STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G248	A. BUILDING _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLINGSWOOD GROUP HOME	214 HOLLINGSWOOD DRIVE STATESVILLE, NC 28677

(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 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure clients have a right to personal privacy for 1 of 3 sampled clients (#5) during client care. The finding is: Observations in the group home on 10/5/22 at 6:45 AM revealed a monitor to be visible and sitting on the kitchen countertop. Continued observation at 8:08 AM revealed the monitor to show client #5 to receive personal care in her room. Observations revealed staff to change client #5's adult brief in which her bottom was exposed and could be seen from the monitor on the kitchen counter. Observation at 8:10 AM revealed the home manager (HM) to turn the monitor showing client #5's room around in the opposite position on the kitchen counter. Review of the record for client #5 on 10/5/22 revealed a person centered plan (PCP) dated 1/28/22. Review of the PCP revealed client #5 has a 1:1 staff 24 hours a day. Review of the occupational therapy assessment dated 1/26/21 listed the following adaptive equipment for client #5: shower chair, shoulder harness, seatbelt, scoop dish, scoop bowl, dycem mat, nosey cup, shirt protector, built up spoon, gait belt, wheelchair and anti-tippers. Review of the PCP and OT evaluation did not include a monitor. Review of the consents for client #5 did not include a monitor to view the client's room on 3rd shift.	W 129		

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

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W 129	Continued From page 1 Interview with the home manager (HM) on 10/5/22 revealed she didn't realize that having the monitor on during client care would be a privacy concern. Continued interview with the HM revealed she turned the monitor in the opposite position to respect the privacy of client #5 and because she didn't know how to turn it off. Interview with the qualified intellectual disabilities professional (QIDP) and program manager (PM) revealed that staff should not have the monitor turned on during the day and when client #5 is not in her room. Continued interview with the PM revealed client #5 has a 1:1 staff at all times and a monitor may not be needed to monitor the client's room. Interview with the PM also revealed the monitor is used when client #5 is sleeping. Further interview with the QIDP and PM revealed all clients should be offered the rights to personal privacy during client care in their rooms.	W 129		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the interdisciplinary team (IDT) completed preliminary accurate assessments within 30 days after admission affecting 1 newly admitted client (#2). The finding is: Review of the record on 10/8/22 of client #2's person centered plan (PCP) dated 5/19/22 revealed the client was admitted to the facility on	W 210		

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W 210	Continued From page 2 4/19/22. Further review of client #2's initial interdisciplinary evaluations revealed a psychological evaluation dated 1/20/22. Continued review of the record did not reveal any other assessments completed as required. Interview on 10/8/22 with the qualified intellectual disabilities professional (QIDP) and program manager (PM) verified no other assessments or evaluations were completed for client #2 within 30 days after admission as required.	W 210		
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 the person centered plan (PCP) for 1 of 3 sampled clients (#5). The finding is: Afternoon observations in the group home on 10/4/22 at 5:00 PM revealed staff to transition client #5 to the table for the dinner meal. The dinner meal consisted of the following: salmon stir fry, brown rice, fruit jello salad, apple	W 249		

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W 249	Continued From page 3	W 249		

cinnamon bread pudding, milk, water and sugar free beverage. Observation at 5:10 PM revealed staff to feed client #5 the dinner meal at a ground consistency with the following utensils: weighted spoon, high sided divided dish, shirt protector, dycem mat and nosey cup. At no point during the observation did staff attempt to allow client #5 to feed herself with partial assistance throughout the dinner meal.

Morning observations in the group home on 10/5/22 at 7:45 AM revealed staff to transition client #5 to the kitchen to prepare her food for the breakfast meal. The breakfast meal consisted of 2 boiled eggs, whole wheat bagel, cream cheese, orange juice and milk. Observation at 7:50 AM revealed staff to feed client #5 the breakfast meal at a ground consistency with the following utensils: weighted spoon, high sided divided dish, dycem mat, shirt protector and nosey cup. Observations did not reveal staff to prompt client #5 to attempt to feed herself with partial assistance during the breakfast meal.

Review of the record for client #5 on 10/5/22 revealed a person centered plan (PCP) dated 1/28/22. Review of the PCP revealed the following program goals: chop food in food processor, assist staff with condiments, wash hands, toileting schedule, provide opportunities to walk, attend to a task, tolerate interaction with presented items and attempt to feed herself with partial assistance. Review of the occupational therapy (OT) assessment dated 1/26/21 revealed client #5 uses the following adaptive equipment during mealtimes: scoop dish, scoop bowl, dycem mat, nosey cup, shirt protector and built up spoon.

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W 249	Continued From page 4 Interview with the program manager (PM) and qualified intellectual disabilities professional (QIDP) on 10/5/22 revealed staff should have prompted client #5 to attempt to feed herself even if she refused to do so. Continued interview with the PM and QIDP verified that all of client #5's program goals are current. Further interview with the QIDP and PM verified that staff should follow all program goals for client #5 as written.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: The specially constituted committee, designated as the human rights committee (HRC) failed to assure written consent was obtained from 6 of 6 clients' (#1, #2, #3, #4, #5, #6) legal guardians regarding the use of a gated fence and laundry room keypad as evidenced by observations, interview and record verification. The finding is: Observations in the group home during the 10/4-10/5/22 survey revealed the group home is surrounded by a white gated fence with a lock on the gate. Continued observation also revealed a keypad on the laundry room door, leisure closet, food pantry and an intrusive door alarm on client #6's bedroom door. Review of the record for client #6 revealed a PCP dated 4/6/22. Continued review revealed a behavior support plan (BSP) for client #6 dated 6/8/22 which indicates the following target behaviors: self-injurious behaviors (SIBs), head	W 263		

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W 263	Continued From page 5 banging, yells, screams, bites, drops down to knees, taking things that don't belong to her, leaving a supervised area and transport guidelines including a 5-point harness (travel harness). Further review of the BSP revealed client #6 has the following interventions in place to increase the level of safety and security relative to the client's target behaviors: exit door alarms, secured laundry area, in-line of sight level of supervision and front porch secured with a gate. Additional review of client #6's record revealed no consents were obtained for the gated fence. Subsequent review of client documentation did not reveal client #1, #2, #3, #4 and #5's consents were obtained from the clients' guardians to assure informed consent was provided for the gated fence and keypad on the laundry room door. Interview with the qualified intellectual disabilities professional (QIDP) and program manager (PM) revealed the gated fence and keypad on the laundry room is a part of client #6's behavior programming due to targeted behaviors. Continued interview with the QIDP and PM verified that the restricted areas effects all clients (#1, #2, #3, #4, #5, #6) and consents should be signed annually by the legal guardian.	W 263		
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.	W 436		

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W 436	Continued From page 6 This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure that adaptive equipment was furnished or used as prescribed for 1 of 3 sampled clients (#5). The finding is: Observations in the group home on 10/4/22 from 5:00 PM to 5:45 PM revealed client #5 to participate in various activities with staff assistance. Continued observation at 5:00 PM revealed client #5 to enter the group home from an outing without a helmet. Further observation from 5:15 PM - 5:45 PM revealed staff to assist client #5 in washing her hands, to blend her food in the kitchen, participate in the dinner meal and participate in a leisure activity. At no point during the observation period did staff retrieve and put on client #5's helmet as prescribed. Review of the record for client #5 on 10/5/22 revealed a person centered plan (PCP) dated 1/28/22 and occupational therapy (OT) evaluation dated 1/26/21 which indicates the client has the following adaptive equipment: helmet due to seizure activity, waterproof helmet during showers, shower chair (with shoulder harness, seat belt and footrest), adult briefs, scoop dish, scoop bowl, dycem mat, nosey cup, shirt protector, built up spoon, wheelchair, floor mat, gait belt and anti-tippers. Continued review of the OT evaluation dated 1/26/21 revealed client #5 must wear her helmet at all times due to seizure activity. Review of the OT evaluation did not reveal the helmet for client #5 was discontinued or to be used on an as needed (PRN) basis. Interview with the facility nurse on 10/5/22 revealed client #5 can wear her helmet as needed (PRN) and it is no longer required to be	W 436		

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W 436	Continued From page 7 worn throughout the day. Interview with the qualified intellectual disabilities professional (QIDP) and program manager (PM) on 10/5/22 revealed client #5 should wear her helmet as prescribed unless it has been discontinued by a medical professional.	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 quarterly fire evacuation drills were conducted for each shift of personnel for the review year. The finding is: Review of the facility fire drill reports on 10/4/22 for the 12-month review year from 10/2021 - 9/2022 revealed only 8 out of 12 fire drills were conducted. Continued review of fire drill reports revealed fire evacuation drills were completed on the following dates and shifts: 9/18/22 (3rd), 8/30/22 (2nd), 7/10/22 (1st), 6/22/22 (3rd), 5/27/22 (2nd), 3/22/22 (3rd), 2/17/22 (2nd), and 1/31/22 (1st). Interview with the home manager (HM) on 10/5/22 revealed that fire drills for each shift of personnel could not be located during the survey. Continued interview with the qualified intellectual disabilities professional (QIDP) and program manager (PM) verified that each facility should have conducted fire evacuation drills for each shift of personnel each quarter of the review year.	W 440		