| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G190 | A. BUILDING _____ B. WING _____ | 08/18/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRICES CREEK ROAD HOME | 3000 BRICES CREEK ROAD NEW BERN, NC 28562 |

| (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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| E 015 | Subsistence Needs for Staff and Patients<br>CFR(s): 483.475(b)(1)<br><br>§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)<br><br>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:<br><br>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:<br>(i) Food, water, medical and pharmaceutical supplies<br>(ii) Alternate sources of energy to maintain the following:<br>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(B) Emergency lighting.<br>(C) Fire detection, extinguishing, and alarm systems.<br>(D) Sewage and waste disposal.<br><br>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.<br>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:<br>(iii) The provision of subsistence needs for | E 015 | Intentionally Left Blank<br><br>DHSR - Mental Health<br>SEP 08 2021<br>Lic. & Cert. Section | |

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

Louie Winstead, RN, Compliance Specialist - POC — 09-02-2021

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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| E 015 | Continued From page 1<br>hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:<br>(A) Food, water, medical, and pharmaceutical supplies.<br>(B) Alternate sources of energy to maintain the following:<br>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(2) Emergency lighting.<br>(3) Fire detection, extinguishing, and alarm systems.<br>(C) Sewage and waste disposal.<br>This STANDARD is not met as evidenced by:<br>Based on observations, policy review and staff interview, the facility failed to ensure emergency provision for subsistence needs for staff and clients included adequate food as identified in the emergency preparedness (EP) plan. This potentially affected all clients (#1, #2, #3, #4, #5 and #6). The finding is:<br><br>During observation in the home on 8/18/21 at 7:21 AM, the contents of the dry storage pantry was observed. There was no container of dedicated emergency food; only 3 1/2 cases of bottled water was observed.<br><br>Review on 8/18/21 of the facility's 2020 Emergency Plan revealed a sample list of a three day disaster menu for 6 clients and 2 staff.<br><br>During an interview on 8/18/21 with the Residential Manager (RM) revealed that she realized in June, 2021 when she became manager of the home that she needed to replace the plastic tote container and purchase emergency food. The RM indicated that she had | E 015 | The Residential Manager will have all required emergency food in place by 9-10-21. Checking the emergency food supply will be added to the monthly checklist for the residential manager to monitor regularly. RM will immediately notify the RTL if any discrepancies are noted. | 9/15/21 and ongoing |

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| E 015 | Continued From page 2<br>a list of the required food to store, but did not go shopping yet. | E 015 | | |
| E 020 | Policies for Evac. and Primary/Alt. Comm.<br>CFR(s): 483.475(b)(3)<br><br>§403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2)<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]<br><br>[(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.<br><br>*[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):]<br>Safe evacuation from the [RNHCI or ASC] which includes the following:<br>(i) Consideration of care needs of evacuees.<br>(ii) Staff responsibilities.<br>(iii) Transportation. | E 020 | Intentionally Left Blank | |

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| E 020 | Continued From page 3<br>(iv) Identification of evacuation location(s).<br>(v) Primary and alternate means of communication with external sources of assistance.<br><br>* [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):]<br>Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients.<br><br>* [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to develop specific policies and procedures to address emergency preparedness (EP) including evacuation locations based on a community and facility risk assessment. The finding is:<br><br>Review on 8/17/21 of the facility's EP plan revealed the plan did not include any information in regards to the facility's evacuation locations in the event of flood, fire, tornadoes, hurricanes, winter storms, bio terrorism or other emergencies.<br><br>During an interview on 8/18/21, the qualified intellectual disabilities professional (QIDP) confirmed the EP did not include any information regarding evacuation procedures. | E 020 | Brice's Creek Group Home will evacuate to the Holiday Inn and this site will be added to the Site-Specific Plan. | 10/18/21 |

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| E 037 | EP Training Program<br>CFR(s): 483.475(d)(1)<br><br>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]<br>(1) Training program. The [facility] must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.<br>(ii) Demonstrate staff knowledge of emergency procedures. | E 037 | Intentionally Left Blank | |

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| E 037 | Continued From page 5<br>(iii) Provide emergency preparedness training at least every 2 years.<br>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.<br>(v) Maintain documentation of all emergency preparedness training.<br>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) After initial training, provide emergency preparedness training every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures.<br>(iv) Maintain documentation of all emergency preparedness training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under | E 037 | Intentionally Left Blank | |

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| E 037 | Continued From page 6<br>arrangement, contractors, participants, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.<br>(iv) Maintain documentation of all training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.<br><br>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years. | E 037 | Intentionally Left Blank | |

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| E 037 | Continued From page 7<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.<br><br>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency | E 037 | Intentionally Left Blank | |

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| E 037 | Continued From page 8<br>preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.<br>This STANDARD is not met as evidenced by:<br>Based on document review and interviews, the facility failed to ensure direct care staff were adequately trained on the facility's emergency prepardness (EP) plan. The finding is:<br><br>Review on 8/17/21 of the facility's EP manual (2020) did not include any information regarding training of staff.<br><br>During an interview on 8/19/21, the qualified intellectual disabilities professional (QIDP) confirmed there was no information included in the EP concerning training of the staff. | E 037 | All staff at Brice's Creek will be in-serviced on the site-specific emergency preparedness plan by 10-18-2021. This in-service will include relocation procedures in the event of an emergency. Staff training is stored in Relias. | 10/18/21 |
| W 130 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(7)<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interview, the facility failed to ensure privacy during personal care for 1 of 5 audit clients (#5). The finding is:<br><br>During afternoon observations in the home on | W 130 | All Direct Support Staff at Brice's Creek will be in-serviced to ensure clients have privacy while utilizing the bathroom. Weekly observations will be completed for 3 months to ensure the privacy of all Individuals are met while utilizing the rest room. | 10/18/21 |

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| W 130 | Continued From page 9<br>8/17/21 at 11:37am, client #5 entered the bathroom, pulled down his clothing and sat down on the toilet. Further observations revealed Staff A standing the doorway with the door remaining open while client #5 was sitting on the toilet. Staff A then entered the bathroom, turned around and stood in the open door while client #5 stood up and pulled up his clothing. At no time was client #5 given privacy during personal care.<br><br>During evening observations in the home on 8/17/21 at 5:37pm, client #5 entered the bathroom, pulled down his clothing and sat down on the toilet. Staff A was observed standing in the doorway while the door remained open. At no time was client #5 given privacy during personal care.<br><br>During an interview on 8/17/21, the residential manager (RM) stated client #5 needs a verbal prompt to shut the bathroom for privacy.<br><br>During an interview on 8/18/21, the qualified intellectual disabilities professional (QIDP) confirmed client #5 needs a verbal prompt to shut the bathroom door for privacy. | W 130 | Intentionally Left Blank | |
| W 189 | STAFF TRAINING PROGRAM<br>CFR(s): 483.430(e)(1)<br><br>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure staff were sufficiently trained to | W 189 | | |

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| W 189 | Continued From page 10<br>ensure the fingernails of 1 of 5 audit clients (#5) was kept neat and trimmed. The finding is:<br><br>During observations throughout the survey on 8/17/21 - 8/18/21, client #5's fingernails length were grown over the tip of his fingers. At no time during the survey where client #5's fingernails cut and trimmed.<br><br>During an interview on 8/18/21, Staff E stated the staff on second shift are responsible for cutting the fingernails of client #5. Further interview revealed Staff E was unsure of the day or time when client #5's fingernails are to be cut.<br><br>During an interview the qualified intellectual disabilities professional (QIDP) confirmed client #5's fingernails need to be cut. | W 189 | All staff will be in-serviced by the LTSS nurse on how to maintain nails of individuals supported.<br><br>After in-service, staff will begin to maintain a weekly nail maintenance task to be performed every Saturday on first shift. Documentation of this will be ongoing and sent to Team Lead for 3 months. | 10/18/21<br><br>Ongoing |
| W 213 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(3)(ii)<br><br>The comprehensive functional assessment must identify the client's specific developmental strengths.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure 3 of 5 audit clients (#2, #5 and #6) comprehensive functional assessment (CFA) was completed. The findings are:<br><br>A. Review on 8/17/21 of client #2's record revealed he was admitted to the facility on 12/30/08. Further review revealed client #2 does not have a CFA.<br><br>B. Review on 8/17/21 of client #5's record | W 213 | The Comprehensive Functional Assessments will be completed on all 3 clients by October 18, 2021.<br>Director of Program Operations will review on October 19, 2021 to ensure assessments are in record for the three individuals indicated in survey. | 10/18/21 |

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| W 213 | Continued From page 11<br>revealed he was admitted to the facility on 8/6/03. Further review revealed client #5 does not have a CFA.<br><br>C. Review on 8/17/21 of client #6's record revealed she was admitted to the facility on 10/28/09. Further review revealed client #6 does not have a CFA.<br><br>During an interview on 8/18/21, the qualified intellectual disabilities professional (QIDP) confirmed clients #2, #5 and #6 do not have a completed CFA. | W 213 | | |
| W 217 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(3)(v)<br><br>The comprehensive functional assessment must include nutritional status.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure 3 of 5 audit clients (#2, #3 and #6) nutritional assessments have been updated. The findings are:<br><br>A. Review on 8/17/21 of client #2's individual program plan (IPP) dated 4/30/21 revealed he was admitted to the facility on 12/30/08. Further review indicated client #2's nutritional assessment was completed on 10/9/19.<br><br>B. Review on 8/18/21 of client #3's IPP dated 2021 revealed she was admitted to the facility on 12/18/08. Further review indicated client #3's nutritional assessment was completed on 10/9/19. | W 217 | The Nutritional Assessment will be completed by the dietitian on all 3 clients by October 18, 2021. Director of Program Operations will review on October 19, 2021 to ensure assessments are in record for the three individuals indicated in survey. | 10/18/21 |

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|---|---|---|---|
| | 34G190 | A. BUILDING _____ B. WING _____ | 08/18/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| W 217 | Continued From page 12<br>C. Review on 8/18/21 of client #6's IPP dated 5/7/21 revealed she was admitted to the facility on 10/28/08. Further review indicated client #6's nutritional assessment was completed on 7/21/20.<br><br>During an interview on 8/18/21, the qualified intellectual disabilities professional (QIDP) confirmed clients #2, #3 and #6 nutritional assessments have not been updated. | W 217 | | |
| W 247 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(6)(vi)<br><br>The individual program plan must include opportunities for client choice and self-management.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to ensure 1 of 5 audit clients (#2) was provided the opportunity of choice. The finding is:<br><br>During morning observations in the home on 8/18/21 at approximately 8:34am, client #2 was observed walking around the home. Staff C told client #2 to go sit down on the couch; while pulling him by his arm towards the couch. At 8:46am, client #2 was observed standing next to a surveyor, when Staff C said to him, "Have a sit" while pulling him by his arm towards the couch. Client #2 was observed standing near a surveyor at 8:54am, when Staff C stated to him. "Go sit down"; while pulling him by his arm towards the couch. Further observations revealed all three times, client #2 sat down on the couch when Staff C told him to.<br><br>During an immediate interview on 8/18/21, Staff C | W 247 | All staff at Brice's Creek will be in-serviced on Client #2's person specific behavior plan addressing how to redirect him. Visual monitoring will be conducted weekly for 3 months and documented using data observation forms for behavior plan. | 10/18/21 |

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| W 247 | Continued From page 13<br>revealed client #2 can move around freely. When asked why she kept telling client #2 to sit down, she was unable to give an answer.<br><br>During an interview on 8/18/21, the qualified intellectual disablilites professional (QIDP) stated client #2 is allowed free movement within his home. | W 247 | | |
| W 340 | NURSING SERVICES<br>CFR(s): 483.460(c)(5)(i)<br><br>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, documentation and interview, nursing services failed to ensure that staff were sufficiently trained in the wearing of face masks and taking the temperature of visitors in regards to COVID-19 protocol. This potentially effected all clients (#1, #2, #3, #4, #5 and #6) residing in the facility. The findings are:<br><br>A. During observations in the home on 8/17/21 through 8/18/21, staff were consistently observed to wear their face masks below their nose, mouth and chin during times of leisure activities, objective training and dining.<br><br>B. During morning observations in the home on 8/19/21 at 6:31am, the surveyor entered the home. Further observations revealed Staff D who opened the door did not take the temperature of | W 340 | Staff will be in-serviced again to ensure the proper way to wear a mask while working in the Group Home. The Residential Manager will monitor services weekly to ensure masks are worn correctly and consistently. Mask Observation Form to be used to document weekly for 3 months.<br><br>Staff will be in-serviced on COVID 19 visitation observations and screening processes. Covid 19 visitation protocols will be reviewed at each monthly staff meeting for the next 3 months or longer if warranted. | 10/18/21 |

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| W 340 | Continued From page 14<br>the surveyor. Staff D did not ask the surveyor any questions regarding COVID-19 protocol. Further observations revealed when the second surveyor entered the home at 6:41am, their temperature was not taken and they were not asked any questions regarding COVID-19 protocol.<br><br>During an interview on 8/18/21, the qualified intellectual disabilities professional (QIDP) stated while staff are working in the home, they are to always wear a face mask. Additional interview revealed their masks are to cover their nose and mouth at all times. The QIDP revealed all staff have been trained in the proper wearing of face masks. Further interview revealed all visitors are to be screened at the door; which includes taking the visitors temperature and asking COVID-19 protocol questions. | W 340 | | |
| W 342 | NURSING SERVICES<br>CFR(s): 483.460(c)(5)(iii)<br><br>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to ensure staff demonstrated competency in detecting signs of injury and weight gain to the facility nurse. This affected 2 of 5 audit clients (#5 and #6). The | W 342 | Staff will be in-serviced on fall protocols as outlined in Monarch policy. This will be reviewed at each monthly staff meeting for the next 3 months or longer if warranted. | 10/18/21 |

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| W 342 | Continued From page 15<br>findings are:<br><br>A. During morning observations in the home on 8/18/21 at 7:48am, client #5 was pushed by client #3. Further observation revealed client #5 fell backwards, landing on his back and hitting his head on the floor. Additional observations revealed one staff was in the medication room and two staff where in the kitchen. At 7:51am, client #5 was still sitting on the floor rubbing the back of his head. Staff C assisted client #5 to his feet and told him to come into the medication room. Client #5 sat down in the chair and consumed his medications. Client #5 was observed standing in the hallway before he went into his bedroom and sitting on his bed. Additional observations at 8:11am, revealed client #5 in his bed with the covers over his head.<br><br>During an interview on 8/18/21 at 7:55am, when asked Staff C stated she would tell her supervisor about client #5 being pushed, falling and then hitting his head on the floor.<br><br>During an interview on 8/18/21 at 8:20am, the residential manager (RM) revealed she was not informed about client #5 being pushed, falling and then hitting his head on the floor. The RM then called the qualified intellectual disabilities professional (QIDP) and explained what happened with client #5. Further interview revealed the QIDP told her to call the facility's nurse. The RM stated the nurse told her to take client #5 to the local emergency room to be assessed for a any injuries.<br><br>During an interview on 8/18/21, the QIDP revealed the RM should have been notified immediately about client #5 being pushed, falling | W 342 | Intentionally Left Blank | |

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| W 342 | Continued From page 16<br>and hitting his head. Further interview revealed the nurse then should have been called to get further instructions.<br><br>B. Review on 8/17/21 of client #6's Nutritional Evaluation dated 7/21/21 read that she weighed 235 pounds and and had unplanned weight gain. A further review on 8/17/21 of client #6's monthly weight record read the following:<br><br>On 5/1/21, client #6's weight was recorded at 247.9 pounds. On 6/5/21, client #6's weight was recorded at 256.7 pounds. On 7/3/21, client #6's weight was recorded at 258.2 pounds. On 8/7/21, client #6's weight was recorded at 246.1 pounds.<br><br>During an interview on 8/17/21 with the Resident Manager (RM) revealed that a digital scale is kept in the office for staff to weigh clients each month. She was unaware of any problems with the scale and had not been notified of variances of weight gain and weight loss with client #1 in the last quarter. The RM did not think that the weights had been discussed with the nurse. | W 342 | LTSS nurse will in-service staff on proper monitoring of weights and how to identify concerns and relay to residential manager and nurse.<br>LTSS nurse will monitor weights weekly in electronic health record and address any concerns or discrepancies with Team Lead and/or Director of program Operations. | 10/18/21 |
| W 348 | DENTAL SERVICES<br>CFR(s): 483.460(e)(1)<br><br>The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the | W 348 | | |

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| W 348 | Continued From page 17<br>facility failed to make a dental referral for 1 of 5 audit clients (#6) who required further treatment. The finding is:<br><br>Review on 8/18/21 of client #6's Physician/Specialist Orders and Directions Form, dated 7/20/20 read that on 7/28/21 patient's (client #6) cooperation declined and a standard of care was no longer able to be achieved. Patient referred to a college facility practice for special needs patients for continued care.<br><br>During an interview on 8/18/21 with the Qualified Intellectual Development Professional (QIDP) revealed that she has only been assigned to the facility for a few months. The QIDP was unaware that the facility did not coordinate speciality dental services for client #6 as recommended last year, until her review today. | W 348 | In-service to all staff on protocol for referrals to outside agencies and appropriate follow up. Manager will be responsible for monitoring all appointments and referrals to ensure individual receives proper care. The physician's forms will be sent to Residential Manager and Team Lead after each appointment for 3 months to ensure all referrals are followed up on. | 10/18/21 |
| W 368 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(1)<br><br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure medications were administered in compliance with physician's orders. This affected 1 of 5 audit clients (#3). The finding is:<br><br>During morning medication administration in home on 8/18/21 at 7:25am and 7:30am, client #3 consumed four pills. Further observations revealed client #3 did not receive any other | W 368 | Staff to be in-serviced on proper procedures to re-order medication to ensure that all medications are in the home. The Residential Manager will do weekly medication cart checks and will forward them to the RN. RN will run medication variance reports weekly. Any discrepancies will be discussed with the Residential Manager the Team Leader. | 10/18/21 |

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| W 368 | Continued From page 18<br>medications.<br><br>During an interview on 8/18/21, Staff C stated client #3 is suppose to receive Polyethylene Powder. Further interview revealed Staff C was unable to locate the container of Polyethylene Powder in the medication room. Staff went and told her supervisor how she was unable to locate the Polyethylene Powder.<br><br>During review on 8/18/21 of client #3's physician orders stated, "Polyethylene Powder Mix 1 capful (17GM) in 8 oz of liquid and drink by mouth once daily as directed".<br><br>During an interview on 8/18/21, the residential manager (RM) revealed the electronic medication record record (MAR) was signed indicating that client #3 received her dosage of Polyethylene Powder. | W 368 | | |
| W 383 | DRUG STORAGE AND RECORDKEEPING<br>CFR(s): 483.460(l)(2)<br><br>Only authorized persons may have access to the keys to the drug storage area.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure only authorized persons have access to keys to the drug storage area. The finding is:<br><br>During morning observations in the home on 8/18/21 at 6:59am, Staff E opened an unlocked cabinet in the kitchen and removed the medication key and went to the medication room and opened the door. Staff E then returned the | W 383 | All staff will be in-serviced to always have keys on them during their shift and to pass directly to next shift's person responsible for medications. Residential manager will monitor weekly to ensure keys are with staff responsible for medications and not in cabinet. A key observation form will be used to monitor weekly for next 3 months. | 10/18/21 |

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| W 383 | Continued From page 19<br>medication room key to the unlocked cabinet in the kitchen. At 8:51am, Staff C removed the medication key from the unlocked cabinet in the kitchen.<br><br>During an immediate interview on 8/18/21, Staff E confirmed she was removing the medication key from an unlocked cabinet in the kitchen.<br><br>During an interview on 8/18/21, the qualified intellectual disabilities professional (QIDP) confirmed the medication key was being stored in an unlocked cabinet. | W 383 | | |
| W 486 | DINING AREAS AND SERVICE<br>CFR(s): 483.480(d)(4)<br><br>The facility must direct self-help dining procedures.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and staff interview, the facility failed to direct self help dining procedures related to providing utensils for 1 of 5 audit clients (#2) and ensuring 1 of 5 audit clients (#6) sat at the table, while eating. The findings are:<br><br>A. During morning observations in the home on 8/18/21 at 7:28 AM, client #2 was observed sitting at the dining room table with a plate of food but no utensils. Client #3 proceeded to pick up with scrambled eggs and pieces of waffles with his fingers. At 7:29 AM, Staff A gave client #2 a spoon to use, however, client #3 had consumed almost all of his food.<br><br>Review on 8/18/21 of client #3's individual | W 486 | All staff will be in-serviced on proper dining procedures to include providing utensils appropriate for meal. Manager will monitor meals weekly to ensure proper utensils are provided during meals, as appropriate. Monitoring will occur on the meal observation form for the next 3 months. | 10/18/21 |

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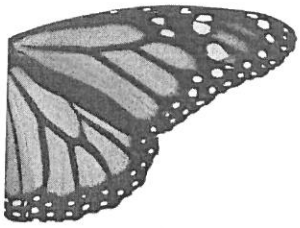
| W 486 | Continued From page 20<br>program plan (IPP) dated 4/30/21 stated, "He requires redirection to use utensils because he likes to eat with his hands".<br><br>B. During morning observations in the home on 8/18/21 at 7:45 AM, client #6 was given a plate of waffles and scrambled eggs to eat. The Resident Manager (RM) stood next to client #6 who did not sit down to eat. Client #6 was not prompted to eat while sitting.<br><br>Review on 8/17/21 of client #6's IPP dated 5/7/21 revealed that she required graduated redirection/verbal reprimand and redirection from staff.<br><br>During an interview on 8/18/21 with the Residential Manager (RM), she acknowledged that client #6 should have sat at the table to eat.<br><br>During an interview on 8/18/21 with the Qualified Intellectual Development Professional (QIDP), she acknowledged that the plate should not be placed on the table without utensils. | W 486 | All staff will be in-serviced to prompt any Individual to sit while eating their food. Manager will monitor meals weekly to ensure all Individuals are sitting while eating their meals. Monitoring will occur on the meal observation form for the next 3 months. | 10/18/21 |

Monarch
Helping Dreams Take Flight



September 2, 2021

Eugenia Barnes, Facility Compliance Consultant I
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

RE: Brice's Creek / Recertification / August 17-18, 2021

Hello,

Please find enclosed the Plan of Correction for deficiencies cited during the survey referenced above.

If you need additional information or have any questions, please contact me directly at the number below.

Sincerely,

Louise Winstead, RN

Louise Winstead, RN
Compliance Specialist – Plan of Corrections
louise.winstead@monarchnc.org
252-289-6512