STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G217	A. BUILDING _____ B. WING _____	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATES STREET ICF/MR	306 CATES STREET ROXBORO, NC 27573

(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 325	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(iii) The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure lab work was obtained as ordered by the physician for 1 of 4 audit clients (#4). The finding is: Review on 8/10/22 of a faxed order from the physician to the home manager (HM) on 3/24/22 revealed client #4 was started on Ferrous Sulfate 325 mg twice a day and needed to have a complete Hemoccult cards done and returned to the office. Labs that were drawn on 3/23/22 had revealed the iron serum was 16 L (low) when the average range should be 27-139 and the iron saturation on 3/23/22 was 6% LL (critical low) when the average range should be 15-55%. Review on 8/10/22 of laboratory results drawn on 4/28/22 revealed the Hemoccult card was obtained. The results of the test were as followed: 1st POS, 2nd NEG and 3rd POS. Interview on 8/10/22 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the former nurse notified the physician of the Hemoccult results on 4/28/22 and indicated that blood was found in client #4's stool. The physician made a referral for client #4 to see another doctor for a colonoscopy. The QIDP revealed that before client #4 could be seen for the scheduled colonoscopy she had to be hospitalized on 5/25/22 for a small bowel	W 325		

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

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W 325	Continued From page 1 obstruction. While hospitalized, further testing was done and determined that client #4 had Stage 3 colon cancer. Interview on 8/10/22 with the Director revealed the nurse and home manager were responsible for reviewing laboratory results received and scheduling additonal laboratory tests ordered by the the physician.	W 325		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure fire drills were conducted at varying times and conditions. This had the potential to affect all clients (#1, #2, #3, #4, #5 and #6). The finding is: Review on 8/9/22 of facility fire drill reports for August 2021 to July 2022 revealed fire drills were conducted on first shift at 8:00am, 10:30am, 10:15am and 2:30pm. Fire drills on second shift were conducted at 3:20pm, 3:30pm, 6:00pm and 7:30pm. Fire drills on third shift were conducted at 11:00pm, 11:15pm, 11:30pm for three quarters. In addition, the facility's fire drill schedule form gave instructions to vary the dates and times when drills are performed. Interview on 8/10/22 with the Home Manager (HM) revealed that he was responsible for reviewing the monthly fire drills and had not detected any problems with scheduling. Interview on 8/10/22 with the Director revealed that fire drills should be conducted at varying	W 441		

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W 441	Continued From page 2 times during the shift.	W 441		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of possible infections and prevent possible cross-contamination. This potentially affected all of the clients(#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: During evening observations in the home on 8/9/22 from 5:30pm to 6:00pm, Staff B was observed wearing the same pair of gloves throughout dinner. Staff C assisted client #1 load her food on her spoon, using her gloves to touch the utensil. Staff C was observed using glove hands to touch client #3's straw, stroke client #1's face, carry soiled clothing protectors into the kitchen and shake food debris in the trash can, then transfer protectors to the laundry room, wearing the same gloves. Staff C continued to wear the gloves and rinsed off dirty dishes and placed a sheet of foil over leftover lasagna before putting the food in the refrigerator. Staff C then returned to the dining room where she continued to help client #3 with finishing his meal, using the same gloves. Review on 8/10/22 of the facility's Exposure Control Plan (ECP) dated 5/31/21 revealed staff should change gloves frequently and perform hand hygiene each time gloves are changed, as	W 455		

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W 455	Continued From page 3 dirty gloves can spread germs too. Always change gloves between client care and ensure hands are washed or hand sanitizer is used after glove disposal and before donning a new pair of gloves. Interview on 8/10/22 with the Director revealed that all staff were trained on 9/20/22 for infection control and have been taught to change their gloves between each client.	W 455		
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure clients ate in a manner that was not stigmatizing. This affected 1 of 4 audit clients (#3). The finding is: During dinner observations in the home on 8/9/22 at 5:42pm, client #3 was observed feeding himself, with a clothing protector secured around his neck with the bottom material resting on the table, underneath his plate. Both Staff B and the qualified intellectual disabilities professional (QIDP) were observed interacting with him throughout his meal, but neither removed the clothing protector from underneath his plate. Review on 8/9/22 of client #3's individual program plan (IPP) dated 11/30/21 revealed client #3 only needed a non-slip mat underneath his plate. Interview on 8/10/22 with the home manager revealed that he was unaware it was stigmatizing	W 488		

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W 488	Continued From page 4 to feed clients in this manner and he acknowledged that he had previously placed clothing protectors underneath plates as well.	W 488		