| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G269 | A. BUILDING _____ B. WING _____ | 06/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HICKORY II GROUP HOME | 322 HICKORY AVE SANFORD, NC 27330 |

| (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 189 | STAFF TRAINING PROGRAM<br>CFR(s): 483.430(e)(1)<br><br>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.<br>This STANDARD is not met as evidenced by:<br>Based on observations and interviews with staff, the facility failed to ensure all staff were sufficiently trained to perform their duties efficiently. This affected all the clients residing in the home. The findings are:<br><br>A. During observations in the home on 6/28/22 between 7:20am-7:30am staff E left the kitchen and was observed to argue with staff B in the dining room when staff from the adjacent facility arrived to pick up a key for their facility van. Staff B walked away from staff E and went into the office to finish administering medications. Clients #3 and #6 were still in the dining room and client #1 was helping to clean off the dining room table and taking items into the kitchen.<br><br>B. During observations in the facility on 6/28/22 at 7:45am staff E initiated a verbal altercation with staff B in the kitchen as client #1 was mopping the floor. Staff E made a derogatory comment when staff B asked staff E about assisting client #1 to pull up his pants. Staff B walked away from staff E and went to assist other clients who were in the living room and den areas of the facility.<br><br>When the residential manager (RM) arrived at the facility at 8:00am, the surveyor reported this incident to her and she immediately spoke with staff E and changed her assignment for the day. The RM also indicated she would be reporting this incident to the qualified intellectual disabilities | W 189 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G269 | A. BUILDING _____ B. WING _____ | 06/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HICKORY II GROUP HOME | 322 HICKORY AVE SANFORD, NC 27330 |

| (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 189 | Continued From page 1<br>professional (QIDP) and to the Program Director.<br><br>During continued observation at the facility on 6/28/22 at 8:55am, after all clients had finished loading into the van and 3 individuals loaded into a staff B's car, staff E backed her car down the driveway and squealed her tires as she drove down a residential street.<br><br>Interview on 6/28/22 with the facility Program Director and the Associate Executive Director confirmed staff E's behavior was not appropriate. Further interview revealed their expectations were for direct care staff to put the individual's needs first. Both the Program Director and Associate Executive Director stated they would be addressing this incident with staff E on 6/28/22. | W 189 | | |
| W 224 | INDIVIDUAL PROGRAM PLAN<br>CFR(s): 483.440(c)(3)(v)<br><br>The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community.<br>This STANDARD is not met as evidenced by:<br>Based on record review and confirmed by interviews with staff, the comprehensive functional assessment (CFA) for 1 of 5 audit clients (#6) was not completed. The finding is:<br><br>Review on 6/27/22 of client #6's individual program plan (IPP) dated 8/18/21 revealed there were several priority training needs which included: improving oral hygiene, improving money management skills, improving toothbrushing skills improving hygiene skills and improving medication administration skills. Further review of the IPP revealed no | W 224 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G269 | A. BUILDING _____ B. WING _____ | 06/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HICKORY II GROUP HOME | 322 HICKORY AVE SANFORD, NC 27330 |

| (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 224 | Continued From page 2<br>comprehensive functional assessment (CFA) to evaluate client #6's level of independence in bathing, dressing, hygiene, clothing care, dining, money management and medication administration.<br><br>Interview on 6/27/22 with the qualified intellectual disabilities professional (QIDP) revealed he could not locate client #6's CFA and could not confirm this had been completed. | W 224 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to ensure 2 of 5 sampled clients (#4 and #6) received a continuous active treatment program consisting of needed interventions as identified in their individual program plans (IPP's) relative to behavioral intervention, adaptive equipment at mealtime and medication administration. The findings are:<br><br>A. During observations of medication administration on 6/27/22 at 4:29pm staff C poured client #6's water, retrieved his medication | W 249 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G269 | A. BUILDING _____ B. WING _____ | 06/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HICKORY II GROUP HOME | 322 HICKORY AVE SANFORD, NC 27330 |

| (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 249 | Continued From page 3 | W 249 | | |

bin, punched his pills. Client #6 disposed of his trash.

Review of client #6's individual program plan (IPP) dated 8/18/21 revealed he has a priority training need to improve his medication administration skills. Further review of the IPP revealed an objective to independently take his medication with 50% completion. Further review of this objective revealed it was implemented on 4/12/22.

Interview on 6/28/22 with the residential manager (RM) confirmed staff are trained to promote independence during medication administration and should encourage clients to be as independent as possible.

B. During observations of mealtime on 6/27/22 at 4:35pm revealed client #4 using an adaptive scoop bowl with stir fry shrimp and vegetables, a biscuit and apple slices. Client #4 used a built up spoon and regular cups. He did not have any other adaptive mealtime devices. Staff assisted him with putting on a clothing protector.

During observations of breakfast on 6/28/22 at 7:10am, client #4 was noted to have a scoop bowl and adaptive built up spoon. He was assisted to serve oatmeal, scrambled eggs, toast, whole sausage and peaches. Staff assisted him with putting on a clothing protector.

Throughout observations on 6/27/22 from 3:30pm-6pm and on 6/28/22 from 6:00am-9:30am client #4 did not wear any protective sleeves on his arms. There were calluses on both arms with what appeared to be recent sores on his left wrist.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G269 | A. BUILDING _____ B. WING _____ | 06/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HICKORY II GROUP HOME | 322 HICKORY AVE SANFORD, NC 27330 |

| (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 249 | Continued From page 4<br><br>Review on 6/27/22 of client #4's IPP dated 4/7/21 revealed the following adaptive equipment: protective arm sleeves on both arms, plate riser, soft fall mat, clothing protector and small bendable spoon.<br><br>Interview on 6/28/22 with the RM revealed staff were not aware client #4's plate riser and his protective sleeves were still listed as adaptive equipment in his IPP. Further interview revealed staff had not used either the plate riser or protective sleeves in several months. Additional interview revealed client #4 had an episode of self injurious behavior about 2 weeks ago that resulted in injury to his wrist that was currently being treated. | W 249 | | |
| W 255 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(1)(i)<br><br>The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interviews with staff the facility failed to consider clients for additional training after they met criteria for completion. This affected 2 of 5 audit clients (#2 and #4). The findings are:<br><br>A. Review on 6/27/22 of client #2's individual program plan (IPP) dated 7/29/21 revealed he had the following formal training objective identified: cleaning his bedroom with 90% independence for 3 consecutive months. Review | W 255 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G269 | A. BUILDING _____ B. WING _____ | 06/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HICKORY II GROUP HOME | 322 HICKORY AVE SANFORD, NC 27330 |

| (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 255 | Continued From page 5<br>of the progress summaries revealed the following:<br><br>Cleaning his bedroom with 90% independence for 3 consecutive months:<br>November: 96%<br>December : 95%<br>January: 96%<br>February: 94%<br>March: 95%<br>April: 92%<br><br>Interview on 6/27/22 with the qualified intellectual disabilities professional (QIDP) revealed client #2 met criteria for completion in January 2022 however this program has not been revised.<br><br>B. Review on 6/27/22 of client #4's IPP dated 4/7/22 revealed had the following objective training programs: will brush his teeth for 2 minutes after each meal with 45% completion, Will independently take his medication at designated time with 40% completion. Review of the progress summaries revealed the following:<br><br>1) Will brush his teeth for 2 minutes after each meal with 45% completion:<br>January 2022: 95%<br>February 2022: 93%<br>March 2022: 95%<br>April: 92.8%<br><br>2) Will independently take his medication at designated time with 40% completion:<br>January 2022: 94%<br>February 2022: 92%<br>March 2022: 97%<br>April 2022: 92.3% | W 255 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G269 | A. BUILDING _____ B. WING _____ | 06/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HICKORY II GROUP HOME | 322 HICKORY AVE SANFORD, NC 27330 |

| (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 255 | Continued From page 6<br>Interview on 6/27/22 with the qualified intellectual disabilities professional (QIDP) revealed client #4 met criteria for completion in March 2022 however these programs have not been revised. | W 255 | | |
| W 263 | PROGRAM MONITORING & CHANGE<br>CFR(s): 483.440(f)(3)(ii)<br><br>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.<br>This STANDARD is not met as evidenced by:<br>Based on record reviews and interview the facility failed to assure that 1 of 5 audit clients (#4) had consent for their restrictive behavior plans prior to implementation of them. The finding is:<br><br>Review on 6/27/22 of client #4's individual program plan (IPP) dated 4/7/22 revealed he has target behaviors of non-compliance, self injurious behaviors and inappropriate verbalizations. Additional review of the IPP revealed client #4 has been adjudicated incompetent and assigned a Guardian of the Person. Further review of this IPP revealed this behaviors are addressed by a behavior support program (BSP) which incorporates the use of Clonazepam, Clonidine and Trazedone.<br><br>Review on 6/27/22 of client #4's BSP dated 11/20/19 revealed no written informed consent from client #4's legal guardian for this restrictive BSP.<br><br>Interview on 6/27/22 with the qualified intellectual disabilities professional (QIDP) revealed he had not obtained written informed consent from client | W 263 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G269 | A. BUILDING _____ B. WING _____ | 06/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HICKORY II GROUP HOME | 322 HICKORY AVE SANFORD, NC 27330 |

| (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 263 | Continued From page 7<br>#4's legal guardian for this BSP. | W 263 | | |
| W 322 | PHYSICIAN SERVICES<br>CFR(s): 483.460(a)(3)<br><br>The facility must provide or obtain preventive and general medical care.<br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to assure 1 of 5 clients (#1) received general and preventive medical care relative to scheduling follow up appointments as recommended by his physician. The finding is:<br><br>Review on 6/28/22 of client #1's medical record revealed he was seen for a colonoscopy on 8/13/19 and the physician indicated that the bowel preparation was insufficient and asked for client #1 be seen for a follow up appointment to repeat this colonoscopy as soon as possible.<br><br>Interview on 6/28/22 with the facility Nurse confirmed that client #1 should be scheduled for a repeat colonoscopy as soon as possible and this procedure had not been scheduled. Additional interview with the Nurse confirmed she was responsible for scheduling these follow up appointments. | W 322 | | |
| W 460 | FOOD AND NUTRITION SERVICES<br>CFR(s): 483.480(a)(1)<br><br>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure 3 of 5 audit | W 460 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G269 | A. BUILDING _____ B. WING _____ | 06/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HICKORY II GROUP HOME | 322 HICKORY AVE SANFORD, NC 27330 |

| (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 460 | Continued From page 8 | W 460 | | |

clients (#1, #3 and #4) received their specially-modified diets as indicated. The findings are:

A. Observations of meal preparation on 6/27/22 at 4pm revealed staff F using the blender to mechanically chop stir fry rice, vegetables and shrimp in the blender. Staff used a small cup of water with this mixture. The texture of the mechanically chopped food was ground with several lumps in the mixture.

During observations of supper on 6/27/22 at 4:30pm, client #3 was assisted to serve mechanically chopped stir fry shrimp, vegetables and rice onto her adaptive scoop plate by staff C. Client #3's food was in a ground texture and had lumps in the mixture. Her liquids were thin and in adaptive spout cups with lids and straws.

Immediate interview with staff F, who prepared supper and with staff F revealed client #3 is the only client in the home that receives a mechanically altered diet. When staff F was asked how she was trained to modify client #3's food texture she stated it is mechanically chopped in the blender. Additional interview confirmed she has worked in the facility for less than three months.

During observations of breakfast on 6/28/22 at 7:10am staff E assisted client #3 in serving mechanically chopped scrambled eggs, oatmeal, sausage and toast onto her adaptive scoop bowl. The texture of the food was ground and was noted to have several lumps in the mixture.

Review on 6/28/22 of client #3's nutritional evaluation dated 2/15/22 revealed she is

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G269 | A. BUILDING _____ B. WING _____ | 06/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HICKORY II GROUP HOME | 322 HICKORY AVE SANFORD, NC 27330 |

| (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 460 | Continued From page 9 | W 460 | | |

prescribed a regular puree texture diet with nectar thin liquids.

Review on 6/28/22 of a occupational therapy protocol dated 3/31/22 for client #3 based on a recent Barium Swallow test completed during her hospitalization in January 2022 revealed a regular pureed diet was recommended with nectar thick liquids if coughing was noted.

Interview on 6/28/22 with the residential Manager (RM) revealed client #3 is the only client in the home, staff were told that needed modified textures. Additional interview confirmed the Dietician has not completed any recent training regarding diet textures.

Interview on 6/28/22 with the facility Nurse revealed client #3's physician orders in March 2022 prescribed a pureed diet with thin liquids. Further interview revealed staff were instructed to contact the facility Nurse if coughing was noted and the team may consider nectar thick liquids. Additional interview confirmed the dietician had not completed any recent training on diet textures and that pureed diets were mechanically altered with liquids added and the texture was smooth like,"baby food or apple sauce."

B. During observations of mealtime on 6/27/22 at 4:35pm revealed client #4 using an adaptive scoop bowl with stir fry shrimp and vegetables, a biscuit and apple slices. Client #4 used a built up spoon and regular cups. Client #4's serving of rice was regular texture, as was his stir fry topping that had shrimp, broccoli and other vegetables over an inch in size. He was also given a regular texture roll.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G269 | A. BUILDING _____ B. WING _____ | 06/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HICKORY II GROUP HOME | 322 HICKORY AVE SANFORD, NC 27330 |

| (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 460 | Continued From page 10 | W 460 | | |

During observations of breakfast on 6/28/22 at 7:10am, client #4 was noted to have a scoop bowl and adaptive built up spoon. He was assisted to serve oatmeal, scrambled eggs, toast, two pieces of whole sausage and peaches. Client #4 ate his sausage with his hands and bit off pieces of the sausage patties as he held them. He was noted to cough three times during breakfast.

Review on 6/27/22 of client #4's nutritional evaluation dated 2/15/22 revealed he is prescribed a regular double portion diet with ground meat and all sides mechanically soft or finely chopped with no larger than 1/2 inch pieces.

Interview on 6/28/22 with the RM revealed she was not aware that client #4's food texture was to be modified.

C. During observations of supper on 6/27/22 at 4:30pm, client #1 was assisted to serve 2 servings of rice, stir fry shrimp vegetables, 2 rolls and a serving of canned peaches. Client #1's food texture was not modified.

Interview on 6/27/22 with staff F revealed the menu for supper included a serving of rice, 1 serving of stir fry shrimp and vegetables, 1 roll and 1 serving of peaches.

During observations of breakfast on 6/28/22 at 7:10am client #1 was assisted to serve scrambled eggs, a piece of toast, 2 pieces of sausage and 2 servings of oatmeal. Client #1's sausage texture was not modified.

Interview on 6/28/22 with staff E revealed the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G269 | A. BUILDING _____ B. WING _____ | 06/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HICKORY II GROUP HOME | 322 HICKORY AVE SANFORD, NC 27330 |

| (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 460 | Continued From page 11<br>menu for breakfast included 1 serving of scrambled eggs, 1 piece of toast, 1 sausage patty, a serving of oatmeal and fruit.<br><br>Review on 6/28/22 of client #1's nutritional evaluation dated 12/8/21 revealed client #1 is prescribed a 1500 calorie diet with coarsely chopped meats not to exceed 1/4"-1/2" pieces, may have seconds of one preferred food item.<br><br>Interview on 6/28/22 with the facility Nurse confirmed client #1 is prescribed a 1500 calorie diet with coarsely chopped meats not to exceed 1/4"-1/2" pieces, may have seconds of one preferred food item. Further interview confirmed client #1's desired weight range is 155-165 pounds and that as of 9/30/21, he weighs 198 pounds. Additional interview confirmed client #1 had gained 12 pounds in over 12 months in 2021. | W 460 | | |