STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	34G168		07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBAY GROUP HOME	1907 NORTHBAY DRIVE BROWN SUMMIT, NC 27214

(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 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, review of record and interviews, the habilitation support plan (HSP) failed to have a training objective to meet the identified client needs for 1 of 3 sampled clients (#1) relative to closing bathroom door for privacy. The finding is: Observations in the group home on 7/19/22 at 7:46 AM revealed client #1 to leave the living room and enter the bathroom. Continued observation revealed client #1 to turn on bathroom light and to sit on the toilet. Further observation at 7:49 AM revealed client #1 to remain on the toilet with the bathroom door open. Subsequent observation revealed client #1 to turn off the light and exit the bathroom. Additional observation at 7:50 AM revealed staff to prompt client #1 to return to the bathroom to wash hands. At no time during the observation was staff observed to close the bathroom door or prompt client to close the door. Review of records for client #1 on 7/19/22 revealed an HSP dated 8/24/21 with training objectives to wash hands after using bathroom, shopping, to bathe upper body and medication administration. Continued review of record revealed an adaptive behavior inventory dated 8/14/20 that revealed client #1 closes the bathroom door before using the toilet with total independence.	W 227	The facility will ensure the development of training objectives to meet privacy and/or other priority needs for clients. For Client # 1, the QIDP will schedule a team meeting to address privacy during care of personal needs. The ABI and Habilitation Service Plan will be reviewed and updated to address necessary training and support to this client on privacy. For Client #1, the QIDP will schedule in-service training for all staff assigned to the home. Staff will be instructed to implement the Habilitation Service Plan and always ensure privacy for Client #1 and for all other individuals during toileting and other personal care needs. The program manager will monitor twice a week in the home to ensure privacy for all clients. The QIDP will monitor weekly in the home to ensure privacy for all clients. The QIDP will review the IPPS monthly and address priority needs and training.	

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

Lorianne Jarrell, Clinical Supervisor — 8/3/2022

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 Interview on 7/19/22 with staff B revealed that client #1 does not close the door upon entering the bathroom without staff prompting the client to close the door. Continued interview with staff B revealed client #1 would benefit from a training objective to close the bathroom door before using the toilet. Interview on 7/19/22 with the regional manager (RM) verified the 8/24/21 HSP for client #1 is current. Continued interview with the RM revealed client #1 should close the bathroom door for privacy.	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 observations, interview and record review, the facility failed to assure a continuous active treatment program was implemented for 2 of 3 sampled clients (#1 and #2) relative to medication administration. The findings are: A. The facility failed to implement the medication administration program for client #1. For example:	W 249	The facility will ensure that all clients are afforded training when appropriate to participate in the administration of their medications and have opportunities to participate in learning/knowledge of their medications to include name, purpose and side effects, etc. For clients #1 and #2 QIDP will schedule a team meeting to address medication administration. The Habilitation Service Plan will be reviewed and updated to address necessary training and support to these clients on medication administration.	

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W 249	Continued From page 2 Observation in the group home on 7/19/22 at 7:06 AM revealed client #1 to pour water in a cup. Continued observation revealed staff E to remove medication packet from medication closet and prepare medications for administering by pouring them into the medication cup. Continued observation revealed staff E to pour medications into the mouth of client #1 and the client to drink water with Gavilax Powder. Client #1 was not observed to receive any training during medication pass or to participate beyond taking medications from staff E and pouring water. Review of records for client #1 revealed a habilitation support plan (HSP) dated 8/24/21. Review of the HSP revealed client #1 has a goal to participate in medication administration with a behavior chain to locate medication bin, to pick up medication bin and to set medication bin on counter. Interview on 7/19/22 with the regional manager (RM) verified the 8/24/21 HSP for client #1 is current. Continued interview with the RM verified that staff should have implemented the medication administration goal for client #1. B. The facility failed to implement the medication administration program for client #2. For example: Observation in the group home 7/19/2/22 at 7:15 AM revealed staff E to remove medication packet from medication closet and sign medication book. Continued observation revealed staff E to pour medications into medication cup, pour water into cup, and pour medications into the mouth of client #2. Further observation at 7:25 AM revealed client #2 to drink water and exit the	W 249	For clients #1 and #2 , the QIDP will schedule training for all staff assigned to the home. All the clients Habilitation Service Plans will be reviewed with staff relative to client training and participation in medication administration. Staff will be instructed to allow clients to pour water and prepare medication from pill pack to medication cup in an effort to promote client independence in medication administration. Per Habilitation Service Plan, as applicable staff will be instructed to prompt clients to respond to staff questions concerning the name of medications, purpose and side effects, per their respective Habilitation Service Plan. The QIDP and program manager will monitor on a weekly basis during the medication administration routine to ensure client training to participate in self-administration of their medications.	

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W 249	Continued From page 3 medication area. Client #2 was not observed to receive any training during medication pass or to participate beyond taking medications from staff E. Review of records for client #2 revealed an HSP dated 7/11/22. Review of the HSP revealed client #2 has a goal implemented 8/8/21 to participate in medication administration. Continue review of medication administration goal revealed the client to perform the following with prompts: Pick up medication bin, use sanitizer to wash hands, pour water into glass/cup, take medications and throw medication cup into trash can. Interview on 7/19/22 with the regional manager (RM) verified the 7/11/22 HSP for client #2 is current. Continued interview with the RM verified that staff should have implemented the medication administration goal for client #2.	W 249		
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 2 clients (#2) observed during medication administration. The finding is: Observation in the group home on 7/19/22 at 7:15 AM revealed client #2 to enter the medication room for morning medications. Observation of the medication pass for client #2 revealed staff E	W 368	The facility will ensure for all clients that medications are administered as outlined in the physician's orders,with no exceptions. For client #2 and all other clients in the home, the QIDP will schedule in-service training for all staff assigned to the home. The RN will be present to assist the QP in the training. The RN and QP will address any concerns with staff on the administration of all medications.	

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W 368	Continued From page 4 to remove pill packets from medication closet, pour water into a cup and pour all medications from pill packet into medication cup. Further observation revealed staff E to pour medications into client #2's mouth and the client to swallow medications drinking water. During observation, staff was not observed to administer Miralax to client #2. Review of physician orders for client #2 on 7/19/22 revealed an order dated 3/1/22 for Polyethylene Glycol 3350 Miralax powder 255GM small. Review of the Polyethylene Glycol 3350 order revealed: Dissolve 1 capsule (17 grams) in 4oz to 8 oz in juice or water and drink by mouth every morning and evening. Interview with the facility nurse on 7/19/22 verified that client #2 is prescribed Polyethylene Glycol 3350 Miralax powder 255GM small. Continued interview with the facility nurse revealed she was not notified that client #2 did not receive morning dosage of Miralax. Further interview with the facility nurse revealed that client #2 has constipation concerns and should have received prescribed medication.	W 368	The program manager will monitor the home twice a week during the medication administration routine to ensure compliance to physician's orders. The QIDP will monitor once a week in the home to ensure continued compliance to physician's orders.	
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the system for drug administration	W 371	The facility will ensure that all staff will provide client training during medication administration relative to participation in administering medication; knowledge of name, purpose,side effects of medications.	

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W 371	Continued From page 5 failed to assure 2 of 2 clients (#1, and #2) observed during medication administration were provided the opportunity to participate in medication self-administration or provided teaching related to name, purpose and side effects of medication administered. The findings are: A. The system for drug administration failed to assure client #1 was provided the opportunity to participate in medication self-administration. For example: Observation in the group home 7/19/22 at 7:06 AM revealed client #1 to pour water in a cup. Continued observation revealed staff E to remove medication packet from medication closet and prepare medications for administering by pouring them into the medication cup. Continued observation revealed staff E to pour medications into the mouth of client #1 and the client to drink water with Gavilax Powder. Client #1 was not observed to receive any training during medication pass or to participate beyond taking medications from staff E and pouring water. Review of records for client #1 revealed a habilitation support plan (HSP) dated 8/24/21. Review of the HSP revealed client #1 has a goal to participate in medication administration with a behavior chain to locate medication bin, to pick up medication bin and to set medication bin on counter. Interview with staff E on 7/19/22 revealed that staff E would typically educate verbal clients. Continued interview with staff E revealed that non-verbal clients are told that it is healthy to take medications and staff E would explain to them the	W 371	The QIDP will schedule a team meeting to review the ABI and Habilitation Service Plan for client #4 The ABI will be updated to address needs, supports and training to increase his knowledge of medications. The QIDP will provide training to all staff on updates to the ABI and Habilitation Service Plan as applicable training in clients' knowledge of medication. The QIDP will review the ABI and Habilitation Service Plan on a monthly basis to address any updates in teaching clients' medication administration skills. The QIDP and /or the program manager will monitor the medication pass weekly in the home to ensure continued compliance.	

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W 371	Continued From page 6 reason it is healthy to take medications. Interview with the facility nurse on 7/19/22 verified that staff should train and educate all clients during medication administration. Continued interview with the facility nurse revealed that staff will receive further training to educate clients during medication administration. B. The system for drug administration failed to assure client #2 was provided the opportunity to participate in medication self-administration. For example: Observation in the group home on 7/19/2/22 at 7:15 AM revealed staff E to remove medication packet from medication closet and sign medication book. Continued observation revealed staff E to pour medications into medication cup, pour water into cup, and pour medications into the mouth of client #2. Further observation at 7:25 AM revealed client #2 to drink water and exit the medication area. Client #2 was not observed to receive any training during medication pass or to participate beyond taking medications from staff E. Review of records for client #2 revealed an HSP dated 7/11/22. Review of the HSP revealed client #2 has a goal implemented 8/8/21 to participate in medication administration. Continued review of medication administration goal revealed the client to perform the following with prompts: Pick up medication bin, use sanitizer to wash hands, pour water into glass/cup, take medications and throw medication cup into trash can. Interview with staff E on 7/19/22 revealed that staff E would typically educate verbal clients.	W 371		

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W 371	Continued From page 7 Continued interview with staff E revealed that non-verbal clients are told that it is healthy to take medications and staff E would explain to them the reason it is healthy to take medications. Interview with the facility nurse on 7/19/22 verified that staff should train and educate all clients during medication administration. Continued interview with the facility nurse revealed that staff will receive further training to educate clients during medication administration.	W 371		

COMMUNITY
INNOVATIONS, INC.
4214 Beechwood Drive Suite 106
Greensboro, NC 27410
Phone (336) 370-4177 ~ Fax (336) 370-1023

August 3, 2022

DHSR
Mental Health Licensure and Certification Section
Lisa Jones, Facility Compliance Consultant 1
2718 Mail Service Center
Raleigh, NC 27699-2718

Ms. Jones,

Please find enclosed the Plan of Correction for Northbay Residential recertification survey completed on July 19, 2022. If you have any questions regarding the Plan of Correction, please contact me at (336)215-1750.

Sincerely,

Lorianne Jarrell, CS

Lorianne Jarrell, Clinical Supervisor