STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G227	A. BUILDING _____ B. WING _____	04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOWE DRIVE GROUP HOME	628 FLOWE DRIVE CHARLOTTE, NC 28213

(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 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to implement training objectives to address identified behavioral and health needs for 1 of 3 sampled clients (#2). The findings are: A. The facility failed to implement objectives relative to the health needs for client #2 relative to rate of eating. For example: Observations in the group home on 4/18/22 at 5:40 PM revealed client #2 to sit at the dining room table and participate in the dinner meal. The dinner meal consisted of the following: chicken thighs, sautéed spinach and onions, lima beans, water and tea. Continued observations revealed client #2 to stuff her mouth with large bites of food and to start coughing. Observations revealed client #2 to request an additional serving of spinach, lima beans and chicken. Further observations at 5:55 PM revealed client #2 to cough and choke on her food which led to the client vomiting. At no point during the observation period was client #2 prompted to slow her rate of eating and not stuff her mouth with food. Review of the record for client #2 on 4/19/22 revealed an individual habilitation plan (IHP) dated 1/9/22 which indicated the client has the following diagnosis: I/DD severe, Down's Syndrome, Alopecia, Dementia and Hypothyroidism. Review of the behavior support	W 227		

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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plan (BSP) dated 5/10/21 revealed client #2 has the following target behaviors: physical aggression, toileting accidents, self-injurious behaviors (SIBs) and non-compliance. Continued review of the IHP revealed client #2 has the following dietary guidelines: high fiber, heart healthy, no double portions and chopped meats. Further review of the IHP for client #2 revealed the client had a choking incident 6 years ago which led to hospitalization. The following evaluations for client #2 were not available for review: nutritional, choking and nursing assessments. Additional review of the record for client #2 did not reveal any interventions relative to choking or rate of eating.

Interview with the home manager (HM) on 4/19/22 revealed she could not recall client #2 choking in the past. Continued interview with the HM revealed she contacted the facility nurse to report client #2's choking incident. Further interview with the HM verified that she was instructed to continue to monitor client #2 for choking and report back to the nurse as deemed necessary.

Interview with the qualified intellectual disabilities professional (QIDP) on 4/19/22 revealed that to his knowledge, client #2 has not had any previous choking incidents since admission to the group home. Continued interview with the QIDP revealed that the HM contacted the nurse on 4/18/22 to report client #2's choking incident according to agency protocol. Further interview with the QIDP verified that nursing, choking or nutritional assessments have not been completed for client #2 since her admission on 4/30/21. Additional interview with the QIDP verified that client #2 could benefit from formal assessments

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and interventions to address the client's health needs relative to rate of eating and choking.

B. The facility failed to implement objectives for client #2 relative to privacy. For example:

Afternoon observations in the group home on 4/18/22 from 4:00 PM - 6:20 PM revealed client #2 to use the bathroom a total of four times with the door open and exposing her bottom at 4:40 PM, 5:04 PM, 6:00 PM and 6:15 PM. At no point during the observation period did staff prompt client #2 to close the door while toileting.

Morning observations in the group home on 4/19/22 at 7:05 AM revealed client #2 to enter the bathroom and pull down her pants exposing her bottom with the door open. Continued observations at 8:00 AM revealed staff to prompt client #2 to use the bathroom. Observations revealed client #2 to enter the bathroom and leave the door open while toileting.

Review of the record for client #2 revealed an IHP dated 1/9/22 which includes the following program goals: tolerate toothbrushing, choose her drink during meals, set the table, 3-hour toileting schedule, exercise goals and select an activity of choice. Continued review of the record revealed a BSP dated 5/10/21 indicating that client #2 has the following target behaviors: physical aggression, toileting accidents, non-compliance and self-injurious behaviors (SIBs). Further review of the record did not reveal training objectives relative to privacy.

Interview with the HM on 4/19/22 revealed that client #2 often goes to the bathroom and leaves the door open. Continued interview with the HM

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W 227	Continued From page 3 revealed client #2 does not have any formal programs relative to privacy during toileting. Interview with the QIDP on 4/19/22 verified that client #2's training objectives are current. Continued interview with the QIDP verified that client #2 could benefit from training objectives relative to privacy.	W 227		
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 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, interviews and record reviews, the facility failed to assure a continuous active treatment program identified as an individual need was implemented for 1 of 3 sampled clients (#5). The finding is: Observation in the group home on 4/18/22 at 4:00 PM revealed client #5 to sit at the dining room table with blocks. Continued observation at 5:40 PM revealed client #5 to eat her dinner meal. Further observation at 6:03 PM revealed client #5 to finish the dinner meal and staff to take dishes to the kitchen. Subsequent observation revealed staff A to wipe client #5's hands and face with a wipe and remove shirt protector. At no time during observation was client #5 prompted to take	W 249		

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W 249	Continued From page 4 dishes to the kitchen and load dishwasher. Morning observation in the group home on 4/19/22 at 6:48 AM revealed client #5 to eat the breakfast meal. Continued observation at 7:10 AM revealed client #5 to be finished with bowl and staff to take bowl to kitchen. Further observation at 7:15 AM revealed client #5 to finish eating and staff to wipe client #5's hands and mouth. Subsequent observation revealed staff D to take client #5's dishes to the kitchen. At no time during observation was client #5 prompted to take dishes to kitchen and load dishwasher. Review of record on 4/19/22 for client #5 revealed an individual habilitation plan (IHP) dated 12/7/21. Review of the IHP revealed that client #5 has goals to exercise, use the Big Mac switch, use the bathroom, load the dishwasher after meals and brush teeth. Continued review of records revealed client #5 to have daily living skills assessment dated 2/19/22. Further review of daily living skills assessment revealed client #5 to carry dirty dishes to sink with assistance, load silverware into dishwasher with supervision and put dishes into dishwasher with assistance. Interview on 4/19/22 with the qualified intellectual disabilities professional (QIDP) verified that client #5's IHP is current. Continue interview with the QIDP on 4/19/22 confirmed that staff should have implemented client #5's goal to load dishwasher after meals.	W 249		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed	W 436		

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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. This STANDARD is not met as evidenced by:
Based on observations, record review and interview, the facility failed to furnish prescribed eyeglasses for 1 of 3 sampled clients (#3). The finding is:

Observation in the group home throughout the 4/18-4/19/22 survey revealed client #3 to participate in various activities, including writing, playing bingo, assisting with cooking dinner meal, setting the table, chores and looking at magazines. Continued observation revealed at no time throughout the survey was staff observed to prompt client #3 to wear prescribed eyeglasses.

Review of records for client #3 revealed an individual habilitation plan (IHP) dated 3/13/22. Continued review of record for client #3 revealed a vision consult dated 2/9/22 with a diagnosis of hyperopia or farsightedness and astigmatism in both eyes. Further review of the vision consult revealed client #3 to be prescribed glasses for distance and reading.

Interview on 4/19/22 with the qualified intellectual disabilities professional (QIDP) confirmed that client #3 should be wearing prescribed eyeglasses. Continue interview with the QIDP revealed that client #3's eyeglasses broke and a new pair was ordered on 2/9/22. Further interview with the QIDP verified that client #3 currently does not have prescribed eyeglasses available to wear.