STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G327	A. BUILDING _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLENDALE GROUP HOME	4165 NC HWY 127 TAYLORSVILLE, NC 28681

(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 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 6 clients in the group home (#1) observed during medication administration. The finding is: Observation in the group home on 8/22/22 at 4:00 PM revealed client #1 to be assisted into the medication room for evening medications. Continued observation of the medication pass for client #1 revealed staff B to sanitize his hands and to sanitize the client's hands, remove the pill packet basket and medication administration record from the medication closet and to assist client to punch medications into medicine cup. Further observation revealed staff B to assist client #1 hand over hand to pour tang into nosey cup, to put all medications into pudding, feed to client and to assist client to drink tang. During the medication observation staff was not observed to add Thick It to the client's beverage. Observation in the group home on 8/23/22 at 7:10 AM revealed client #1 to be assisted into the medication room for morning medications. Continued observation of the medication pass for client #1 revealed staff F to sanitize the client's hands, take the client's temperature, take the client's blood pressure, remove the pill packet basket and medication administration record from the medication closet. Further observation revealed staff F to offer a choice of applesauce or	W 368		

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

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	34G327	A. BUILDING _____ B. WING _____	08/23/2022

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W 368	Continued From page 1 pudding and the client to choosing pudding. Subsequent observation revealed staff F to hand over hand punch all medications into medicine cup and add to pudding to feed to client. Additionally, staff F mixed 1 capful of Gavilax Powder into water and assisted client #1 to drink until it was all finished. During the medication observation staff was not observed to add Thick It to the client's beverage. Review of records on 8/23/22 for client #1 revealed an individual program plan (IPP) dated 1/26/22. Review of physician orders for client #1 on 8/23/22 revealed an order dated 7/7/22 for Thick IT Powder for nectar thickening liquids. Interview with staff F revealed that she did not provide client #1 Thick IT in water with Gavilax Powder. Continue interview with staff F revealed that the Gavilax Powder with water can be administered with or without Thick IT. Interview with the facility nurse on 8/23/22 verified that client #1 is prescribed Thick IT Powder for nectar thickening liquids. Continued interview with the facility nurse revealed that staff should have provided client #1 with Thick IT in his beverages.	W 368		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to furnish prescribed	W 436		

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	34G327	A. BUILDING _____ B. WING _____	08/23/2022

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W 436	Continued From page 2	W 436		

eyeglasses for 1 of 4 sampled clients (#3). The finding is:

Observation in the group home on 8/23/22 at 7:57 AM revealed client #3 to enter the bathroom on the other side of the home and to exit the bathroom dressed for the day carrying empty clothes hangers. Continued observation revealed client #3 to walk and sit in a living room chair and for staff to prompt client to the kitchen for breakfast. Subsequent observation at 8:23 AM revealed staff to offer client #3 a choice of ham, eggs with biscuit or muffins with the client receiving 2 muffins with juice and milk. Further observation at 9:05 AM revealed client #3 to participate in medication administration and to exit the medication room wearing prescribed eyeglasses. Subsequent observation revealed at no time throughout the morning was staff observed to prompt client #2 to wear prescribed eyeglasses.

Review of records on 8/23/22 for client #3 revealed an individual program plan (IPP) dated 1/24/22. Continued review of record for client #3 revealed a vision consult dated 10/21/21 with a diagnosis of esotropia. Further review of the vision consult revealed client #3 to be prescribed glasses for esotropia.

Interview on 8/23/22 with the residential manager (RM) revealed that client #3 typically placed her eyeglasses on the nightstand and that third shift would remove the eyeglasses to place in office area after 8:00 PM eye drops are administered. Interview on 8/23/22 with the qualified intellectual disabilities professional (QIDP) confirmed that client #2 should be wearing prescribed eyeglasses. Continue interview with the QIDP

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W 436	Continued From page 3 revealed that the QIDP was unaware of the prescribed eyeglasses being kept in the office area/medication room and that client #3 can manage and care for prescribed eyeglasses in her possession.	W 436		