STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G115	A. BUILDING _____ B. WING _____	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DARTMOUTH ROAD GROUP HOME	210 DARTMOUTH ROAD RALEIGH, NC 27606

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W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 4 audit clients (#4) had the right to be treated with dignity regarding the use of incontinence padding. The finding is: During observations in the home throughout the survey on 1/17 - 1/18/23, client #4 was seated in a wheelchair with an incontinence pad positioned on the seat underneath her. The pad was visible to anyone in the area. Interview on 1/18/23 with Staff B revealed the incontinence pad was placed in the seat of client #4's wheelchair just in case she has a toileting accident. The staff noted if her seat cushion gets wet it will be "stinky". Review on 1/18/23 of client #4's Community/Home Life Assessment (CHLA) dated 12/12/22 revealed the client requires physical assistance with her toileting needs and can indicate the need to go with a verbal cue. Additional review of the client's Rights Acknowledgement form (no date) revealed the client has the right to "a humane treatment environment in which personal dignity and self-esteem are promoted." Interview on 1/18/23 with the Area Supervisor	W 125		

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

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W 125	Continued From page 1 (AS) confirmed staff should not be placing an incontinence pad on the seat of client #4's wheelchair to address her toileting needs.	W 125		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure client #6's Behavior Support Plan was sufficiently monitored. This affected 1 of 4 audit clients. The finding is: Review on 1/17/23 of client #6's BSP dated 8/8/22 revealed three separate objectives to exhibit 0 episodes of physical aggression, inappropriate verbalizations and self-injurious behaviors (SIB) per month for 12 consecutive months. Additional review of behavior progress notes for September '22 - December '22 revealed information regarding the client's physical aggression and inappropriate verbalizations; however, no information or progress notes regarding the client's self-injurious behaviors was available. Interview on 1/18/23 with the Area Supervisor (AS) and the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6's BSP was current and ongoing; however, no explanation for the lack of review of the SIB objective was provided.	W 159		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe	W 240		

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W 240	Continued From page 2 relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #1's Individual Program Plan (IPP) included specific information to support her use of a protective helmet. The finding is: During observations in the home on 1/17/23 from 10:47am - 1:00pm and 3:30pm - 6:00pm, client #1 ambulated independently throughout the home while performing various tasks and activities. The client did not wear a protective helmet. Upon arrival to the home on 1/18/23 at 6:10am, client #1 was not wearing a protective helmet. At 6:32am, client #1 was noted wearing a protective helmet for approximately 1 minute before she independently removed it. During additional observations in the home on 1/18/23 from 6:33am - 8:01am, the client ambulated independently throughout the home and completed various tasks without wearing a protective helmet. Interview on 1/18/23 with Staff A revealed client #1 does not have to wear her helmet everyday but does wear it "when she's moving". Additional interview indicated the client wears the helmet due to having seizures. Review on 1/18/23 of client #1's IPP dated 3/25/22 revealed the client wears a protective helmet to reduce head trauma. The IPP indicated the helmet is worn daily to protect the client's head in case of a seizure. Additional review of the IPP; however, did not provided specific information regarding when and under what circumstances the client should be wearing the	W 240		

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W 240	Continued From page 3 helmet. Interview on 1/18/23 with the Area Supervisor (AS) confirmed client #1 wears her protective helmet due to seizures. The AS noted the client needs to be reminded to wear her helmet. Additional interview indicated the helmet is required when the client is up and walking but can be removed when she is seated.	W 240		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #4 was provided consistent opportunities for choice and self-management in her home environment. This affected 1 of 4 audit clients. The finding is: During observations in the home throughout the survey on 1/17 - 1/18/23, various staff periodically locked client #4's wheelchair as she sat in the living room looking at a word search book. During observations in the home on 1/18/23 at 6:34am, client used her feet to move her wheelchair from the living room to the kitchen counter without assistance. Review on 1/17/23 of client #4's Individual Program Plan (IPP) dated 12/9/22 revealed, "[Client #4] is in a wheelchair that she can propel independently. [Client #4] will continue to propel herself with assistance as needed." Additional review of client #4's guidelines for wheelchair use dated 4/4/22 noted, "[Client #4] propels her	W 247		

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W 247	Continued From page 4 wheelchair primarily using both feet within the group home." Interview on 1/18/23 with the Area Supervisor (AS) confirmed client #4 can move her own wheelchair and her wheelchair should not be locked in the home.	W 247		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure client #6's Individual Program Plan (IPP) was revised after she had successfully completed objectives. This affected 1 of 4 audit clients. The finding is: Review on 1/17/23 of client #6's Behavior Support Plan (BSP) dated 8/8/22 revealed objectives to exhibit 0 episodes of Physical Aggression per month for 12 consecutive months and to exhibit 0 episodes of Inappropriate verbalizations per month for 12 consecutive months. Additional review of behavior progress notes for November '21 - December '22 revealed no behaviors were exhibited for both objectives 13 months. Interview on 1/18/23 with the Area Supervisor (AS) and the Qualified Intellectual Disabilities Professional (QIDP) indicated client #6 does not have many behaviors; however, the interdisciplinary team had not reviewed or revised	W 255		

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W 255	Continued From page 5 her IPP to address the completion of her behavior objectives.	W 255		
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: Based on record reviews and interviews, the facility failed to ensure written informed consent was obtained from guardians for the Behavior Support Plans (BSP) for 2 of 4 audit clients (#4 and #6). The findings are: A. Review on 1/17/23 of client #4's BSP dated 12/6/22 revealed three objectives to exhibit 1 or fewer episodes of inappropriate verbalizations, noncompliance and crying per month for 12 consecutive months. Additional review of the BSP identified the use of Clonazepam and Lamotrigine to address the behaviors. Further review of the record did not include written informed consent from the client's guardian. Interview on 1/18/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no written informed consent from client #4's guardian was available for review. B. Review on 1/17/23 of client #6's BSP dated 12/6/22 revealed three objectives to exhibit 0 or episodes of inappropriate verbalizations, physical aggression and self-injurious per month for 12 consecutive months. Additional review of the BSP identified the use of Depakote and Ativan to address the behaviors. Further review of the	W 263		

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W 263	Continued From page 6 record did not include written informed consent from the client's guardian. Interview on 1/18/23 with the QIDP confirmed no written informed consent from client #6's guardian was available for review.	W 263		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all food was served at an appropriate temperature. The finding is: During morning observations in the home on 1/18/23 at 7:08am, waffles were removed from the oven, placed in a bowl and covered with aluminum foil. At 7:14am, scrambled eggs were finished cooking and were removed from the burner but left in the pan. At 7:25am, Staff A began to process a portion of the eggs and waffles in a small chopper to a pureed consistency. Water from the faucet was added to the food items while in the chopper. At 7:45am, clients began serving themselves all food items (whole and pureed). Food items were not reheated and the temperature of the food was not taken prior to serving. Interview on 1/18/23 with Staff A revealed they have been trained to follow guidelines for serving hot and cold foods noted in the menu book. Review on 1/18/23 of the menu book located in the kitchen of the home revealed, "All hot food and beverages must be held to 140 or higher. All	W 473		

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W 473	Continued From page 7 cold food and liquids must be held at 40 or lower. Once food items taken from heat keeping and/or cold keeping devices they must be served to clients within 15 minutes." Interview on 1/18/23 with the Area Supervisor (AS) confined staff should be following the food temperature guidelines noted in the menu book.	W 473		