STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G032	A. BUILDING _____ B. WING _____	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY ICF/MR GROUP HOME	115 STORYBOOK LANE SYLVA, NC 28779

(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 218	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: The facilty failed to assure the comprehensive functional assessment developed as part of the individual habilitation plan (IHP) for 1 of 4 sampled clients (#3) included updated assessment of the client's sensorimotor development as evidenced by observations, interview and record verification. The finding is: Afternoon observations in the group home on 4/13/22 revealed client #3 to sit in a wheelchair and use her feet to propel herself around the group home. Further observations revealed the client to lean to her right side against the arm rail unless prompted and repositioned by staff. Continued observation at supper at 6:30 PM revealed the client to have an adaptive built up handled spoon and a scoop plate for use during the meal. Staff was observed to assist client #3 with hand over hand assistance during the first half of the meal until the client became to tired and refused to feed herself. Subsequent observations during supper revealed staff finished the meal by feeding client #3. Morning observations in the group home on 4/14/22 revealed client #3 to again sit in a wheelchair while leaning and propelling herself in the same method. Further observations of breakfast at 8:25 AM revealed client #3 to again have an adaptive spoon and scoop plate for use during the meal, but was also given a plastic tray to raise her plate closer to her mouth and wrist weights to help control involuntary arm movements. Continued observations however,	W 218	The QIDP will meet with all staff and retrain on Dining Guidelines to ensure consistency in supporting Client #3 during meals. Please see attached in-service training sheet and Dining Guidelines. The QIDP has contacted Client #3's primary care physician and scheduled an appointment set for to discuss referral/order for OT evaluation. The QIDP will contact Client #3's neurologist and request an evaluation for any possible changes in global functioning. Additionally, the QIDP will request the MCH PT and dietician to observe Client #3 and assess for any noted physiological changes as well as recommendations for changes to current exercises/devices/supports. Evidence of these will be located in progress notes within the medical record. Any changes to supports/strategies provided to Client #3 will be documented in the QIDP summary. DHSR - Mental Health MAY 20 2022 Lic. & Cert. Section	4/29/2022 5/6/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christi Huff — TITLE: Executive Director — (X6) DATE: 5.4.2022

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G032	A. BUILDING _____ B. WING _____	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY ICF/MR GROUP HOME	115 STORYBOOK LANE SYLVA, NC 28779

(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 218	Continued From page 1 revealed the client did not feed herself during the meal and instead needed staff to feed her the entire meal. Interview with the group home manager on 4/14/22 revealed the client has a neurological condition that has caused her decrease in her abilities. Further interview revealed the client gets tired as the day goes on and her skills decline as she tires. Review of client #3's IHP dated 10/7/21 revealed the client is diagnosed with Basal Ganglia Deterioration which is slowly causing her loss of skills. Further review of the IHP revealed an updated physical therapy (PT) evaluation dated 9/22/21 but no monitoring by the PT during the year regarding the client's skills or needs. Continued review of the IHP, substantiated by interview with qualified intellectual disabilities professional (QIDP), revealed no occupational therapy (OT) evaluation is included in the IHP to evaluate the need for the client's current dining equipment or strategies to best assist the client with eating and declining sensorimotor skills.	W 218		

IN-SERVICE TRAINING SIGNATURE SHEET

Topic/Title of Training: _____
Summary of Training: _____
_____
_____
_____
Presenter(s): _____
Date(s) of Training: _____

Name	Title	Name	Title

By signing this form, I agree that I have attended this training class in its entirety. The information was presented in a language I understand and I had the opportunity to ask questions of the trainer.

6/10;5/11; 8/17; 2/22

MCH

Harrison Avenue Group Home
Iotla Street Group Home
Macon Group Home
Macon Citizens
Enterprises
Smoky Group Home
Webster Group Home
Yonce House

P.O Box 698
Franklin, NC 28744
Phone: (828) 524-5888
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Email: mch@maconcitizens.org
Web: www.maconcitizens.org

May 4, 2022

Steven C. Yost, MSW. QDDP
ICF/IID Branch Manager
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Dear Steve,

Please find enclosed a plan of correction for deficiencies cited at the recertification survey completed on April 14, 2022 for Smoky ICF Group Home (MHL# 050-004). Sample attachments are included. If you have any questions or if there are any corrections needed, please contact me at (828) 524-5888 ext. 218.

Thank you so much for your visit. We hope to see you again.

Sincerely,

Christi

Christi Huff
Executive Director

DHSR - Mental Health
MAY 20 2022
Lic. & Cert. Section