STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G046	A. BUILDING _____ B. WING _____	04/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILLINGTON GROUP HOME	1110 NC 210 SOUTH LILLINGTON, NC 27546

(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 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure personal privacy for 1 of 5 audit clients (#1). The finding is: During observations in the home on 4/11/22 and 4/12/22, a large, lime-green sign was seen on the outside of the medicine cabinet door; the sign stated that client #1 must wear pull-ups at night, per nurse, and that staff must ensure she wore pull-ups. The cabinet was located in a public area, easily visible to anyone exiting or entering the home and also beside the public restroom area. Review of client #1's IPP, dated 7/29/21 revealed that she could independently walk to the bathroom, but may need assistance for wiping and washing hands. In addition, pull-ups may be necessary at night. Interview on 4/12/22 with Staff A revealed there was an indisciplinary team meeting (IDT) for client #1 on 3/30/22 and it was determined that she needed to wear pull ups at night. Staff A stated the next day, the sign was placed on the medication room cabinet. Interview on 4/12/22 with qualified intellectual disabilities professional (QIDP) revealed staff were made aware that medical notes for clients should be placed in either in the medication administration record book (MAR) or inside of the cabinet. When asked where client toileting and	W 129		

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

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W 129	Continued From page 1 nursing information should be placed for communication, she confirmed that staff knew not to put it in public places.	W 129		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all data relative to the accomplishment of Individual Program Plan (IPP) was documented. This affected 1 of 5 audit clients (#3). The findings is: During evening observations at the home on 4/11/22 from 6:15pm to 6:25pm, client #3 ran into an open pantry 2 x attempting to take food. Staff A had to redirect client #3 from the pantry after each incident. An additional observation on 4/12/22 at 7:25am, client #3 walked past client #4 at the dining room table and grabbed her shoulder. Client #4 turned around and took client #3's hands off her shoulders; he responded by raising his hand to strike her but client #3 started to flail her arms at him. Staff D in the dining room, intervened and commanded him to stop by using the phrase "hands", then client #3 returned to his room. Record review on 4/12/22 of client #3's behavior support plan (BSP) dated 7/15/21 identified his targeted behaviors to reduce as inappropriate	W 252		

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W 252	Continued From page 2 touching, physical aggression and taking food and beverage. The review on 4/12/22 of client #'3's program data book, revealed attempted food taking from the pantry and touching client #4 incidents, were not recorded for behavior data collection. Interview on 4/12/22 with the qualified intellectual disabilities professional (QIDP) revealed that staff have been trained that any behavior that's inappropriate and targeted should be recorded as well as the interventions used.	W 252		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to administer medications for 1 of 5 audit clients (#5) without error. The finding is: During morning observations in the home on 4/12/22 at 9:23am, Staff A administered Aspirin low tab 81MG EC and 2 tablets of Niacin 500MG to client #5 at the same time. Client #5 ingested the pills. Review on 4/12/22 of client #5's Physician Orders, signed on 3/24/22 revealed Aspirin low tab 81MG EC take 1 tablet by mouth daily 30 minutes prior to Niacin to minimize flushing. Interview on 4/12/22 with Staff A revealed that she was unaware the two medications should be spaced 30 minutes apart.	W 369		

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W 369	Continued From page 3 Interview on 4/12/22 with the qualified intellectual disabilities professional (QIDP) revealed staff were trained on medication administration and to follow doctor's orders. Interview on 4/12/22 with the nurse revealed that staff should give medications as ordered.	W 369		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure foods were served at appropriate temperature. This potentially affected all clients in the home (#1, #2, #3, #4, #5, and #6). The findings are: During dinner observations in the home 4/11/22, Staff A assisted client #4 with food preparation at 6:00pm. At 6:25pm, all clients were seated at the dining table, and food was placed on the table at 6:30pm for family-style serving to begin. At no time were food temperatures checked prior to eating. Observations on 4/12/22 at 7:00am revealed Staff A assisted client #2 with preparing oatmeal. At 7:15am, the oatmeal was placed in a plastic container with lid on the kitchen counter. At 7:48am, the oatmeal was served to the table. Staff A was observed to make several comments about the thickness of the oatmeal to the home manager. The home manager referred to the oatmeal and asked, "Is it hot?"; Staff A replied, "No". At 7:50am, all clients were served food for breakfast. At no time was an attempt made to	W 473		

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W 473	Continued From page 4 thin or reheat the oatmeal. Review of the facility breakfast schedule on 4/12/22 revealed that breakfast was scheduled to be served at 6:45am. Review of dining protocol within the home dining book revealed that food should be kept warm. Interview on 4/12/22 with the qualified intellectual disabilities professional (QIDP) revealed that staff had recently been trained on appropriate food temperatures. The QIDP confirmed that food should be kept warm until time for consumption.	W 473		
W 485	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must supervise and staff dining rooms adequately. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to have sufficient staff supervise meal preparation activities in order to prevent client behaviors for 2 of 5 audit clients (#3 and #4). The findings is: During dinner observations in the home on 4/11/12 at 6:15pm, Staff A noticed client #3 needed to be changed and took him to his room. Staff B was left alone with clients (#1, #2, #5 and #6) in the living room. Client #4 was assisted by Staff A earlier to prepare dinner and was left unsupervised in the kitchen with an oven on 170 degrees. At 6:22pm, client #3 runs into the kitchen instead of taking his clothes to the laundry as directed by Staff A. Once in the kitchen, client #3 runs into the opened pantry to steal food. Client #4 went into the pantry to confront him. Client #4 went into the pantry and was heard	W 485		

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W 485	Continued From page 5 yelling at client #3, telling him to get out. Staff A was on the back hall, near client #3's room, heard the noise and went to the pantry. Staff A separated the clients and lead client #3 out of the pantry. The clients ate dinner at 6:30 pm, thirty minutes after it was scheduled. Review on 4/12/22 of client #3's individual program plan (IPP) 4/18/21 revealed he was prone to aggression toward peers when they are impeding something that he wants to do. The IPP also revealed that due to client #3's persistent food seeking and ingestion of items that are not prepared to the correct consistency, the team supported the need for an alarm on the refrigerator and a lock on the pantry door. Interview on 4/11/22 with Staff A revealed more then 2 staff were needed to supervise the clients in the afternoon. Staff A stated it was challenging to be off the floor whenever they had to transfer client #6 who needed a mechanical lift as well as monitoring client #3 who steals food. Interview on 4/12/22 with the qualified intellectual disabilities professional (QIDP) revealed staff were supposed to keep the pantry door locked to prevent client #3 to enter it to steal food. The QIDP acknowledged the home manager was called into work but did not arrive until after dinner had started.	W 485		