STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G110	A. BUILDING _____ B. WING _____	05/03/2022

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MOSS II GROUP HOME	**1615-B MOSS SPRINGS ROAD ALBEMARLE, NC 28001**

(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 218	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure the comprehensive functional assessment developed as part of the person-centered plan (PCP) for 1 of 3 non-sampled clients (#4) included updated assessment of the client's sensorimotor development. The finding is: Observations throughout the 5/2-3/22 survey revealed #4 to experience on-going tremors ranging from slight to severe. Observation on 5/2/22 at 6:30 PM revealed client #4 to participate in the dinner meal and utilize the following adaptive equipment: high-sided plate, weighted curved spoon, non-slip mat, clothing protector, and right wrist weight. Continued observation of the dinner meal revealed client #4 to utilize a plastic cup for drinking water, and for the qualified intellectual disabilities professional (QIDP) to assist with holding the cup steady while client #4 drank. Further observation at 6:40 PM revealed client #4 to experience a severe tremor while drinking and splash water across the table, floor, and onto client #1 and the QIDP. Observation on 5/3/22 at 7:00 AM revealed client #4 to participate in the breakfast meal and utilize the following adaptive equipment: high-sided plate, weighted curved spoon, non-slip mat, clothing protector, and right wrist weight. Continued observation of the breakfast meal revealed client #4 to utilize a plastic cup for drinking water, and for staff E to assist with holding the cup steady while client #4 drank, as	W 218		

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

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W 218	Continued From page 1 well as place a small tub underneath client #4 to catch spillage. Further observation at 7:22 PM revealed client #4 to experience a severe tremor while drinking and splash water across the table, floor, and onto staff E. Review of client #4's record revealed a PCP dated 10/1/21. Review of the PCP revealed client #4 is diagnosed with severe IDD, seizure disorder, pharyngeal incoordination, and exotropia. Continued review of the PCP revealed client #4's adaptive equipment to include a walker, wheelchair, wrist weights as necessary, high-sided plate, weighted curved spoon, non-slip mat, and clothing protector. Further review of the PCP indicated client #4 "will receive an occupational therapy (OT) evaluation to determine if OT services are needed after this plan meeting as the team agreed." Additional review of client #4's record did not reveal any OT evaluation or monitoring or an updated physical therapy (PT) evaluation. Interview with the QIDP on 5/3/22 revealed they were not aware of the team's agreement to refer client #4 for OT due to recently taking over for the previous QIDP. Continued interview with the QIDP verified there is not an updated PT evaluation and OT services are not in place at this time and no appointment has been scheduled. Further interview with the QIDP revealed staff's intervention with the small tub to catch spillage is a staff training issue and is not common practice.	W 218		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include	W 247		

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W 247	Continued From page 2 opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide opportunities for choice and self management for 1 of 3 sampled clients (#6) relative to medication administration. The finding is: Observations in the group home on 5/3/22 at 7:07 AM revealed client #6 to participate in the breakfast meal. Continued observation on 5/3/22 at 7:12 AM revealed staff G to request client #6 to the office for medication administration. Further observation revealed client #6 to leave her breakfast meal and to go take morning medications in the office. Subsequent observation at 7:26 AM revealed client #6 to return to the dining room to finish her breakfast meal that remained on the table. At no time during the observation was client #6 allowed the opportunity to finish her breakfast meal prior to taking medications. Interview with the qualified intellectual disabilities professional (QIDP) revealed that it is not the practice of the facility to interrupt meals for medications. Continued interview with the QIDP revealed that staff will require further training in providing choices.	W 247		
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 observation, record review and	W 369		

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interview, the facility failed to assure all drugs were administered without error for 2 of 2 clients (#4, and #6) observed during medication administration. The findings are:

A. The facility failed to assure all drugs were administered without error for client #4. For example:

Observation in the group home on 5/3/22 at 7:46 AM revealed staff G to prepare morning medications for client #4. Continued observation revealed staff G to punch all tablets or pills into medicine cup and mix with apple sauce. Further observation revealed staff G to feed the medications and apple sauce to client #4.

Review of records for client #4 on 5/3/22 revealed physician orders dated 5/3/22. Review of the 5/3/22 physician orders revealed medications to administer at 8:00 AM to be lorazepam tab 2 MG, levetiraceta tab 500 MG, Lamotrigine tab 150 MG, Calcium tab 600 MG, gabapentin cap 30 MG, vitamin D3 tab 400 unit, lamotrigine tab 25 MG, omeprazole cap 20 MG, and polyethylene glycol powder-238 GM 17 GM/scoop powder. During survey observation staff G was not observed to administer polyethylene glycol powder-238 GM 17 GM/scoop powder.

Interview with qualified intellectual disabilities professional (QIDP) on 5/3/22 verified the physician orders dated 5/3/22 to be current. Continued interview with the QIDP verified that staff G did not notify the facility nurse that the prescribed medication was not given. Further interview with QIDP on 5/3/22 revealed that the staff administering the medications would typically mix the polyethylene glycol powder with the

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breakfast beverage. Surveyors did not observe any medications to be mixed into the breakfast beverages.

B. The facility failed to assure all drugs were administered without error for client #6. For example:

Observation in the group home on 5/3/22 at 7:15 AM revealed staff G to walk into the dining room during breakfast meal to have client #6 to go to the medication room for medication administration. Continued observation revealed staff G to hand over hand punch 2 tablets or pills into medicine cup with client #6. Further observation revealed staff G to punch remaining tablets or pills into medicine cup and to mix sucralfate sus 1 GM/10 ML. Subsequent observation revealed client #6 to administer nasal spray and staff to administer eye drops. Additionally, client #6 took all tablets or pills whole with the mixed sucralfate sus 1 GM/10 ML.

Review of records for client #6 on 5/3/22 revealed physician orders dated 5/3/22. Review of the 5/3/22 physician orders revealed medications to administer at 8:00 AM to be risperidone tab 1 MG, pantoprazole tab 40 MG, methimazole tab 5 MG, one a day vita-craves, vitamin D3 50 MCG, fluticasone Spray 50 MCG, olopatadine solo. 2%, sucralfate sus 1 GM/10ML, nasal decongest tab 10 MG, Align cap 4 MG, low-ogestrel tab, and polyethylene glycol powder-238 GM 17GM/scoop powder. Continue review of physician orders revealed sucralfate sus 1 GM/10ML to be administered by mouth 3 times a day 2 hours after meals and client #6 received medication during breakfast. During survey observation staff G was not observed to administer polyethylene

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W 369	Continued From page 5 glycol powder-238 GM 17 GM/scoop powder. Interview with QIDP on 5/3/22 verified the physician orders dated 5/3/22 to be current. Continued interview with the QIDP verified that staff G did not notify the facility nurse that the prescribed medications were not given as prescribed. Further interview with QIDP on 5/3/22 revealed that the staff administering the medications would typically mix the polyethylene glycol powder with the breakfast beverage. Surveyors did not observe any medications to be mixed into the breakfast beverages.	W 369		
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 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 maintain adaptive equipment in good repair for 1 of 3 non-sampled clients (#4). The finding is: Observations in the group home throughout the 5/2-3/22 survey revealed #4 to ambulate in a wheelchair. Continued observations throughout the survey revealed the padding on the wheelchair's arms to be torn off on one side and partially torn off on the other side. Further observation of the wheelchair revealed stains and other dirt/debris to be visible on the back, seat, and inside of the wheels.	W 436		

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W 436	Continued From page 6 Review of client #4's record on 5/3/22 revealed a person-centered plan (PCP) dated 10/1/21. Review of the PCP revealed client #4 ambulates with a walker and utilizes a wheelchair for doctor's appointments and long outings. Interview with the qualified intellectual disabilities professional (QIDP) on 5/3/22 revealed client #4 is temporarily using the wheelchair due to their walker being broken. Continued interview with the QIDP revealed the walker has been broken for approximately a week and a half and there is a current work order to have it repaired. Further interview with the QIDP verified client #4's wheelchair is damaged and in poor condition, and revealed there is no current work order to have it repaired.	W 436		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to serve food in a form consistent with the developmental level of 2 of 3 sampled clients (#5, #6). The findings are: A. The facility failed to follow client #5's diet as prescribed. For example: Observations in the group home on 5/2/22 revealed the dinner meal to be three ounces baked chicken, peas, glazed carrots, mixed fruit, milk and water. Continued observations at 6:25 PM revealed staff to provide hand over hand assistance to serve client #5 the dinner meal as prepared. Continued observation revealed client	W 474		

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W 474	Continued From page 7 #5 to eat independently and for staff to regularly prompt the client to slow their rate of eating. Observations in the group home on 5/3/22 revealed the breakfast meal to be one breakfast burrito, sliced bananas, whole green grapes, milk and water. Continued observations at 7:00 AM revealed staff to provide hand over hand assistance to serve client #5 the breakfast meal as prepared. Further observation revealed client #5 to immediately consume the breakfast burrito in two large bites before staff could intervene, then reached for and grab a second burrito, consuming half in one bite before staff could intervene. Review of client #5's record on 5/3/22 revealed a person-centered plan (PCP) dated 12/1/21. Review of the PCP revealed client #5 is prescribed a cardiac diet, low saturated fat, low cholesterol, bite size pieces. Interview with the qualified intellectual disabilities professional (QIDP) on 5/3/22 confirmed client #5 prescribed diet. Further interview with the QIDP confirmed specially modified diets should be followed at all times as prescribed. B. The facility failed to follow client #6's diet as prescribed. For example: Observations in the group home on 5/3/22 revealed the breakfast meal to be one breakfast burrito, sliced bananas, whole green grapes, milk and water. Continued observations at 7:05 AM revealed staff to provide hand over hand assistance to serve client #6 a whole burrito, green grapes and sliced bananas. Further observation at 7:09 AM revealed client #6 to	W 474		

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W 474	Continued From page 8 place large pieces of the burrito on a spoon and to consume in large amounts. Surveyor did not observe staff assisting client #6 to cut breakfast burrito during breakfast meal. Review of client #6's record on 5/3/22 revealed a PCP dated 3/1/22. Review of the PCP revealed client #6 to be prescribed a 1400 calorie, low acid diet meeting food preferences, tough meats cut into bite sizes. Additionally, no hotdogs, spicy foods, orange juice or any citrus juices, or ketchup. Interview with the QIDP on 5/3/22 confirmed client #6's prescribed diet. Further interview with the QIDP confirmed specially modified diets should always be followed as prescribed.	W 474		