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	34G089	A. BUILDING _____ B. WING _____	09/20/2022

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W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: The facility failed to ensure the privacy of 1 of 7 clients residing in Hawksbill (#10) during care of personal needs as evidenced by observations and interviews. The finding is: Morning observations in Hawksbill on 9/20/22 at 6:25 AM revealed 2 staff exiting a bedroom and crossing the hall with client #10 sitting naked in a shower chair. Staff then entered client #10's bedroom and assisted the client with getting dressed for the day. Interview with staff revealed currently all clients in Hawsbill are using one shower located in the bathroom which only has access by walking through the bedrooms of clients. Further interview with staff and the qualified intellectual disabilities professional (QIDP) revealed that client #10 likes to be dressed in his bedroom but staff should ensure the privacy of clients when they are walking through the bedrooms of other residents and in the common areas of the group home.	W 130		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the person-centered plan (PCP) failed to address identified needs for 1 of 8 female clients in Pisgah (#18). The finding is:	W 227		

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 227	Continued From page 1 Observations throughout the 9/19-20/22 survey revealed client #18 to engage in various activities to include "slime" making, identifying currency, listening to music, setting the table, meal preparation and meal participation. Continued observations throughout the survey period revealed client #18's appearance to include noticeable facial hair. Further observations throughout the survey revealed at no time did staff support or educate client #18 on the importance of shaving her face. Review of client #18's record on 9/20/22 revealed a PCP dated 8/30/22. Review of client #18's PCP indicated habilitation goals to include brush hair with verbal prompts, brush teeth with gestural prompts, wash hands with gestural prompts, state the designated number of sight words 100% of the time, show the correct bill needed to purchase common items 100% of the time, and participate in outings or group activities with verbal cues during the day. Continued review of client #18's PCP indicated the prevalence of anxiety and mood disorders has increased significantly in the past two years to include loss of interest in personal appearance such as shaving, showering, putting on make-up and looking nice. Continued review of client #18's record revealed a comprehensive functional assessment (CFA) dated 8/30/22. Review of the CFA indicated client #18 has a history of independence with activities of daily living (ADL) and staff should encourage her to participate in ADLs before doing a task for her and give her plenty of time to complete a task. Interview with the site nurse on 9/20/22 revealed	W 227		

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W 227	Continued From page 2 client #18 has experienced an increase in depression over the last two years due to the deaths of her sister and a close friend. Continued interview with the site nurse revealed client #18 used to initiate shaving her face as part of her hygiene routine, but has recently expressed no desire in completing ADLs and will refuse to allow staff to assist with shaving. Interview with the qualified intellectual disabilities professional (QIDP) on 9/20/22 revealed they are aware of client #18's refusal to shave among other hygiene refusals. Continued interview with the QIDP revealed they are attempting to prioritize how staff support client #18's hygiene needs. Further interview with the QIDP confirmed formal training programs to promote the client's completion of activities such as shaving would benefit client #18 in addition to supporting staff to intervene with the client consistently.	W 227		
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 observation, interviews and record review, the facility failed to ensure a continuous active treatment program consisting of needed interventions were implemented as identified in	W 249		

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W 249	Continued From page 3	W 249		

the person centered plan (PCP) for client #7 in Beaucatcher Home. The finding is:

Observations in the group home on 9/20/22 from 6:40 AM - 8:30 AM revealed client #7 to participate in various activities in the group home. Continued observation at 7:30 AM revealed staff to transition client #7 from the living room to the dining table using a gait belt and holding the client around her shoulder. Further observations revealed staff to sit client #7 in a dining room chair using the gait belt and holding the client around the waist. At no point during the observation did staff obtain and use client #7's bilateral ankle foot orthoses (AFO) shoe inserts and bilateral knee braces.

Review of the record for client #7 on 9/20/22 revealed a PCP dated 6/23/22. Continued review of the record revealed an occupational (OT) evaluation dated 5/16/22 which states that client #7 has the following adaptive equipment to address severe planovalgus and improve lower extremity (LE) alignment: UCB style orthotic shoe inserts, bilateral knee braces, gait belt and wheelchair. Review of the 5/2022 OT evaluation revealed client #7 has walking guidelines to address concerns with patellar dislocation, joint/bone health and gait safety. Review of the physical therapy (PT) evaluation dated 5/18/22 revealed client #7 has knee orthoses to facilitate medical stabilization and patellar tracking control to help reduce or prevent episodes of knees buckling when walking. Review of the medical evaluation dated 2/2/22 revealed client #7 must wear AFOs and knee braces during all waking hours. Staff know to check that the client's "braces are firmly in place and in the correct position before assisting her to ambulate".

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W 249	Continued From page 4 Review of the record did not reveal walking guidelines during the survey to verify adaptive equipment wear and usage. Interview with the qualified intellectual disabilities professional (QIDP) on 9/20/22 revealed walking guidelines for client #7 could not be located during the survey. The QIDP revealed during the interview the material on the knee braces has been giving client #7 an allergic reaction. The QIDP also revealed staff will place the knee braces on client #7 after breakfast and morning shower. Continued interview with the QIDP revealed all of client #7's programs and interventions are current. Further interview with the QIDP verified client #7 must wear her adaptive equipment as prescribed to ensure joint health and gait safety.	W 249		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: The facility failed to assure that medications administered to 1 of 1 sampled clients in Hawksbill (#14) were administered without error as evidenced by observation and interview. The finding is: Morning observation in the group home on 9/20/22 revealed staff administering client #14 his morning medication at 8:06 AM. Further observations revealed staff getting client #14 to help punch medications from 6 different pill packs and included the medications Ducosate Sodium 100 mg, Lexapro 20 mg, Vitamin D3 400 IU,	W 369		

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W 369	Continued From page 5 Metformin ER 500 mg- 2 tablets, Fish Oil 1000 mg and Lisinopril 20 mg in that order. Continued observations revealed the client was observed to leave the medication room after taking his medications with water. Review of client #14's electronic medication administration record, substantiated by interview with the qualified intellectual disabilities professional (QIDP), revealed on 9/1/22 the client started an additional medication for his blood pressure, Hydrochlorothiazide 25 mg tab at 8:00 AM. Subsequent morning observations in Hawksbill on 9/20/22 revealed staff failed to pull this medication from the medication cart to administer it to client #14 as prescribed.	W 369		
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 observation, record review and interview, the facility failed to furnish and maintain in good repair the use of adaptive equipment for client (#5) in Beaucatcher Home. The finding is: Observations during the 9/19/22-9/20/22 survey revealed client #5 to ambulate throughout the group home in a wheelchair. Continued observation on 9/19/22 at 4:15 PM revealed client #5 to show this surveyor a large Band-Aid attached to the right arm rest of her wheelchair. Further observations revealed client #5 to have	W 436		

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W 436	Continued From page 6 the left arm rest covered by neon pink duct tape to hold the arm rest in place. Review of documentation on 9/20/22 revealed a work order to include numerous wheelchair parts for clients. Review of the documentation did not reveal a work order for client #5 for new arm rests. Interview with staff on 9/20/22 revealed they could not determine how long client #5's arm rest has been torn, however management has ordered wheelchair parts for client #5 to include new arm rests. Continued interview with staff revealed the Band-Aid was put in place to ensure that the torn area would not scratch client #5's skin until the arm rests could be replaced. Interview with the qualified intellectual disabilities professional (QIDP) revealed a work order specific to client #5's new arm rests could not be located during the survey. Continued interview with the QIDP verified that all clients should have adaptive equipment repaired and in good working order.	W 436		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure evacuation drills were held at least quarterly for each shift of personnel. The finding is: Review of fire drill records at Pisgah Home on 9/19/22 from 8/2021 to 9/2022 revealed four fire drills were conducted during the first and second	W 440		

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W 440	Continued From page 7 quarters of 2022. Further review revealed 3rd shift drills to be missing from the first and second quarters of 2022. Interview with the qualified intellectual disabilities professional on 9/20/22 confirmed fire drills should have been conducted quarterly for each shift of personnel.	W 440		