STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G119	A. BUILDING ______ B. WING ______	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENDOVER HOME	631 OLD PARK ROAD MAIDEN, NC 28650

(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	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, interviews and record review, the facility failed to ensure 1 sampled client (#3) received a continuous active treatment program consisting of needed interventions as identified in their person centered plan (PCP). The finding is: Observations in the group home on 7/27/22 at 6:45AM revealed client #3 to sit at the dining table to prepare for the breakfast meal. Continued observations at 6:50 AM revealed client #3 to stand from his chair and strike client #2 in the head multiple times with a closed fist. Observations revealed staff to ask client #3 to refrain from hitting his peers with a calm voice. Further observations at 6:52 AM revealed client #3 to return to his seat in the dining room. Observations from 6:55 AM to 7:10 AM revealed client #3 to repeatedly strike clients #1, #2, #4, and #5 in the top of the head with a closed fist, choking them with his hands, placing the clients in a choke hold while pulling their ear and hitting the clients in the back of the neck. Observations revealed staff to consistently request that client #3 refrain from striking his peers and stated	W 249		

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.

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W 249	Continued From page 1 "that's not nice. You shouldn't hit others". Observations at 7:10 AM revealed clients to cry and scream for client #3 to stop hitting them. Observations at 7:11 AM revealed staff to move clients in their rooms to remove them from the area and from immediate harm. Subsequent observations at 7:13 AM revealed client #3 to walk behind client #6 and place the client in a choke hold, while pulling the client's ear and refusing to release the client after several prompts from staff. Three staff were observed to attempt to remove client #3's hands from around client #6's neck. Observations revealed staff to successfully remove client #3's arms from around the client's neck and place client #6 in his room. Continued observations at 7:15 AM revealed staff to provide client #3 with breakfast and provide 1:1 supervision while the client participated in the breakfast meal. Observations at 7:35AM revealed client #3 to complete the breakfast meal and place his dishes in the kitchen. Further observations at 7:37AM revealed client #3 to enter into the living room area and slap client #5 in the face with an open hand. Observations revealed client #5 to scream out "ouch, you hit me. Please stop". Observations also revealed staff to run into the living room to intervene and remove client #3 from the area. Observations at 7:45 AM revealed staff to escort client #3 to the facility van and remain in the van until the departure to the day program at 8:10 AM. At no point during the observation period was client #3 escorted to his room to calm down. Staff also did not offer any alternatives to assist the client with de-escalation. Observations did not reveal staff to complete any restrictive interventions with client #3 to attempt to de-escalate his aggressive behaviors.	W 249		

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W 249	Continued From page 2	W 249		

Review of the record for client #3 on 7/27/22 revealed a PCP dated 2/23/22 which included the following program goals: choose an activity, personal space, bathing goal, clean his room and an oral hygiene goal. Review of the record for client #3 also revealed a positive behavior support plan (BSP) dated 6/1/21, which included the following target behaviors: uncooperative/resistance, property destruction, aggression (i.e. hitting, kicking, scratching, pinching, biting, spitting, pulling hair, etc.), self-injurious behavior (SIBs) and elopement. Continued review of the 6/1/21 BSP revealed if client #3 is aggressive, staff should move him and the person targeted apart and staff should block any further attempts. When calm for a minute, offer appropriate alternative activities to support his appropriate behavior. If behaviors continue, staff should attempt to block the client and direct him to move to a low stimulus area to calm down.

Review of behavior data for client #3 from 6/2022-7/2022 revealed client #3 had 3 aggressive behaviors in June 2022 and 13 aggressive behaviors in July 2022. Continued review of behavior data revealed client #3 has also shown an increase in aggressive behaviors targeted to 3 out of 4 clients (#1, #2, and #4) over the past month.

Review of mini-team minutes dated 7/13/22 revealed client #3 has shown an increase in aggressive behaviors. Continued review of the mini-team minutes revealed client #3 received a medication increase (seroquel) and was not getting appropriate rest at night.

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Interview with staff A on 7/27/22 revealed client #3 has shown an increase in aggressive behaviors over the last several weeks. Staff A also revealed during the interview that staff are supposed to utilize restrictive interventions on client #3 when his behaviors escalate, however she is afraid that she would hurt him so she chooses not utilize any therapeutic holds to de-escalate the client's behaviors. Staff A also revealed during the interview that client #3 slept well the previous night without interruptions. Continued interview with staff A and B revealed client #3 usually only targets client #1 and would be easily redirected to his room.

Interview with the staff psychologist on 7/27/22 revealed the interdisciplinary team (IDT) met on 7/13/22 to further discuss client #3's increasing aggressive behaviors and the need to revisit interventions to ensure the safety of all clients in the facility. Further interview with the staff psychologist verified that the team is looking further into the behavior changes for client #3 and will identify interventions to assist staff in better managing the client's behaviors towards his peers and staff.

Interview with the qualified intellectual disabilities professional (QIDP) revealed that although client #3 has shown an increase in aggressive behaviors there has not been a BSP update to address the increasing concerns. Continued interview with the QIDP also revealed that staff are utilizing interventions from the 6/1/21 BSP for client #3. Further interview with the QIDP revealed that all of client #3's goals and interventions are current. Interview with the QIDP verified that staff have received inservice training on client #3's BSP and restrictive interventions.

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W 249	Continued From page 4 The QIDP also verified that staff did not follow client #3's BSP as prescribed and updates are needed to address the client's increasing aggressive behaviors.	W 249		