STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G087	A. BUILDING _____ B. WING _____	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNY LANE #1	2840 HWY 70 EAST CLAREMONT, NC 28610

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure that privacy was maintained for 6 of 6 clients. The findings are: A. The facility failed to assure that privacy was maintained for client #3 while receiving personal care. For example: Afternoon observations in the group home on 3/28/22 from 4:15 PM to 6:30 PM revealed a visual monitor sitting on a table in the living room to reveal what was occurring in client's #3 bedroom. Continued observations at 6:15 PM revealed client #3 in his bedroom receiving personal care while the visual monitor remained on. Further observation revealed other clients to sit in the living room watching television while the visual monitor was on. Morning observations in the group home on 3/29/22 from 5:30 AM to 8:30 AM revealed a visual monitor sitting on a side table in the living room revealing client #3 asleep and later awakened by staff C at 5:45 AM to get up and prepare for his morning routine and removal of clothing in preparation for his shower. Further observation revealed other clients to sit in the living room watching television while the monitor remained on. Continued observation at 7:15 AM revealed staff C to assist client #3 to the bathroom as the visual monitor remained on. Review of record for client #3 on 3/29/22 revealed	W 130		

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

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W 130	Continued From page 1 a PCP (person centered plan) dated 12/27/21. Further review revealed an annual nursing evaluation dated 2/4/02 indicating client #6 should be monitored closely at all times due to severe nature of his seizures and limited understanding of danger in his environment. Continued review of client #6's record revealed consent for rights limitation signed on 12/7/21 to include sound/video monitor in bedroom. Interview with the qualified intellectual disabilities professional (QIDP) on 3/29/22 confirmed the sound/visual monitor for client #3 should not have been left on in an area visible to clients or visitors while personal care is being provided. B. The facility failed to assure that privacy was maintained for client #1, #2, #4, #5, #6. For example: Morning observations in the group home on 3/29/22 from 6:30 AM to 8:45 AM revealed the home manager to enter and exit all clients' bedrooms throughout the morning observations without knocking on their doors. Interview with the facility qualified intellectual disabilities professional (QIDP) revealed the group home is the client's home and should be treated in that regard with staff demonstrating a show of dignity and respect by knocking on their doors before entering their rooms. Continued interview with the QIDP verified that knocking at the client's doors is the standard expectation of all staff.	W 130		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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W 249	Continued From page 2 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active 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 observation, record review and interview, the facility failed to ensure the behavior support plan (BSP) for client #3 was implemented as prescribed relative to active treatment. The finding is: Observation in the group home on 3/28/22 from 4:00 PM to 6:45 PM revealed client #3 to sit in the dining room unengaged to watch his peers to participate in the dinner meal preparation, the setting of the dining room table and other leisure activities of their choice. At no time during observations did staff offer client #3 a choice in any of the activities or one of his own preference. Observations in the group home on 3/29/22 from 7:40 AM to 8:45 AM revealed client #3 to self-propel himself into the dining room where he remained unengaged by staff while his peers participated in preferred activities of their choice. At no point was client #3 offered an activity for engagement. Review of records for client #3 on 3/29/22 revealed a person centered plan (PCP) dated 12/7/21. Further review of th PCP revealed a behavior support plan (BSP) dated 2/28/19.	W 249		

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W 249	Continued From page 3 Continued review of the BSP revealed target behaviors of physical aggression, self-injury and property destruction/disruption. Subsequent review of the BSP revealed recommendations to provide supervision, redirection and engagement in preferred activities. Additional review of records for client #3 on 3/29/22 revealed a adaptive behavior inventory (ABI) dated 11/20. Further review of the 11/20 ABI revealed client #3 to have partial independence with washing hands with soap, drying hands washing face with soap, drying face with towel, sets table with dishes already selected, selects correct flatware and dishes, cleans off dirty dishes, uses of dishwasher, cleans and straightens kitchen properly, use of electric can opener and recognizes spoiled foods. Interview with the facility qualified intellectual disabilities professional (QIDP) revealed client #3's behavior plan should be implemented as prescribed to ensure active treatment. Continued interview with the QIDP verified staff should encourage client #3 to participate in preferred activities.	W 249		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure techniques to manage inappropriate behavior were not used as a substitute for active treatment for 1 of 3	W 288		

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W 288	Continued From page 4	W 288		

sampled clients (#4). The finding is:

Observation in the group home on 3/28/22 at 6:15 PM revealed client #4 to exit his bedroom independently when staff A prompted him to return to his room until prompted to come out. Further observation revealed client #4 to return to his bedroom as instructed. When surveyor observing question staff A regarding use of client bedroom as a restrictive intervention, staff A further explained client #4 needed to be safe and while staff A and B provided personal care to client #3 and #4 would need to remain in his room until one of the staff was free to provide client #4 with supervision outside of his bedroom.

Review of record for client #4 on 3/29/22 revealed a person centered plan (PCP) dated 10/25/21. Further review of PCP revealed a behavior support plan (BSP) dated 2/2/17 to include targeted behaviors of AWOL, agitation, property destruction, aggression, taking items not belonging to him, invading privacy, and self injury.

Interview with the qualified intellectual disabilities professional (QIDP) on 3/29/22 confirmed use of client #4's bedroom is not part of the BSP's intervention. Further interview with the QIDP revealed staff used this restrictive practice for staff convenience to ensure client #4's safety and to restrict access to areas of the home outside of staff's line of sight. Continued interview with the QIDP revealed this was not a trained or acceptable practice by staff and the BSP intervention were not followed as prescribed.

Interview with the behavior support specialist on 3/29/22 confirmed use of client #4's bedroom was not an approved behavior strategy written into

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W 288	Continued From page 5 client #4's current BSP. Further interview with the behavior support specialist confirmed this was not a trained or acceptable practice and the BSP was not followed as prescribed.	W 288		