STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G168	A. BUILDING _____ B. WING _____	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBAY GROUP HOME	1907 NORTHBAY DRIVE BROWN SUMMIT, NC 27214

(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 observations, review of record and interviews, the habilitation support plan (HSP) failed to have a training objective to meet the identified client needs for 1 of 3 sampled clients (#1) relative to closing bathroom door for privacy. The finding is: Observations in the group home on 7/19/22 at 7:46 AM revealed client #1 to leave the living room and enter the bathroom. Continued observation revealed client #1 to turn on bathroom light and to sit on the toilet. Further observation at 7:49 AM revealed client #1 to remain on the toilet with the bathroom door open. Subsequent observation revealed client #1 to turn off the light and exit the bathroom. Additional observation at 7:50 AM revealed staff to prompt client #1 to return to the bathroom to wash hands. At no time during the observation was staff observed to close the bathroom door or prompt client to close the door. Review of records for client #1 on 7/19/22 revealed an HSP dated 8/24/21 with training objectives to wash hands after using bathroom, shopping, to bathe upper body and medication administration. Continued review of record revealed an adaptive behavior inventory dated 8/14/20 that revealed client #1 closes the bathroom door before using the toilet with total independence.	W 227		

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

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W 227	Continued From page 1 Interview on 7/19/22 with staff B revealed that client #1 does not close the door upon entering the bathroom without staff prompting the client to close the door. Continued interview with staff B revealed client #1 would benefit from a training objective to close the bathroom door before using the toilet. Interview on 7/19/22 with the regional manager (RM) verified the 8/24/21 HSP for client #1 is current. Continued interview with the RM revealed client #1 should close the bathroom door for privacy.	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 observations, interview and record review, the facility failed to assure a continuous active treatment program was implemented for 2 of 3 sampled clients (#1 and #2) relative to medication administration. The findings are: A. The facility failed to implement the medication administration program for client #1. For example:	W 249		

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Observation in the group home on 7/19/22 at 7:06 AM revealed client #1 to pour water in a cup. Continued observation revealed staff E to remove medication packet from medication closet and prepare medications for administering by pouring them into the medication cup. Continued observation revealed staff E to pour medications into the mouth of client #1 and the client to drink water with Gavilax Powder. Client #1 was not observed to receive any training during medication pass or to participate beyond taking medications from staff E and pouring water.

Review of records for client #1 revealed a habilitation support plan (HSP) dated 8/24/21. Review of the HSP revealed client #1 has a goal to participate in medication administration with a behavior chain to locate medication bin, to pick up medication bin and to set medication bin on counter.

Interview on 7/19/22 with the regional manager (RM) verified the 8/24/21 HSP for client #1 is current. Continued interview with the RM verified that staff should have implemented the medication administration goal for client #1.

B. The facility failed to implement the medication administration program for client #2. For example:

Observation in the group home 7/19/2/22 at 7:15 AM revealed staff E to remove medication packet from medication closet and sign medication book. Continued observation revealed staff E to pour medications into medication cup, pour water into cup, and pour medications into the mouth of client #2. Further observation at 7:25 AM revealed client #2 to drink water and exit the

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W 249	Continued From page 3 medication area. Client #2 was not observed to receive any training during medication pass or to participate beyond taking medications from staff E. Review of records for client #2 revealed an HSP dated 7/11/22. Review of the HSP revealed client #2 has a goal implemented 8/8/21 to participate in medication administration. Continue review of medication administration goal revealed the client to perform the following with prompts: Pick up medication bin, use sanitizer to wash hands, pour water into glass/cup, take medications and throw medication cup into trash can. Interview on 7/19/22 with the regional manager (RM) verified the 7/11/22 HSP for client #2 is current. Continued interview with the RM verified that staff should have implemented the medication administration goal for client #2.	W 249		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the system for drug administration failed to assure all drugs were administered in compliance with physician orders for 1 of 2 clients (#2) observed during medication administration. The finding is: Observation in the group home on 7/19/22 at 7:15 AM revealed client #2 to enter the medication room for morning medications. Observation of the medication pass for client #2 revealed staff E	W 368		

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W 368	Continued From page 4 to remove pill packets from medication closet, pour water into a cup and pour all medications from pill packet into medication cup. Further observation revealed staff E to pour medications into client #2's mouth and the client to swallow medications drinking water. During observation, staff was not observed to administer Miralax to client #2. Review of physician orders for client #2 on 7/19/22 revealed an order dated 3/1/22 for Polyethylene Glycol 3350 Miralax powder 255GM small. Review of the Polyethylene Glycol 3350 order revealed: Dissolve 1 capsule (17 grams) in 4oz to 8 oz in juice or water and drink by mouth every morning and evening. Interview with the facility nurse on 7/19/22 verified that client #2 is prescribed Polyethylene Glycol 3350 Miralax powder 255GM small. Continued interview with the facility nurse revealed she was not notified that client #2 did not receive morning dosage of Miralax. Further interview with the facility nurse revealed that client #2 has constipation concerns and should have received prescribed medication.	W 368		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the system for drug administration	W 371		

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failed to assure 2 of 2 clients (#1, and #2) observed during medication administration were provided the opportunity to participate in medication self-administration or provided teaching related to name, purpose and side effects of medication administered. The findings are:

A. The system for drug administration failed to assure client #1 was provided the opportunity to participate in medication self-administration. For example:

Observation in the group home 7/19/22 at 7:06 AM revealed client #1 to pour water in a cup. Continued observation revealed staff E to remove medication packet from medication closet and prepare medications for administering by pouring them into the medication cup. Continued observation revealed staff E to pour medications into the mouth of client #1 and the client to drink water with Gavilax Powder. Client #1 was not observed to receive any training during medication pass or to participate beyond taking medications from staff E and pouring water.

Review of records for client #1 revealed a habilitation support plan (HSP) dated 8/24/21. Review of the HSP revealed client #1 has a goal to participate in medication administration with a behavior chain to locate medication bin, to pick up medication bin and to set medication bin on counter.

Interview with staff E on 7/19/22 revealed that staff E would typically educate verbal clients. Continued interview with staff E revealed that non-verbal clients are told that it is healthy to take medications and staff E would explain to them the

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reason it is healthy to take medications.

Interview with the facility nurse on 7/19/22 verified that staff should train and educate all clients during medication administration. Continued interview with the facility nurse revealed that staff will receive further training to educate clients during medication administration.

B. The system for drug administration failed to assure client #2 was provided the opportunity to participate in medication self-administration. For example:

Observation in the group home on 7/19/2/22 at 7:15 AM revealed staff E to remove medication packet from medication closet and sign medication book. Continued observation revealed staff E to pour medications into medication cup, pour water into cup, and pour medications into the mouth of client #2. Further observation at 7:25 AM revealed client #2 to drink water and exit the medication area. Client #2 was not observed to receive any training during medication pass or to participate beyond taking medications from staff E.

Review of records for client #2 revealed an HSP dated 7/11/22. Review of the HSP revealed client #2 has a goal implemented 8/8/21 to participate in medication administration. Continued review of medication administration goal revealed the client to perform the following with prompts: Pick up medication bin, use sanitizer to wash hands, pour water into glass/cup, take medications and throw medication cup into trash can.

Interview with staff E on 7/19/22 revealed that staff E would typically educate verbal clients.

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W 371	Continued From page 7 Continued interview with staff E revealed that non-verbal clients are told that it is healthy to take medications and staff E would explain to them the reason it is healthy to take medications. Interview with the facility nurse on 7/19/22 verified that staff should train and educate all clients during medication administration. Continued interview with the facility nurse revealed that staff will receive further training to educate clients during medication administration.	W 371		