

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/27/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G357	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/19/2022
NAME OF PROVIDER OR SUPPLIER MORROW VALLEY FARMSTEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 44012 MORROW MOUNTAIN 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 227	<p>INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)</p> <p>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:</p> <p>The facility failed to assure the individual support plans (ISPs) for 3 of 4 sampled clients (#2, #9 and #10) included objective training to meet the clients' meal preparation skill needs as evidenced by observation, interview and record verification. The findings are:</p> <p>Afternoon observation in the group home on 7/18/22 revealed staff to complete all aspects of meal preparation and serving clients except for clients #2 and #9 assisting to set the table. Further observations on 7/19/22 during breakfast again revealed staff to complete almost all meal preparation and serving except for client #2 and #9 setting the table and client #2 making cinnamon buttered toast. Continued observations of the clients in the home, substantiated by interviews with staff and review of client records, revealed many of the clients have the ability to participate in their meal preparation but currently clients do not have any objective training to increase their skills. For example:</p> <p>A. Review of client #2's ISP dated 6/14/22 revealed the client to have several advanced programs including completing 2 household chores each day, completing laundry and learning to self-administer medications. Further review of the ISP revealed the client can complete most family style dining tasks independently however client #2 requires verbal and gestural prompting for meal preparation tasks. Interview with the</p>	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G357	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/19/2022
NAME OF PROVIDER OR SUPPLIER MORROW VALLEY FARMSTEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 44012 MORROW MOUNTAIN 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 227	<p>Continued From page 1</p> <p>qualified intellectual disabilities professional (QIDP), substantiated by continued review of the ISP, revealed the client currently does not have any meal preparation objectives but does have the need to learn those skills.</p> <p>B. Review of client #9's ISP dated 5/26/22 revealed the client to have several advanced programs including completing household chores daily, completing showering routine and learning to self-administer medications. Further review of the ISP revealed the client can complete most family style dining tasks independently however client #9 requires verbal and gestural prompting for meal preparation tasks. Interview with the QIDP, substantiated by continued review of the ISP, revealed the client currently does not have any meal preparation objectives but does have the need to learn those skills.</p> <p>C. Review of client #10's ISP dated 8/1/21, substantiated by interview with the QIDP, revealed the client to have previously lived in a sister facility before moving into the group home. Further interview and record review revealed the client's ISP from his previous placement was accepted at the new group home until time for his new ISP planning meeting. Review of the client's ISP revealed the client requires verbal and gestural prompting to complete all aspects of meal preparation however the ISP notes that the client "will continue to receive regular opportunities to assist in the kitchen participating in various simple meal preparation activities to increase his skills." Continued interview with the QIDP revealed the client does not currently participate in meal preparation at his new group home.</p>	W 227			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/27/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G357	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/19/2022
NAME OF PROVIDER OR SUPPLIER MORROW VALLEY FARMSTEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 44012 MORROW MOUNTAIN 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 247 W 247	Continued From page 2 INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: The facility failed to assure opportunities for client choice and self-management were provided during mealtimes for 10 of 10 clients in the home (#1, #2, #3, #4, #5, #6, #7, #8, #9 and #10) as evidenced by observations, interviews, and record verification. The finding is: Afternoon observations in the group home on 7/18/22 at 5:10 PM revealed client #2 and #9 assisting with setting the table. Further observations at 5:20 PM revealed staff to bring out supper in aluminum heating pans on a cart where clients were individually served by staff the menu of turkey, stuffing, greens, peas, peaches and bread. Interview with the facility nurse revealed the cooking for supper is completed by staff earlier in the day and is heated up for supper. Further interview revealed client participation is limited and meal preparation is usually completed at this point for special client specific foods. Morning observations in the group home on 7/19/22 at 7:35 AM again revealed clients #2 and #9 assisting with setting the table. Further observation of breakfast at 7:55 AM revealed the clients to be served cereal that was pre-measured into a ziploc bag by staff, toast that staff spread jelly on for everyone in the kitchen and sausage for some of the clients per their specified diets. Staff were also observed to pour clients' milk, orange juice and water. Continued	W 247 W 247			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/27/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G357	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/19/2022
NAME OF PROVIDER OR SUPPLIER MORROW VALLEY FARMSTEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 44012 MORROW MOUNTAIN 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 247	Continued From page 3 observations revealed the only client participation in the morning meal besides setting the table was with client #2 who assisted in making his preferred cinnamon buttered toast. Interview with the qualified intellectual disabilities professional (QIDP), substantiated by review of client individual support plans (ISPs), revealed clients currently do not have programming for learning mealtime self-management skills. Further interview with the QIDP revealed the team was working on some changes to the meal time process as all of the clients were settled into the group home now. However, as of the 7/18-19/22 survey those changes have not been implemented.	W 247			