STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G069	A. BUILDING _____ B. WING _____	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARIE G. SMITH GROUP HOME	1921 PALMETTO DRIVE 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 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, review of records and interview, the individual support plan (ISP) failed to have sufficient training to meet identified client needs for 1 of 4 sampled clients (#6). The finding is: Observation in the group home on 1/4/21 at 5:15 PM revealed client #6 to participate in the dinner meal. Continued observation throughout the dinner meal revealed staff A to assist client #6 with fixing his plate. Further observations revealed client #6 to immediately begin eating at a rapid pace and to shove food into his mouth with his fingers. Subsequent observations revealed the home manager (HM) to serve client #6 two additional food items which he also shoved into his mouth with his fingers. The qualified intellectual developmental professional (QIDP) was further observed to provide verbal prompts to client #6 to use his utensils. Subsequent observations revealed client #6 to finish his meal at 5:30 PM. At no time during observations did staff prompt client #6 to slow down his rate of eating. Review of records for client #6 on 1/5/21 revealed an individual support plan (ISP) dated 1/1/22. Continued review of the ISP revealed training objectives to include; hygiene and oral routine, tidy his room, table manners, remain clothed, privacy, activity engagement, medication administration and leisure activities. Continued	W 227	W227 3-6-2022 The team will meet to discuss Client #6 in the area of eating to include use of fingers and to slow down his rate of eating to include a plan to address this need. The team will review all individuals ISP in eating to determine if training is warranted. Stff will be trained on all individuals current eating skills per the ISP. The team will conduct mealtime observation for 2 months and/or until the issue is resolved. RECEIVED JAN 24 2022 DHSR-MH Licensure Sect	

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

Chief Regulatory Officer 1/20/2022

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 227	Continued From page 1 review of objective training to address table manners revealed staff will assist the client in learning appropriate table manners by prompting him as needed to wipe his mouth with a napkin. Interview with the QIDP revealed client #6 tends to eat at a rapid pace based on the food items offered during meals and if the items are something that he really likes. Continued interview with the QIDP confirmed client #6 could benefit from a training objective relative to slowing down his rate of eating to prevent choking incidents.	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, record review and interview, the facility failed to ensure 1 of 4 sample clients (#1) received a continuous active treatment program as identified in the individual support plan (ISP) relative to table manners and eating at an appropriate rate. The finding is: Observation in the group home on 01/4/22 at 5:19 PM revealed client #1 to participate in the dinner meal. Continued observation throughout the	W 249	W249 3-6-2022 The team will meet to review Client # 1 in the area of table manners and implementation of eating at an appropriate rate. The team will review all individuals ISP in eating to determine if training is warranted. The staff will be inservice on all ISP in table manners/eating skills. The team will monitor by conducing mealtime assessments for 2 months and/or until the issue is resolved.	

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W 249	Continued From page 2 dinner meal revealed staff to assist client #1 with serving cabbage onto his plate. Further observation revealed client #1 to pick the cabbage off his plate with his fingers and to shove the cabbage into his mouth at a rapid rate. Subsequent observations revealed staff A to assist client #1 with serving two additional food items which the client rapidly shoved into his mouth with his fingers. Additional observation revealed staff A to provide multiple verbal prompts to the client to use his silverware. Review of records for client #1 on 01/4/22 revealed an ISP dated 9/22/21. Review of the ISP for client #1 revealed training objectives to address keeping room tidy, appropriate table manners, oral hygiene, exercise, appropriate social interaction, activity engagement, and medication administration. Continued review of goals revealed an objective for staff to monitor and redirect rate of eating and drinking, food stuffing, encourage chewing food thoroughly, avoid talking with food in mouth and swallowing food at a slow rate. Further review of records for client #1 revealed a nutritional evaluation dated 5/12/21. Review of the nutritional evaluation revealed recommendations to cut food into bite size pieces (size of fruit cocktail) to avoid food stuffing and possible choking. Subsequent review revealed the need for staff to sit next to the client at meals and to direct the client to use utensils and put utensils down between bites to slow rate of eating. Additional review of the recommendations revealed staff need to direct the client to avoid talking with food in his mouth, food stuffing, to slow rate of eating and chew food thoroughly to avoid choking.	W 249		

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W 249	Continued From page 3 Interview with the facility qualified intellectual disabilities professional (QIDP) on 1/5/22 verified client #1 did not receive adequate prompts or redirections during the dinner meal to address rate of eating. Continued interview with QIDP revealed client #1 has a goal to address rate of eating and drinking, food stuffing and to encourage chewing food thoroughly. Further interview with the QIDP verified guidelines to address rate of eating as identified in the nutritional assessment and training objective were not followed as prescribed.	W 249		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assu that all drugs are administered in compliance the physician's orders. This STANDARD is not met as evidenced by Based on observation, record review and interview, the facility failed to assure all drugs were administered without error for 2 sample clients (#2, #5). The findings are: A. Medications were not administered as prescribed per physician order for client #5. F example: Observation in the group on 1/5/22 at 6:50 AM revealed all clients in the group home to be awake, dressed and engaged in various activ in the group home. Continued observation at AM revealed client #5 to enter and participate morning medication administration. Continue observation of client #5 revealed the client to the medication administration area at 6:55 AM	W 368	W368 The team will meet to review Client #2 and Client #5 medications administration times in relation to school schedule. Physician Orders will be obtained by nursing and activated to grant an administration window of 2 hours before/after the ordered medication time for Individuals on school days. This order will remain active and utilized during school times. Staff will be educated by nursing on "school administration timing range" for medication administration (timing and documentation requirements for compliance). Medication Administration for all individuals will be audited x 30 days by nursing to ensure medication administration is within the approved 2-hour administration window for individuals involved in school and within the 1-hour administration range for non-school Individuals. If no compliance concerns noted following the 30-day monitoring period conducted by nursing, future audits will occur on a PRN basis as warranted.	3-6-2022

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W 368	Continued From page 4 A review of physician orders dated 1/1/22 for client #5 revealed multiple medications ordered at 8:00 AM that included: diazepam 5mg, guanfacine 1mg, propranolol 40mg and vitamin D3. Interview with the facility nurse on 1/5/22 revealed medication can be administered up to one hour before and one hour after the time prescribed. Continued interview with the facility nurse verified she was not contacted by the group home staff to indicate medications were administered before 7:00 AM on 1/5/22. B. Medications were not administered as prescribed per physician orders for client #2. For example: Observation in the group home on 1/5/22 at 7:15 AM revealed client #2 to enter the medication administration area of the group home and participate in the morning medication pass, exiting the medication administration area at 7:18 AM. Review of the physician orders dated 1/1/22 for client #2 revealed medications ordered at 9:00 AM that included: Concerta ER 18mg. Interview with the facility nurse on 4/13/21 revealed medication can be given up to one hour before and one hour after the time prescribed. Continued interview with the facility nurse verified client #2's medications should not have been administered before 8:00 AM.	W 368		