

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/19/2022
NAME OF PROVIDER OR SUPPLIER QUEEN'S POND			STREET ADDRESS, CITY, STATE, ZIP CODE 651 QUEEN'S CREEK ROAD HUBERT, NC 28539		
(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	<p>PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)</p> <p>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. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 3 audit clients (#9). The finding is:</p> <p>Review on 7/18/22 of client #9's Behavior Support Plan (BSP) dated 3/8/22 revealed an objective to decrease frequency of physical aggression to one or less incidents per month for ten of twelve months. Additional review of client #9's BSP revealed a target behavior consisting of physical aggression. Further review of the BSP revealed written informed consent had not been obtained by the legal guardian.</p> <p>Interview on 7/19/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that although attempts have been made, written informed consent has not been obtained by the legal guardian.</p>	W 263			
W 441	<p>EVACUATION DRILLS CFR(s): 483.470(i)(1)</p> <p>and under varied conditions to- This STANDARD is not met as evidenced by: Based on review of fire drill reports and interviews, the facility failed to ensure fire evacuation drills were conducted at varied times. This potentially affected all clients residing in the home. The finding is:</p>	W 441			

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.

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

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W 441	<p>Continued From page 1</p> <p>Review on 7/18/22 revealed five fire drills were conducted on second shift at: 4:05pm, 3:15pm, 4:10pm, 4:15pm and 5:30pm. Further review there where four fire drills conducted on third shift: 5:30am, 5:45am, 6:15am and 5:30am.</p> <p>During an interview on 7/19/22, the Residential Manager (RM) stated second shift hours are from 3:00pm until 11:30pm and third shift hours are from 11pm until 7:30am.</p> <p>During an interview on 7/19/22, the management staff confirmed the fire drills where not conducted at varied times on second and third shifts.</p>	W 441			