STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G043	A. BUILDING _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ERWIN AVENUE HOME	100 ERWIN AVENUE ERWIN, NC 28339

(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 217	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 of 3 audit clients (#3, #4 and #6) nutritional assessments have been updated. The findings are: A. Review on 3/7/22 of client #3's individual program plan (IPP) dated 8/5/21 revealed she was admitted to the facility on 5/18/90. Further review revealed client #3's had no evidence of an annual nutritional assessment being completed in 2021. B. Review on 3/7/22 of client #4's IPP dated 3/11/21 revealed she was admitted to the facility on 5/27/86. Further review indicated client #4's nutritional assessment was completed on 1/29/19. C. Review on 3/7/22 of client #6's IPP dated 3/11/21 revealed she was admitted to the facility on 3/7/19. Further review indicated client #3's nutritional assessment was completed on 3/12/19. During an interview on 3/8/22, the qualified intellectual disabilities professional (QIDP) confirmed clients #3, #4 and #6 nutritional assessments have not been updated.	W 217		
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	W 249		

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

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 249	Continued From page 1 treatment program consisting of needed interventions and services in sufficient number 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 reviews and interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of sensory programs and meal guidelines. This affected 2 of 3 audit clients (#4 and #6). The finding are: A. During afternoon observations at the day program on 3/7/22 at 12:35pm, client #4 was observed eating lunch. Client #4 was not wearing a weighted vest at this time. Review on 3/7/22 of client #4's meal guidelines dated 12/17/20 revealed, "Staff is to perform heavy proprioceptive input through the wearing of her weighted vest and brushing prior to her eating. She is to apply her weighted vest approximately 5 minutes prior to sitting at the table and removed when meal is finished." Interview on 3/8/22 with the Home Manager (HM) confirms that client #4 should have completed body brushing and worn her weighted vest during lunch on 3/7/22. B. During observations in the home on 3/7/22, the clients returned home from the day program at approximately 3:15pm. Client #6 was not noted at	W 249		

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W 249	Continued From page 2 any time during the afternoon engaging in body brushing with staff. Review on 3/7/22 of client #6's sensory guidelines dated 10/1/19 revealed, "Between 3:30 and 4:30pm-whole body brushing using terry cloth in bathroom or her bedroom." Further observation on 3/8/22 client #6 was noted to be wearing a weighted vest at 7:45am. Client #6 still had the vest on when surveyor exited the home at 9:00am. Review on 3/7/22 of client #6's sensory guidelines dated 10/1/19 states, "Apply weighted vest for 30 minutes and then remove-avoid wearing it longer than 30 minute intervals." Interview on 3/8/22 with HM confirms that body brushing was not done with client #6 on 3/7/22 after returning from the day program. HM acknowledged that client #6 did wear her vest on 3/8/22 for longer than the specified time of 30 minute intervals.	W 249		
W 259	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure adaptive behavior inventory (ABI) were updated as needed. This affected 3 of 3 audit clients (#3, #4 and #6). The findings are:	W 259		

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W 259	Continued From page 3 A. Review on 3/7/22 of client #3's ABI revealed it had not been updated since 3/3/20. B. Review on 3/7/22 of client #4's ABI revealed it had not been updated since 2/14/19. C. Review on 3/7/22 of client #6's record revealed she was admitted on 3/7/19. There was no evidence that an ABI was ever performed. During an interview on 3/8/22, the qualified intellectual disabilities professional (QIDP) confirmed ABI's had not been updated since 2019 for client #4 and 2020 for client #3. Further interview revealed the QIDP was unable to locate an ABI for client #6.	W 259		
W 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) 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. This STANDARD is not met as evidenced by: Based on observation, review and interviews, the facility failed to ensure staff demonstrated competency in detecting signs of injury and report new skin conditions to the facility nurse. This affected 1 of 3 audit clients (#3). The finding is: During observation in the home on 3/7/22 at 4:00pm, client #3 had red marks on left arm, a cluster of red bumps on right sideburn and right side of neck. Client #3 also had a long linear scratch on the left side of her face underneath	W 342		

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W 342	Continued From page 4	W 342		

her eye. There were small tiny nicks on the skin of her left inner ear.

Review of nurse progress notes for March 2022, had no evidence of staff reporting new marks found on client #3 from self-injurious behaviors (SIB).

Interview on 3/7/22 with Staff B revealed that client #3 went home over the weekend and returned with new marks on her skin from SIB.

Interview on 3/8/22 with the home manager (HM) revealed that Staff E was present when client #3's family picked her up last week. Staff E was supposed to record skin condition prior to leaving the facility. The HM stated upon client #3's return someone should have completed the form to document if there were new skin injuries; then report them to the nurse.

Interview on 3/8/22 with the qualified intellectual disabilities professional (QIDP) revealed that in February, 2022 she conducted an in-service with staff to ensure they were knowledgeable of when to report bruises or new skin injuries to management and the nurse. The QIDP confirmed the last incident report she received for client #3 was on 2/11/22 and it was not related to SIB.

Interview on 3/8/22 with the nurse revealed that she had not been made aware of any new skin injury for client #3. The nurse reviewed her records of skin injury reports on client #3; the last incident was reported on 8/26/21. The nurse acknowledged that she should be informed because client #3 will continuously pick at her skin until it becomes infected.