| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G078 | A. BUILDING _____ B. WING _____ | 08/24/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WATSON'S GROUP HOME | 1310 ELWELL AVENUE GREENSBORO, NC 27420 |

| (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 288 | MGMT OF INAPPROPRIATE CLIENT BEHAVIOR<br>CFR(s): 483.450(b)(3)<br><br>Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interviews, the facility failed to ensure all techniques to manage inappropriate behavior were incorporated into an active treatment program for 1 of 3 sampled clients (#3). The finding is:<br><br>Morning observations in the group home on 8/24/21 from 5:45 AM to 7:15 AM revealed client #3 to refuse to participate in active treatment upon several prompts from staff. Continued observation revealed staff G to request that client #3 go to the medication room to participate in medication administration in which she refused. Observation revealed client #3 to continue to sit in the living room area as the client's voice continued to escalate. Further observation at 6:40 AM revealed client #3 to scream and hit client #2 in the chest two times with a closed fist. Observation revealed staff to escort the remaining clients to their rooms in order to maintain the safety of all clients.<br><br>Subsequent observation at 7:00 AM revealed staff F to request for client #3 to enter into the kitchen area and participate in the breakfast meal in which she refused. Additional observation revealed staff G to enter into the living room area and client #3 to hit the staff in the groin area with a book bag. Staff G was observed to attempt a | W 288 | 1) Watson's Group Home Facility Director will remove the latch off the door leading to the kitchen to keep it from being locked and replace door handle to a Pop-Up door handle. (Latch removed 8/24/21).<br><br>Watson's Group Home Psychologist will inservice/ train all Direct Care Support Personnel on client # 2's Behavior Support Plan (BSP). If changes are made, all Direct Support Personnel will be re-inserviced/ trained. | 10/24/21 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Churchill Watson | TITLE: Director | (X6) DATE: 09/15/21

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.

RECEIVED
SEP 22 2021
DHSR-MH Licensure Sect

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G078 | A. BUILDING _____ B. WING _____ | 08/24/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WATSON'S GROUP HOME | 1310 ELWELL AVENUE GREENSBORO, NC 27420 |

| (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 288 | Continued From page 1<br>therapeutic hold on client #3 in which she fell to the floor and staff released the client as she continued to display loud vocalizations and talk to herself. Additional observation revealed staff G to sit in the doorway to the right of the kitchen area which led to the dining table where clients were participating in the breakfast meal. Further observation revealed the entry door to the left of the kitchen area to be locked with a latch restricting the door from opening. At no point during the observation period did staff contact clinical support for guidance relative to additional interventions to be used to address client #3's behaviors.<br><br>Review of the record for client #3 on 8/24/21 revealed an individual habilitation plan (IHP) dated 4/14/21. Further review of the IHP revealed a behavior support plan (BSP) dated 4/16/20 which indicated that client #3 has target behaviors such as non-compliance, resistance, physical and verbal aggression, property destruction and self-injurious behaviors (SIBs). Continued review of the BSP revealed that if there is a required activity in which client #3 must participate or if the client's behavior occurs in an area where her health or safety may be endangered, a physical lift from behind and a limited control walk, a non-restrictive NCI procedure will be used in the form of grasping the client's elbow and wrist in order to move the client from one area to another area. A limited control therapeutic walk may be used if needed to move client #3 away from others when she is targeting others.<br><br>Interview with staff G on 8/24/21 verified that he has not seen client #3 display this level of behavior. Continued interview with staff G | W 288 | Watson's Group Home QIDP/Facility Director and/or Psychologist will re-inservice all Direct Support Personnel quarterly on all BSPs to assure that proper techniques are being used according to the active treatment program, and as needed, if any revisions are made. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G078 | A. BUILDING _____ B. WING _____ | 08/24/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WATSON'S GROUP HOME | 1310 ELWELL AVENUE GREENSBORO, NC 27420 |

| (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 288 | Continued From page 2<br>verified that he attempted to complete a therapeutic walk and client #3 fell to the floor. Staff G also verified during the interview that client #3 has exhibited physically aggressive behaviors but it has been quite some time since the behaviors have occurred. Further interview with staff G verified that staff are to remove all clients from the area and send them to their rooms to maintain the safety of others and to complete a therapeutic hold if client #3's behaviors continue to escalate. Staff G verified that he contacted the Assistant Qualified Intellectual Disabilities Professional (QIDP) to report client #3's behaviors. Additional interview with staff G verified that he did what he could in order to maintain the safety of all clients.<br><br>Interview with the Assistant QIDP on 8/24/21 verified that staff contacted her to make her aware that client #3 exhibited escalating behaviors. Continued interview with the Assistant QIDP verified that no one made her aware that they locked one entry to the door to the left and sat on a stool in the doorway to the right in order to maintain the safety of the clients participating in the breakfast meal. Further interview with the Assistant QIDP verified that under no circumstances should staff restrict access to any room by blocking and locking doors. The Assistant QIDP verified during the interview that all staff have received formal training on appropriate therapeutic holds and restrictive interventions. Additional interview with the Assistant QIDP confirmed that all of client #3's programs and interventions are current. The Assistant QIDP also confirmed that staff should follow the behavior support plan for client #3 at all times and utilize appropriate restrictive interventions in order to maintain the safety of | W 288 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G078 | A. BUILDING _____ B. WING _____ | 08/24/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WATSON'S GROUP HOME | 1310 ELWELL AVENUE GREENSBORO, NC 27420 |

| (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 288 | Continued From page 3<br>clients in the home. | W 288 | | |
| W 436 | SPACE AND EQUIPMENT<br>CFR(s): 483.470(g)(2)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interview, the facility failed to assure that clients use and make informed choices relative to eyeglasses as recommended for 2 of 3 sampled clients (#4 and #6). The findings are:<br><br>A. The facility failed to ensure eyeglasses were used as prescribed for client #4. For example:<br><br>Observation at the Vocational Center on 8/23/21 at 1:10 PM revealed client #4 to participate in a coloring activity. Continued observations in the group home from 4:30 PM to 6:30 PM revealed client #4 to participate in outside activities such as corn hole, horseshoes and basketball. Further observation at 5:45 PM revealed client #4 to participate in the dinner meal.<br><br>Morning observations in the group home on 8/24/21 from 5:50 AM to 8:15 AM revealed client #4 to watch television, participate in medication administration and to participate in the breakfast meal. It should be noted that at no time during survey observations on 8/23/21 - 8/24/21 was | W 436 | 2) In regards to client #4, Watson's Group Home Facility Director will contact ophthalmologist to schedule an appointment to either get a prescription for glasses or cataract surgery. (Cataract surgery is scheduled for Monday, September 20, 2021).<br><br>Watson's Group Home Facility Director will follow all orders given by ophthalmologist after surgery and provide all documentation. If glasses are needed, Watson's Group Home Facility Director will | 10/24/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G078 | A. BUILDING _____ B. WING _____ | 08/24/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WATSON'S GROUP HOME | 1310 ELWELL AVENUE GREENSBORO, NC 27420 |

| (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 436 | Continued From page 4<br>client #4 observed to wear glasses or for any staff to prompt the client to put on eyeglasses.<br><br>Review of records for client #4 on 8/24/21 revealed an individual habilitation plan (IHP) dated 9/30/20. Continued review of IHP revealed client #4 is to maintain vision with the use of glasses. Further review of record revealed an eye exam on 7/7/21 which revealed client #4 needs cataract surgery to the right eye. Subsequent review of record revealed a nurse quarterly assessment dated 7/10/21 which revealed client #4 should maintain visual ability with use of glasses.<br><br>Interview with the facility Director on 8/24/21 confirmed client #4 has prescribed eyeglasses. Continue interview with the Director confirmed client #4 was not wearing his prescribed eyeglasses. Further interview with the Director revealed client #4's prescribed eyeglasses were stored in the office area to hold eyeglasses until cataract surgery; however, no physician order was provided.<br><br>B. The facility failed to ensure eyeglasses were used as prescribed for client # 6. For example:<br><br>Observations at the Vocational Center on 8/23/21 at 1:10 PM revealed client #6 to participate in activities such as walk on treadmill, participate in medication administration, and to color a picture. Continued evening observations in the group home on 8/23/21 from 4:30 PM to 6:30 PM revealed client #6 to assist staff C in the kitchen with cooking, setting the dinner table, preparing the dinner plates and eating his dinner meal.<br><br>Morning observations in the group home on | W 436 | assure glasses are ordered and worn at all times during awake hours.<br><br>Proper usage of glasses being worn will be monitored via checklist and completed by Direct Support Personnel daily.<br><br>Facility Director will monitor monthly and Watson's Group Home QIDP and RN will be monitoring quarterly.<br><br>In regards to client #6, Watson's Group Home Facility Director will facilitate an appointment to obtain new glasses. (Completed September 9, 2021). | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G078 | A. BUILDING _____ B. WING _____ | 08/24/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WATSON'S GROUP HOME | 1310 ELWELL AVENUE GREENSBORO, NC 27420 |

| (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 436 | Continued From page 5<br>8/24/21 from 5:50 AM to 8:15 AM revealed client #6 to participate in activities such as watch television, participate in medication administration, eat his breakfast meal, and mop the floor. It should be noted that at no time during survey observations on 8/23/21-8/24/21 did staff prompt client #6 to wear glasses.<br><br>Review of records for client #6 revealed a healthcare appointment summary for an eye exam dated 4/2/21. Continued review of healthcare appointment summary for client #6 revealed a Final Spectacle Rx dated 4/2/21 for eyeglasses.<br><br>Interview with the Director on 8/24/21 confirmed the prescription for eyeglasses for client #6 dated 4/2/21. Continued interview with the Director confirmed that client #6 did not have access to his prescribed eyeglasses during the survey period. | W 436 | Once glasses are obtained, the proper usage of glasses being worn will be monitored via checklist and completed by Direct Support Personnel daily after being inserviced/ trained.<br><br>Watson's Group Home Facility Director will monitor monthly and Watson's Group Home QIDP and RN will monitor quarterly. | |