STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G233	A. BUILDING _____ B. WING _____	01/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEBSTER GROUP HOME	103 LITTLE SAVANNAH RD WEBSTER, NC 28788

(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 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: The facility failed to assure sufficient staff were available to manage and supervise 1 of 4 sampled clients in the group home (#1) in accordance with his individual habilitation program (IHP) as evidenced by observation, interview and record verification. The finding is: Morning observations in the group home on 1/25/22 at 6:45 AM revealed one 3rd shift staff on duty when the group home manager and surveyors entered the group home. Client #1 was observed to be in client #3's bedroom with client #3 and staff while client #2 was asleep on the couch and client #6 had just gotten up and entered the hallway. Further observations revealed the group home manager to immediately begin working with client #6 and assist him with taking a bath as the client had a toileting accident. Third shift staff prompted client #5 to wake up at 6:50 AM and prompted client #1 to come into client #5's bedroom while staff assisted client #5 to get ready for the day including changing clothes. Interview with 3rd shift staff revealed client #1 had been up since 3:00 AM and often does not sleep the whole night. Further interview with staff revealed 3rd shift staff works alone until 1st shift arrive around 7:00 AM. Continued interview with	W 186	The staffing schedule reflects a second staff reporting to work at 6:30am (please see attached staffing schedule). Times when the manager is scheduled to cover an open shift will be documented on the schedule, which is turned in a kept at the Administrative Office. The QIDP will retrain all staff on the importance of arriving to work on time. Resident schedules were reviewed and adjusted as needed to reflect current individual resident preferences for times to wake, bathe and go to bed. The schedules are reviewed with staff during training. The staffing schedule is developed to ensure adequate staff are available to meet the needs of the residents (please see attached resident schedules). The QIDP will retrain all staff on individual schedules (Client #1-6) to ensure they are followed as developed as well as reviewing the importance of structure and consistency in the residents' routines. Evidence of training will be located on an in-service training sheet. To ensure proper implementation of daily schedules, the QIDP, Group Home Manager or ICF Assistance Manager will conduct a random observation at least twice a week for 60 days. Additionally, the QIDP will review, sign and date the staff schedule developed by the group home manager each week to ensure adequate direct care support is available for the residents. Evidence of monitoring will be located on tracking sheet (please see attached document).	2/16/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christi Hyatt — TITLE: Executive Director — (X6) DATE: 2.7.2022

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.

DHSR - Mental Health

FEB 11 2022

Lic. & Cert. Section

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W 186	Continued From page 1 3rd shift staff revealed she is responsible for giving client #3 a bath in the morning and usually prompts client #1 to sit in client #3's wheelchair outside the bathroom door so she can monitor him while giving client #3 a bath. Subsequent interview with 3rd shift staff revealed she knew that the client #1 should not be in client #3's or #5's bedrooms while they are changing clothes and getting ready for the day but due to the need to monitor client #1 she felt she had to disregard their privacy. Review of client #1's IHP dated 4/8/21 revealed a behavior support plan (BSP) to address PICA. Review of the BSP, substantiated by interview with staff, revealed the client should be constantly monitored due to the client taking unsupervised opportunities to eat inedible things or uncooked foods. However, the facility failed to assure adequate staff were available to support the needs of the clients in the group home and monitor client #1 appropriately during early morning hours in the group home.	W 186		
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: The facility failed to assure the individual habilitation plan (IHP) for 1 of 4 sampled clients	W 242	Programs to increase toothbrushing skills and self-feeding will be implemented to improve basic self-care needs for Client #6 (please see attached documents). The QIDP will document past training efforts, modifications and revisions of all future training programs in the "reason" section of the program or guideline to justify the achievement of identified objectives for all residents. The comprehensive functional assessment portion of the IPP will continue to serve as guidance for determining objectives.	2/16/2022

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W 242	Continued From page 2 (#6) included training in personal skills essential for independence in dental hygiene and self-feeding as evidenced by observation, interviews and record verification. The finding is: Review of client #6's IHP dated 10/21/21 revealed the client to have 2 guidelines for the client to scoop from a plate and to complete 4 brushstrokes with his toothbrush. Further review of these guidelines, review of the previous qualified intellectual disabilities professional's (QIDP's) notes, substantiated by interview with the current QIDP revealed the client used to have objective training for eating independently and toothbrushing but these objectives were discontinued in 7/21 due to the client failing to make progress. Continued review of the QIDP notes revealed no evidence that any staff retraining or program modifications occurred before the client's programs were discontinued and moved to guidelines. Further interview with the QIDP and observations of the client revealed the client still has many basic needs and continues to need a lot of staff assistance to both eat and brush his teeth.	W 242	CONT. To ensure proper implementation of programs, the QIDP, Group Home Manager or ICF Assistant Manager will conduct a random observation at least twice a week for 60 days. Evidence of monitoring will be located on tracking sheet (please see attached document).	
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.	W 249		

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W 249	Continued From page 3 This STANDARD is not met as evidenced by: The facility failed to assure guidelines included in the individual habilitation plans (IHPs) for 2 of 4 sampled clients (#5 and #6) were implemented as prescribed as evidenced by observations, interviews and record verfication. The findings are: A. Evening observations in the group home on 1/24/22 at 6:15 PM revealed client #6 and peers to sit down at the table to eat supper. Staff were observed to sit next to client #6 to assist the client with his meal. Further observations revealed staff to keep client #6's food away from the client and prepare spoonfuls of food for client #6 to take into his hand and serve himself. Continued observations revealed staff continued to serve client #6 each spoonful this way thoughout the meal without client #6 using the scoop plate sitting in front of him. Subsequent observations on 1/25/22 at 8:20 AM again revealed staff to start serving breakfast in the same manner. Additional observations at 8:25 AM revealed the group home manager to prompt staff to put part of client #6's food into his scoop plate so the client could scoop his food independently. Staff was observed to put the client's oatmeal into his plate and the client was observed to eat it with staff assisting hand over hand to scoop appropriate portions onto his spoon. Interview with the home manager and qualified intellectual disabilities professional (QIDP), substantiated by review of client #6's IHP dated	W 249	A. Mealtime Guidelines will be revised and staff retrained to ensure a consistent approach is provided to Client #6 (please see attached guidelines). Evidence of staff training will be located on an in-service training sheet. B. A program to increase independence in closing the bathroom door will be implemented for Client #5 (please see attached program). All staff will be retrained on the importance of privacy protection for all residents. Evidence of staff training will be located on an in-service training sheet. A & B: To ensure proper implementation of training, the QIDP, Group Home Manager or ICF Assistant Manager will conduct a random observation of program implementation at least twice a week for 60 days. Evidence of monitoring will be located on tracking sheet (please see attached document).	2/16/2022

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W 249	Continued From page 4 10/21/21, revealed the client to have mealtime guidelines to scoop from his plate and bring it to his mouth. Further interviews revealed staff should implement this guideline each meal. B. Morning observations in the group home on 1/25/22 revealed staff waking client #5 at 6:50 AM and prompting the client to go use the bathroom. Further observations revealed client #5 to exit his bedroom and enter the bathroom while staff stayed in his bedroom to get clothes ready for the client to wear for the day. Continued observations revealed client #5 to toilet with the door open before exiting the bathroom and returning to his bedroom. Review of client #5's IHP dated 10/07/21 revealed the client to have guidelines for privacy during bathroom use. Further review of these guidelines indicated staff provide consisitent training to make sure client #5 remembers to shut the bathroom door for his privacy. No staff were available to provide client #5 a prompt to close the bathroom door. Interview with the home manager and QIDP on 1/25/22, revealed staff should be available when client #5 goes to the bathroom to prompt him per his guidelines to remember to shut the door.	W 249		