STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G156	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN I	3716 WESTWOOD DRIVE HAMPTONVILLE, NC 27020

(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 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, review of records and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to assure facility repairs were conducted timely. The findings are: A. The facility failed to ensure a window of the group home was repaired in a timely manner. For example: Observation of the group home on 2/15/22 revealed a window in the front of the group home to have a hole and the window to be shattered. Continued observation inside the group home on 2/15/22 and 2/16/22 revealed the shattered window to be located directly behind a couch used by various clients at various times throughout survey observations. Interview with multiple facility staff on 2/15/22 revealed the front window of the group home had been broken for several months. Continued interview with the group home manager revealed she began working in the group home in 11/2021 and the window was already broken. Further interview with the group home manager revealed the condition of the broken window had been reported to administration and it was unknown when a repair was to occur or what the delay in repair was. Interview with the facility qualified intellectual disabilities professional (QIDP) on 2/16/22	W 104		

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

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revealed he was unaware of the broken window at the group home. Continued interview with the QIDP revealed there was currently no repair order for the window of the group home.

B. The facility failed to ensure furniture in the group home was in good repair. For example:

Observation of the dining table in the group home on 2/15/22 revealed one of the legs of the dining table to be completely detached from the dining table. Continued observation of the condition of the dining table revealed the detached leg of the table to be held up with support from the weight of the top of the table sitting on top of the detached leg. Further observation revealed the detached leg to completely come out from under the table and to expose a sharp broken screw that protruded from the table. Observation of the table leg revealed tape to be wrapped around the top.

Interview with staff A in the group home on 2/15/22 revealed the leg of the dining table had been broken for a while. Interview with the group home manager on 2/15/22 revealed new furniture was needed in the group home and a new dining table was supposed to have been ordered. Further interview verified concerns with the broken leg of the dining table although no injuries had occurred to any client due to the condition of the table leg.

Interview with the QIDP on 2/16/22 verified furniture in the group home was in need of replacement. Continued interview with the QIDP revealed he was unaware of the severity of the condition of the dining table with a leg detachment. Further interview with the QIDP

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W 104	Continued From page 2 verified he had not ordered any furniture for the group home and he had not responded timely to addressing furniture needs of the group home. C. The facility failed to ensure repairs to a bathroom wall were conducted timely. For example: Observation of the back hallway bathroom of the group home on 2/15/22 revealed a short dividing wall outside the shower. Continued observation revealed the wall to have missing and broken tiles that exposed concrete. Further observation revealed the corners of the wall to be in poor repair with sharp edges. Interview with the facility home manager on 2/16/22 verified concerns with the condition of the bathroom of the group home. Continued interview with staff A and the home manager verified concerns with injury to a client due to the exposed concrete and sharp corners of the short bathroom wall outside the shower. Interview with the QIDP verified no current repair order was in place to address the condition of the short bathroom wall in the back hallway bathroom of the group home.	W 104		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure 5 of 6 clients in the home (#1, #2, #3, #5 and #6) were provided opportunities for choice and self	W 247		

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management relative to meal preparation. The finding is:

Observation in the group home on 2/15/22 at 4:15 PM revealed the home manager to prepare the dinner meal in the kitchen with no client assistance while all clients participated in various leisure activity. Continued observation at 5:00 PM revealed client #1 to assist with setting the table for the dinner meal and then to sit at her place setting awaiting dinner. Further observation revealed staff A and B to assist clients #2, #3, #4, #5 and #6 with handwashing and preparing for the dinner meal.

Subsequent observation at 5:05 PM revealed staff A, B and the home manager to bring all serving dishes to the dinner table and to assist clients with serving portions. Additional observation at 5:15 PM revealed the home manger to return to the kitchen, pour each client an individual cup of milk and to bring the beverages to the table for each client. At no time during the dinner preparation observation was it observed for any client to participate in any meal prep activity.

Observation in the group home on 2/16/22 at 6:55 AM revealed the home manager or prepare the breakfast meal for each client in the kitchen with no client assistance. Continued observation at 7:10 AM revealed each client to sit at the dining table and staff to bring individual bowls to each client from the kitchen with the preferred breakfast item (cereal/oatmeal) prepared in each bowl. Observation also revealed each client to be served a sausage biscuit. Further observation revealed the home manager to return to the kitchen, pour each client a beverage and bring all

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beverage cups to the table to each client. At no time during the breakfast preparation observation was it observed for any client to participate in any meal prep activity.

Observation at 7:20 AM revealed client #3 to request an additional biscuit. Additional observation revealed the home manager to take client #3's plate to the kitchen and to return with an additional biscuit for the client. At no time was client #3 prompted to assist with obtaining a second serving.

Review of the records for clients #1, #2, #3, #5 and #6 on 2/16/22 revealed all clients had a current person centered plan and adaptive behavior inventories (ABI) completed within the past year. Review of the ABI's for all five clients indicated they were fully independent and/or partially independent with multiple areas related to meal preparation tasks.

Interview with the qualified intellectual disabilities professional (QIDP) on 2/16/22 confirmed clients #1, #2, #3, #5 and #6 are all capable of participating with meal preparation tasks with at least partial independence. The QIDP also confirmed that the clients should have been offered the opportunity of choice and self management by assisting with meal preparation on 2/15/22 and 2/16/22.