DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/29/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G110	A. BUILDING ____ B. WING ____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSS II GROUP HOME	**1615-B MOSS SPRINGS ROAD ALBEMARLE, NC 28001**

(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 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 record review and interview, the facility failed to assure sufficient direct care staff were available to manage and supervise 6 of 6 clients in the home (#1, #2, #3, #4, #5 and #6) in accordance with their individual habilitation plans (IHP). The finding is: A review of facility incident reports on 7/15/21 from 1/1/21 through 7/15/21 revealed an incident report dated 6/26/21. Review of the 6/26/21 incident report revealed at 7:30 PM client #1 barricaded himself in client #5's bedroom, then entered client #3's bedroom and hit the client with a belt. Continued review of the incident report revealed client #1 to assault a staff member and the police to be called. Further review revealed client #5 to wake up the morning of 6/27/21 with a swollen black eye and a swollen right hand on 6/28/21. Subsequent review revealed the facility nurse was contacted on 6/27/21 and 6/28/21 regarding the identified injuries. Additional review revealed it was recommended client #5 be transported to the emergency room (ER) on 6/28/21 where it was determined the client had a fractured right thumb. Review of an internal investigation summary	W 186	DHSR - Mental Health AUG 11 2021 Lic. & Cert. Section On 7/6/21 (see attached), all staff were retrained and given a copy of the On Call Manager number. Also, QP and DPO reviewed reasons to use the On Call system. RM will review the On Call Protocol monthly during Staff meetings and document this on the Staff Meeting Agenda form. QP will monitor for this 3rd quarter to ensure it is being reviewed as stated. Monitoring will be completed if 100% compliance is met at that time. If not, monitoring will be re-evaluated.	10/31/21

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

Denise Whitstead, RN, Compliance Specialist — 08/06/2021

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 186	Continued From page 1 completed on 7/12/21, relative to the 6/26/21 incident report, revealed there were two staff on shift at the time of the incident. Review of the facility staffing schedule for May 2021 and June 2021 revealed three staff were scheduled for first and second shift. Continued review of the facility staffing schedule verified two staff worked on third shift on the evening of the incident. Interview with the qualified intellectual developmental professional (QIDP) and Home Manager (HM) on 7/15/21 verified the staff to client ratio in the group home is 3 staff to 6 clients during first and second shift and 2 staff to 6 clients on third shift. Continued interview with the QIDP verified there were three staff scheduled for second shift on 6/26/21, however one staff did not show up. Further interview with the QIDP and HM verified management was not made aware, until after the incident occurred on 6/26/21, that a staff scheduled for second shift did not show up for work. Additional interview with the QIDP and HM confirmed the group home was not within the appropriate staff to client ratio based on identified needs of the facility during the 6/26/21 behavioral incident of client #1.	W 186		