to exit the bathroom leaving client #3 exposed and the door remaining open. Further observations revealed staff to return to the bathroom and continue to assist client #3 with hygiene leaving the door open. At no point did staff close the door to ensure privacy for client #3.

Review of records for client #3 on 2/1/22 revealed a person-centered plan (PCP) dated 3/10/21. Contiued review of the PCP for client #3 dated 3/10/21 revealed goals to use a napkin during meals, match dollar bills, repeat medication names, and handwashing after toileting. Further review of records for client #3 revealed a BSP dated 3/18/21. Review of the 3/18/21 BSP for client #3 revealed target behaviors of refusal of activities, severe agitation, and self-injurious behaviors (SIBs).

Interview with the QIDP on 2/1/22 revealed that staff should have closed the door to ensure privacy for client #3 during toileting. Further interview with the QIDP verified that all clients should be offered privacy during toileting and hygiene in the bathroom. Continued interview with the QIDP confirmed that all staff would be in-serviced on ensuring privacy for all clients

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while toileting and hygiene.

C. The facility failed to ensure the privacy of client #2 during toileting. For example:

Observation in the group home on 1/31/22 at 5:11 PM revealed client #2 to be assisted to the bathroom where staff disrobed client #2 exposing her breast while the bathroom door remained open. Continued observation revealed client #1 to remain in his doorway pacing in the hallway, adjacent to the bathroom. Further observation revealed staff to continue to assist client #2 unclothed and the bathrooom door to remain open.

Review of records for client #2 on 2/1/22 revealed a PCP dated 7/22/21 which revealed that client #2 has a toileting schedule to be implemented every two hours. Continued review of the record for client #2 revealed an occupational therapy (OT) assessment dated 2/10/21. Review of 2/10/21 OT assessment revealed client #2 has a toileting schedule that shold be implemented every two hours.

Interview with the QIDP on 2/1/22 revealed that staff should have closed the door to ensure privacy for client #2 during toileting. Further interview with the QIDP verified that all clients should be offered privacy during toileting and hygiene in the bathroom. Continued interview with the QIDP confirmed that all staff would be in-serviced on ensuring privacy for all clients during personal care.

D. The facility failed to ensure privacy for client #5 during toileting. For example:

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W 130	Continued From page 3 Observation in the group home on 1/31/22 at 5:12 PM revealed client #5 to be assisted in her wheelchair by staff into the bathroom and further assisted onto the toilet with the bathroom door open. Continued observation revealed staff to pull down client #5's pants and assist the client onto the toilet while exposing her bottom which could be seen from the hallway. Further observation revealed client #1 to pace back and forth down the hallway while staff was assisting client #5 with toileting as the door remained open. At no point during the observation did staff close the door to ensure client #5's privacy while toileting. Review of records for client #5 on 2/1/22 revealed a PCP dated 8/4/21. Review of client #5's PCP dated 8/4//21 revealed goals to address: attend to tasks for three minutes, brush teeth, complete bathroom routine, exercise rights, and to be safe. Interview with the QIDP on 2/1/22 revealed that staff should have closed the door to ensure privacy for client #5 during toileting. Further interview with the QIDP verified that all clients should be offered privacy during toileting and grooming in the bathroom. Continued interview with the QIDP confirmed that all staff would be inserviced on ensuring privacy for all clients while toileting and grooming.	W 130		
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	W 249		

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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 interviews, the facility failed to assure a continuous active treatment program was provided for 2 sampled clients (#2, #4) and 1 non-sampled client (#5). The findings are:

A. The facility failed to ensure a communication program was used for client #2. For example:

Afternoon observations in the group home on 1/31/22 from 4:30 PM - 6:15 PM revealed client #2 to participate in various activities such as to sit in the living room watching tv, wash her hands and participate in the dinner meal. At no point during the observation period was client #2 offered or provided a communication picture album.

Morning observations in the group home on 2/1/22 from 6:40 AM to 9:15 AM revealed client #2 to participate in various activities such as to take a shower and get dressed, watch tv, participate in the breakfast meal and medication administration. At no point during the observation period was client #2 offered or provided a communication picture album.

Review of the record for client #2 on 2/1/22 revealed a person-centered plan (PCP) dated 7/22/21 which revealed the following program goals: wash private areas of her body, glove removal, toileting schedule, handwashing goal,

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use her napkin during meals, fire drill goal, task performance and a communication goal. Review of the behavior support plan (BSP) dated 6/25/20 revealed that client #2 should use her communication picture album to improve communication and to transition to various activities.

Interview with staff on 1/31/22 revealed that they were not familiar with a communication picture album for client #2. Interview with the qualified intellectual disabilities professional (QIDP) on 2/1/22 revealed that although all of client #2's interventions and training objectives were current, the client did not have a current communication picture album in the group home. Continued interview with the QIDP revealed that client #2 has not had a picture album in quite some time however she needs updated communication training objectives. Further interview with the QIDP confirmed that the new habilitation specialist will create and implement client #2 a new communication picture album. The QIDP also confirmed that all staff would receive in-service training on client #2's program goals.

B. The facility failed to provide adequate active treatment to engage client #4 during large amounts of unstructured time. For example:

Afternoon observations in group home on 1/31/22 from 4:30 PM until 6:30 PM revealed client #4 to pace around the group home unengaged for 95 minutes of observations. Observation of client #4 at 4:30 PM revealed the client to wander around the group home with no engagement. Continued observation at 4:50 PM revealed client #4 to participate in the dinner meal. Further observation at 5:15 PM revealed client #4 to resume pacing around the group home.

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W 249	Continued From page 6 Subsequent observations at 5:50 PM revealed client #4 to sit in the living room unengaged and to watch staff D eat a meal on the sofa. It is important to mention that during observations, staff D continued to eat a meal while clients remained unengaged in the living room. Additional observation revealed staff B and C to converse with staff D as client #4 and other clients remained unengaged. Morning observation in the group home on 2/1/22 from 6:45 AM until 9:30 AM revealed client #4 to spend 150 out of 165 minutes of observations engaged in no structured activity and pacing around the group home. Observation at 7:00 AM revealed client #4 to sit at the table awaiting the breakfast meal. Continued observation revealed staff to redirect client #4 as the client hit on the dining room table. Further observation at 7:27 AM revealed client #4 to sit in the living room unengaged and to hit a staff's cellphone on the coffee table. Further observations revealed client #4 to pace around the group home and sit on the floor in the dining area and hallway unengaged. Additional observations did not reveal staff to offer client #4 leisure activities to assist with disruptive behavior or hitting objects on surfaces. Review of records for client #4 on 2/1/22 revealed a person-centered plan (PCP) dated 3/1/21. Review of records for client #4 revealed a Behavior Support Plan (BSP) dated 3/30/20. Continued review of the BSP for client #4 revealed target behaviors of: making herself vomit, beating on hard surfaces with an object, verbal disruptions, property destruction, stripping and stealing. Further review of the 3/30/20 BSP revealed if client #4 becomes involved in	W 249		

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disruptive behavior staff should redirect by offering an activity.

Interview with the qualified intellectual disabilities professional (QIDP) on 2/1/22 verified that client #4 should be provided structured and preferred activities to decrease disruptive behaviors. Continued interview with the QIDP revealed that all of client #4's programs and interventions are current. Further interview with the QIDP verified that all staff have been trained to ensure active treatment of all clients throughout their day in addition to regular attendance to their work placement. Interview with the QIDP confirmed that staff will receive in-service training on following program goals and offering leisure activities to clients to promote meaningful active treatment.

C. The facility failed to provide active treatment for client #5 from during large amounts of unstructured time. For example:

Afternoon observations in the group home on 1/31/22 from 4:30 PM until 6:30 PM revealed client #5 to ambulate in her wheelchair between the living room and dining room unengaged for 90 of the 120 minutes of observations. Observation of client #5 at 4:30 PM revealed the client to engage with staff verbally with no participation in a structured activity. Observation at 4:50 PM revealed staff to assist client #5 in preparing for the dinner meal. Further observation at 5:20 PM revealed client #5 to complete the dinner meal and resume ambulating in her wheelchair between the dining room and living room with no activity engagement.

Subsequent observation at 5:50 PM revealed

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client #5 to sit in the living room unengaged and to watch staff D eat a meal on the sofa. It is important to mention that this surveyor observed staff D continue to eat a meal while clients remained unengaged in the living room. Additional observation revealed staff B and C to continue to converse with staff D as client #5 and other clients remained unengaged. At no point during the observation period from 5:20 PM until 6:30 PM was client #5 offered any structured activities.

Morning observations in the group home on 2/1/22 from 6:45 AM until 9:30 AM revealed client #5 to spend 90 of 165 minutes unengaged, talking to staff and ambulating around the group home. Observation from 6:45 AM until 7:30 AM revealed client #5 to be assisted by staff with a morning hygiene routine in her bedroom. Continued observation at 7:30 AM revealed client #5 to participate in the breakfast meal. Further observation at 8:00 AM revealed client #5 to spend the remaining 90 minutes of observations ambulaing around the group home, watching staff clean the kitchen area and talking to staff. At no point during the observation did staff offer client #5 any engagement activities.

Review of records for client #5 on 2/1/22 revealed a person-centered plan (PCP) dated 8/4/21. Continued review of the PCP for client #5 revealed training objectives to address attend task for three minutes, oral hygiene, and toileting. Further review of records for client #5 revealed a behavior support plan (BSP) dated 7/27/21. Review of the BSP revealed target behaviors of hair pulling, inappropriate touch, grabbing others, kissing others, loud vocalizations, PICA and physical aggression. Review of the BSP revealed

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W 249	Continued From page 9 behavior prevention strategies to include the need to prompt and encourage client #5 to become involved in a constructive activity. Interview with the qualified intellectual disabilities professional (QIDP) on 2/1/22 verified that staff should have offered client #5 structured activities throughout the day. Interview with the QIDP verified that client #5's goals and interventions were current. Continued interview with the QIDP verified that all staff have been trained to ensure meaningful active treatment of all clients. Further interview with the QIDP confirmed that staff will receive in-service training on clients' program goals, interventions, and engaging clients in structured activities.	W 249		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interviews, the team failed to assure all medication and biologicals remain locked except when being prepared for medication administration for 1 non sampled client (#6). The finding is: Morning observations in the group home on 2/1/22 at 8:00 AM revealed staff to enter the medication room and unlock the medication cabinet to prepare for medication administration. Observation revealed client #6 to punch out his pills into the medication cup. Continued observation at 8:05 AM revealed staff to exit the medication room and leave client #6 in the medication room unattended with the medication	W 382		

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W 382	Continued From page 10 door open. Further observation revealed client #6 to sit in the medication room with other medications in bins on the shelf and on the table. Subsequent observation revealed staff to return to the medication room with client #6's topical lotion and continue the medication administration. It is important to mention that this surveyor stood in the hallway in front of the medication door and continued to monitor the medication room from the hallway after staff's exit. The facility nurse was not available for interview during the survey. Interview with the qualified intellectual disabilities professional (QIDP) on 2/1/22 revealed that staff should not have left client #6 unattended in the medication room with accessible medications on the shelf, table and counter. Continued interview with the QIDP verified that all staff have been trained on securing the medication room when it is not in use. Further interview with the QIDP verified that the medication cabinet should not have been left unsupervised with open access to the medications. Continued interview with the QIDP confirmed that staff would receive in-service training on securing all medications and ensuring that clients are supervised in the medication room.	W 382		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by:	W 436		

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Based on observation, record review and interview, the facility failed to teach clients to use and make informed choices relative to adaptive equipment for 1 sampled client (#2) and 1 non-sampled client (#5). The findings are:

A. The facility failed to provide and implement wrist weights for client #2. For example:

Afternoon observations in the group home on 1/31/22 at 4:50 PM revealed staff to assist client #2 to transition to the dining table for the dinner meal. The dinner meal consisted of the following: macaroni and cheese, mixed vegetables, juice and a cookie. Continued observations revealed staff to place client #2's food items on a plate and place the plate on a placemat. Further observations revealed client #2 to feed herself independently using a weighted spoon as her hands would tremor and jerk vigorously causing food spillage on the table. At no point during the dinner meal was client #2 provided wrist weights to reduce hand tremors.

Morning observations in the group home on 2/1/22 at 7:00 AM revealed client #2 to transition to the dining table for the breakfast meal. The breakfast meal was observed to consist of: scrambled eggs, whole wheat toast, butter, jelly, 2% milk and decaf coffee. Continued observations revealed staff to place the food items on the plate for client #2 and place it on a placemat. Further observations revealed client #2 to feed herself independently using a weighted spoon as her hands would tremor and jerk vigorously causing food spillage on the table. Observations revealed staff to pick up the food spillage from the table and prompt client #2 to slow her rate of eating. At no point during the

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dinner meal was client #2 provided wrist weights to reduce hand tremors.

Review of the record for client #2 on 2/1/22 revealed a person-centered plan (PCP) dated 7/22/21. Further review of the record for client #2 revealed a diagnosis of I/DD, severe, Angelman's Syndrome, post 5th metacarpal fracture, seizure disorder, constipation, history of choking, osteoporosis, scoliosis, reoccurring acne, urinary incontinence, history of H-Pylori, acid reflux by history and Attention Deficit Disorder. Review of the occupational therapy (OT) assessment dated 2/10/21 revealed that client #2 should have 1 lb. wrist weights on both wrists at meals to reduce tremors and improve eating performance.

Interview with the qualified intellectual disabilities professional (QIDP) on 2/1/22 revealed that the weights for client #2 have not been purchased. Further interview with the QIDP revealed that the weights will be purchased immediately and a program will be created and implemented to support client #2. Continued interview with the QIDP confirmed that staff would receive in-service training relative to client #2's new programming goals and interventions to aid in improving the client's eating performance.

B. The facility failed to provide a non-kid mat for client #2 during mealtimes as prescribed. For example:

Afternoon observations in the group home on 1/31/22 at 4:50 PM revealed staff to assist client #2 to transition to the dining table and prepare for the dinner meal. The dinner meal was observed to consist of the following: macaroni and cheese, mixed vegetables, juice and a cookie. Continued

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observations revealed staff to place client #2's food items on a plate and to place the plate on a placemat. Further observations revealed client #2 to feed herself independently using a weighted spoon as her plate would move around increasing the amount of food spillage on the table. At no point during the dinner meal was client #2 provided a non-skid mat to assist with reducing food spillage.

Morning observations in the group home on 2/1/22 at 7:00 AM revealed client #2 to transition to the dining table for the breakfast meal. The breakfast meal was observed to consist of: scrambled eggs, whole wheat toast, butter, jelly, 2% milk and decaf coffee. Continued observations revealed staff to place the food items on the plate for client #2 and place it on a placemat. Further observations revealed client #2 to feed herself independently without a non-skid mat as the plate would swivel on the table causing excessive food spillage. Observations revealed staff to pick up the food spillage from the table and prompt client #2 to slow her rate of eating. At no point during the dinner meal was client #2 provided a non-skid mat to increase eating performance.

Review of the record for client #2 on 2/1/22 revealed a person-centered plan (PCP) dated 7/22/21. Further review of the record for client #2 revealed a diagnosis of I/DD, severe, Angelman's Syndrome, post 5th metacarpal fracture, seizure disorder, constipation, history of choking, osteoporosis, scoliosis, reoccurring acne, urinary incontinence, history of H-Pylori, acid reflux by history and Attention Deficit Disorder. Review of the OT assessment dated 2/10/21 revealed that client #2 should have the following adaptive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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
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equipment: weighted utensils, non-skid mat, high sided dish, mug with a lid, shirt protector, gloves, gait vest, bedrails and non-recording video monitor. Continued review of the OT assessment revealed that client #2 needs a non-skid mat due to hand tremors and in order to improve eating performance during mealtimes.

Interview with the qualified intellectual disabilities professional (QIDP) on 2/1/22 revealed that the non-skid mat was available but not used during mealtimes as prescribed. Further interview with the QIDP revealed all of client #2's goals and interventions were current. Further interview with the QIDP confirmed that client #2 should have a non-skid mat during all mealtimes to improve eating performance. Interview with the QIDP confirmed that staff would receive in-service training on ensuring that client #2 has adaptive equipment during mealtimes as prescribed.

C. The facility failed to provide a non-skid mat to client (#5) during mealtimes as prescribed. For example:

Afternoon observations in the group home on 1/31/22 at 4:50 PM revealed staff to assist client #5 via wheelchair to the dining table to prepare for the dinner meal. The dinner meal was observed to consist of consisted of: macaroni and cheese, mixed vegetables, juice and a cookie. Continued observations revealed staff to place client #5's food items on a plate and to place the plate on a placemat. Further observations revealed client #5 to feed herself independently as the plate would swivel, increasing the amount of food spillage on the table. At no point during the dinner meal was

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	34G053	A. BUILDING _____ B. WING _____	02/01/2022

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client #5 provided a non-skid mat to assist with reducing food spillage.

Morning observations in the group home on 2/1/22 at 7:30 AM revealed client #5 to transition to the dining table for the breakfast meal. The breakfast meal was observed to consist of the following menu items: scrambled eggs, whole wheat toast, butter, jelly, 2% milk and decaf coffee. Continued observations revealed staff to place the food items on the plate for client #5 and to place it on a placemat. Further observations revealed client #5 to feed herself independently without a non-skid mat as the plate would swivel on the table causing excessive food spillage. At no point during the dinner meal was client #5 provided a non-skid mat to decrease food spillage.

Review of the record for client #5 on 2/1/22 revealed a person-centered plan (PCP) dated 8/4/21. Further review of the PCP revealed client #5 has the following diagnosis: I/DD, severe, PICA, Tics and Tourette's Syndrome. Review of the OT assessment dated 5/24/21 revealed that client #5 should have the following adaptive equipment: non-skid mat, high sided dish, shirt protector, shower chair, gait vest, transport chair and cushion, non-recording video monitor, bed alarm, hospital bed, Velcro shoes, raised toilet seat cushion and cushion for dining. Continued review of the OT assessment revealed that client #5 needs a non-skid mat to improve eating performance during mealtimes.

Interview with the qualified intellectual disabilities professional (QIDP) on 2/1/22 revealed that the non-skid mat was available for client #5 but not used during mealtimes as prescribed. Further

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	34G053	A. BUILDING _____ B. WING _____	02/01/2022

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W 436	Continued From page 16 interview with the QIDP revealed all of client #5's goals and interventions were current. Further interview with the QIDP verified that client #5 should have a non-skid mat during all mealtimes to improve eating performance. Interview with the QIDP confirmed that staff would receive inservice training to ensure that client #5 has adaptive equipment during mealtimes to improve eating performance.	W 436		