DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G062	A. BUILDING ______ B. WING ______	C 12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOXWOOD ACRES	**3464 US HWY 601 SOUTH MOCKSVILLE, NC 27028**

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W 000	INITIAL COMMENTS #NC00195550 and #NC00195493	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: The facility failed to: implement written policies and procedures that prohibit mistreatment, neglect and abuse of a client (W149); and ensure all alleged violations are thoroughly investigated (W154). The cumulative effect of these systemic practices resulted in the facility's failures to provide statutorily mandated services of client protections to its clients.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 1 deceased client (dc #1) was not subject to neglect. The finding is: Review on 12/15/22 of the facility's internal death review dated 11/23/22 - 11/30/22 revealed the assigned staff reported to duty at the approximate time of 3:00pm. The staff reports dc#1 had a typical evening, with dc #1 eating the dinner meal and participating in medication administration. The staff reported that about 10:10pm, while sitting in the living room, dc #1 was heard getting out of bed and ambulating to the bathroom. After	W 149		

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 149	Continued From page 1 a few minutes, she noticed that dc #1 was quiet in the bathroom, so staff "yelled out" to dc #1 that she needed to go back to bed. Dc#1 did not answer, so the staff got up and walked towards the bathroom and saw dc #1 coming out of the kitchen. The staff noted that dc #1 had a mouth full of cupcake and appeared to be choking and was trying to get the cupcake from her mouth. The staff immediately ran to dc #1 and attempted to help get the cupcake from her mouth. Dc #1 continued to show signs of choking, so the staff called 911 while continuing to work on dc #1 with finger sweeps and administering abdominal thrusts until EMS arrived and took over. The staff stated dc#1 was a very smart individual, but also "sneaky" when trying to find food. Review of records on 12/15/22 revealed person-centered plan (PCP) dated 2/8/22. The PCP revealed dc #1 used adaptive equipment during mealtime consisting of high sided divided dish, straw, and a maroon spoon, and was also supported with mealtime guidelines. Staff were to monitor dc #1 while eating to ensure that she did not eat too quickly. Records indicate dc #1's diet was "ordered by her physician and should be followed (1/4" consistency)." Continued review of dc #1's record revealed a behavior support plan (BSP) dated 6/21/22. Review of the BSP revealed dc #1's target behaviors to include inappropriate toileting events, obsessive-compulsive changing behavior, self-injurious behavior, property destruction, invading privacy, inappropriate toilet seeking, and unsafe actions (climbing on shelves and storage containers from which she may fall). Further review of dc #1's record revealed	W 149		

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behavior data sheets dated from 3/1/22 - 11/22/22. Review of the data sheets revealed a history of food seeking behaviors as documented by staff. Continued review of the data sheets indicated a total of 90 incidents from 3/1/22 - 11/22/22 in which dc #1 attempted or successfully engaged in food seeking behavior.

Additional review of records revealed a choking risk assessment dated 6/2/22 that indicates dc#1 has poor control of food/liquid in mouth, eats at a rapid pace, stuffing food in mouth, previous choking incident and currently receives a 1/4" consistency diet.

Review on 12/15/22 of dc #1's annual nursing evaluation dated 2/4/22 revealed recommendations to monitor for episodes of choking and/or aspiration; as well as monitor for and prevent falls.

Review of records revealed an occupational therapy assessment (OT) dated 11/23/21 that revealed recommendations for a high sided divided dish and use of a straw (as needed) as adaptive equipment except when at the day program. Dc #1 required the following mealtime guidelines: staff stands or sits near her, if she begins eating fast, give verbal prompt to slow down. If she takes bites too large give verbal prompts to take smaller bites. If she still eats fast or takes bites too large, give her a benign physical prompt. If that is unsuccessful, pull the plate away and tell her to slow down. Staff reports that dc #1 requires verbal prompts multiple times at each meal and requires benign physical prompts on a regular basis (at least daily) several times each meal, as benign physical prompts are not as successful at this

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time. Client requires hand-over-hand assistance with the use of a knife.

Review of records revealed a physical therapy evaluation (PT) dated 1/3/20. Review of the PT evaluation revealed the following history: dc #1 has ambulated standby/contact guard assistance for several years. Dc #1 looks down but is safe in familiar area going functional household distances with standby to contact guard assistance and RW while wearing gait belt/vest. Dc #1 needs contact guard assistance in unfamiliar areas and un-level surfaces or crowded areas.

Review on 12/15/22 of the facility's NC/MH/IDD/SU Services Manual updated 3/30/22 revealed policy 102.05 Abuse, Neglect and Exploitation which defines neglect as the failure to provide services and supports necessary to protect a person from serious physical and/or psychological harm. Further review of policy 102.05 revealed unintentional neglect with harm is defined as an act of carelessness, omission, accident or distraction that results in a substantiated allegation of neglect whereby there was harm to the person or significant risk for harm. Continued review of the facility's policy revealed the facility has zero tolerance for intentional neglect or unintentional neglect that results in harm or significant risk of harm. Actions taken toward staff involved in incidents that occur due to an act of carelessness, omission, accident or distraction that results in no harm or risk to a person receiving services will be determined by management and may include disciplinary action up to and including termination.

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Interview with the facility administrator (FA) and program manager (PM) on 12/15/22 confirmed dc#1 had prescribed plans, programs, and medical orders that staff provide stand by and/or handheld assistance, within eyesight and video monitoring when out of eyesight to ensure resident safety that was not provided. The FA and PM agree that staff should have followed the prescribed plans to go to dc #1 as soon as staff heard her exit her bedroom to go to the bathroom. The facility failed to monitor dc #1 as prescribed by the guidelines in her PCP, and the team failed to develop interventions to address food seeking behaviors.

W 154

STAFF TREATMENT OF CLIENTS
CFR(s): 483.420(d)(3)

The facility must have evidence that all alleged violations are thoroughly investigated.
This STANDARD is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure an incident of neglect was thoroughly investigated. This affected 1 deceased client (dc #1). The finding is:

Review on 12/15/22 of the facility's internal death review dated 11/23/22 - 11/30/22 revealed the assigned staff reported to duty at the approximate time of 3:00pm. The staff reports dc#1 had a typical evening, with dc #1 eating the dinner meal and participating in medication administration. The staff reported that about 10:10pm, while sitting in the living room, dc #1 was heard getting out of bed and ambulating to the bathroom. After a few minutes, she noticed that dc #1 was quiet in the bathroom, so staff "yelled out" to dc #1 that she needed to go back to bed. Dc#1 did not answer, so the staff got up and walked towards

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the bathroom and saw dc #1 coming out of the kitchen. The staff noted that dc #1 had a mouth full of cupcake and appeared to be choking and was trying to get the cupcake from her mouth. The staff immediately ran to dc #1 and attempted to help get the cupcake from her mouth. Dc #1 continued to show signs of choking, so the staff called 911 while continuing to work on dc #1 with finger sweeps and administering abdominal thrusts until EMS arrived and took over. The staff stated dc#1 was a very smart individual, but also "sneaky" when trying to find food. The conclusion of the level ITR did not address that staff failed to monitor dc #1 at all times, supervising dc #1 to ensure she shuts the bathroom door for privacy, as well as failed to provide dc #1 stand by assist/contact guard assistance when the client is ambulating to support her with balance and avoid falls.

Review on 12/15/22 of the facility's NC/MH/IDD/SU Services Manual updated 3/30/22 revealed policy 102.05 Abuse, Neglect and Exploitation which defines neglect as the failure to provide services and supports necessary to protect a person from serious physical and/or psychological harm. Further review of policy 102.05 revealed unintentional neglect with harm is defined as an act of carelessness, omission, accident or distraction that results in a substantiated allegation of neglect whereby there was harm to the person or significant risk for harm. Continued review of the facility's policy revealed the facility has zero tolerance for intentional neglect or unintentional neglect that results in harm or significant risk of harm. Actions taken toward staff involved in incidents that occur due to an act of carelessness, omission, accident or distraction

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W 154	Continued From page 6 that results in no harm or risk to a person receiving services will be determined by management and may include disciplinary action up to and including termination. Interview on 12/15/22 with the facility administrator (FA) and program manager (PM) confirmed dc #1's PCP is current and staff are trained on PCPs annually. The FA and PM confirmed an investigation was completed with their internal review of the death conducted 11/23/22 - 11/30/22, but did not address that staff failed to monitor dc #1 at all times, supervising dc #1 to ensure she shuts the bathroom door for privacy, as well as failed to provide dc #1 stand by assist/contact guard assistance when the client is ambulating to support her with balance and avoid falls.	W 154		
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: The team failed to: ensure specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment were developed in the individual program plan (IPP) (W227); and ensure that each client received a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training and treatment directed towards the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as	W 195		

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W 195	Continued From page 7 possible (W249). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated active treatment services to the clients.	W 195		
W 196	ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the team failed to assure that a continuous aggressive active treatment program was implemented for one deceased client (dc #1) which provided consistent implementation of the person centered plan (PCP) and interventions in the facility, which promoted client function with as much independence as possible and prevented regression of acquired skills. The findings are: A. Cross reference W227. The facility failed to ensure the PCP included guidelines to address identified needs relative to behavior management for one deceased client (dc #1).	W 196		

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W 196	Continued From page 8 B. Cross reference W249. The facility failed to ensure one deceased client (dc #1) received a continuous active treatment program consisting of needed interventions and services as identified in the PCP.	W 196		
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 record review and interviews, the facility failed to ensure the person-centered plan (PCP) for 1 deceased client (dc #1) included objectives to address behavior management techniques. The finding is: Review of dc #1's record on 12/15/22 revealed a PCP dated 2/8/22. Review of the PCP revealed client's formal programs to include closing the bathroom door with prompts, wash hands with 95% independence, learn to shop to make a purchase at a mock self-checkout, attend to the task of sorting shapes for 10 minutes, and rest her utensils between bites with 95% accuracy. Continued review of dc #1's record revealed a behavior support plan (BSP) dated 6/21/22. Review of the BSP revealed dc #1's target behaviors to include inappropriate toileting events, obsessive-compulsive changing behavior, self-injurious behavior, property destruction, invading privacy, inappropriate toilet seeking, and unsafe actions (climbing on shelves and storage containers from which she may fall).	W 227		

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W 227	Continued From page 9 Further review of dc #1's record revealed behavior data sheets dated from 3/1/22 - 11/22/22. Review of the data sheets revealed a history of food seeking behaviors as documented by staff. Continued review of the data sheets indicated a total of 90 incidents from 3/1/22 - 11/22/22 in which dc #1 attempted or successfully engaged in food seeking behavior. Review of facility records on 12/15/22 revealed an Internal Team Review (ITR) - Level III Incident dated from 11/23/22 - 11/30/22. Review of the ITR indicated dc #1's cause of death was accidental death by choking. Continued review of the ITR revealed, per staff interview, "the client was a very smart individual, but also sneaky when trying to find food." Further review of the ITR revealed, per clinical team interviews which included the qualified intellectual disabilities professional (QIDP), residential team leader (RTL), and program manager (PM), that historically the client did not seek food. Interview with the facility administrator and PM on 12/15/22 confirmed dc #1's record is current. Continued interview revealed the clinical team was in the process of coordinating a plan to address dc #1's food seeking behaviors with the guardian, however, there was a delay with the paperwork. Further interview confirmed the clinical team neglected to formally addressed dc #1's food seeking behaviors in response to staff reports and documented evidence of the behaviors from 3/1/22 - 11/22/22.	W 227		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has	W 249		

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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 record reviews and interviews, the facility failed to ensure 1 deceased client (dc #1) received a continuous active treatment program consisting of needed interventions as identified in the person-centered plan (PCP) relative to supervision. The finding is:

Review of dc #1's record on 12/15/22 revealed a PCP dated 2/8/22. Review of the PCP revealed dc #1 had limited awareness of danger and should be monitored at all times, including a non-recording video monitor in her room at nighttime. Continued review of the PCP revealed staff should supervise dc #1 to ensure she shuts the bathroom and bedroom door for privacy, as well as provide stand by assist/contact guard assistance when the client is ambulating to support her with balance and avoid falls.

Review of facility records on 12/15/22 revealed an Internal Team Review (ITR) - Level III Incident dated from 11/23/22 - 11/30/22. Review of the ITR revealed on 11/22/22 staff reported that at about 10:10 PM they were in the living room and heard dc #1 get out of bed and ambulate to the bathroom. Staff reported that after a few minutes, they noticed that dc #1 was quiet in the bathroom, so they verbalized to the client she needed to go

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W 249	Continued From page 11 back to bed. Dc #1 did not answer so the staff got up and walked towards the bathroom and saw the client coming out of the kitchen with a mouth full of food and appeared to be choking. Interview with the facility administrator and program on 12/15/22 confirmed dc #1's PCP is current and staff are trained on PCPs annually. Continued interview revealed the client's supervision guidelines have been in place for years due to her history of falls and unsafe behaviors. Further interview confirmed staff should have provided immediate supervision to the client, as opposed to remaining in the living room, when the client exited her bedroom as outlined in the PCP.	W 249		