STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G301	A. BUILDING _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTERFIELD GROUP HOME	2287 HARTLAND ROAD MORGANTON, NC 28655

(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 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: The facility failed to assure 2 of 3 sampled clients (#2 and #5) were provided with a continuous active treatment program to meet their communication needs as evidenced by observations, interviews and record verification. The findings are: A. Afternoon observations in the group home on 1/30/23 beginning at 3:45 PM revealed client #2 to be non-verbal, blind and dependent on staff to move him in his wheelchair. Staff were observed to talk to the client and take outside with his peers and then back inside to clip his fingernails. Client #2 was noted to be very vocal and appear to be agitated after his nail cutting program at 4:15 PM so staff was observed to move him into his room to listen to music and calm for 35 minutes. This process was repeated throughout the rest of the survey when client #2 expressed agitation with loud vocals, biting his fingers, lightly tapping his head and upper body movements with staff removing the client from the area either to his bedroom or outside for a short roll around the group home.	W 249	DHSR - Mental Health FEB 08 2023 Lic. & Cert. Section A. The facility will ensure that staff are trained on providing continuous active treatment to meet individuals communication needs the facility will ensure staff are trained on the implementation and documentation of all programs. The QP and designee will monitor through direct observation on a weekly basis within the home	3-31-23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: BSQP | (X6) DATE: 2-6-23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G301	A. BUILDING _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTERFIELD GROUP HOME	2287 HARTLAND ROAD MORGANTON, NC 28655

(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 249	Continued From page 1 Interview with the group home manager and staff revealed the client does not do well in loud environments and moving the client to a different area when agitated helps him to calm. Further interviews, substantiated by further observations, revealed the client also stays calmer when using headphones with Christmas music playing. Continued observations revealed the client used and had access to his headphones throughout the survey. Review of client #2's individual program plan (IPP) dated 7/11/22 revealed the client to have a behavior support plan to address hand chewing/biting and head hitting. Further review of the IPP revealed a 7/10/22 psychological evaluation update which noted the client needs to increase his communication skills to assist with his behaviors. Continued review of the IPP revealed the client to currently have a communication objective to demonstrate attention to auditory stimuli during snack. Subsequent observations in the home during the 1/30-31/23 survey revealed the client did not eat snack during observations and the client's communication objective was not expanded to other meals or activities in the home. Review of client #2's progress on this communication objective revealed no data is available to measure the client's progress since 7/22. The facility failed to assure a continuous active treatment program to meet the client's communication needs by failing to include objective training to increase his communication attempts throughout the day, incorporate a means to for the client to learn to communicate his agitation appropriately and by failing to train and monitor the client's program on a consistent	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G301	A. BUILDING _____ B. WING _____	01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTERFIELD GROUP HOME	2287 HARTLAND ROAD MORGANTON, NC 28655

(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 249	Continued From page 2 basis. B. Observations of client #5 during the 1/30-31/23 survey revealed the client to be non-verbal and communicate through a series of gestures including her favorite of waving to peers and staff in the group home to get their attention. Review of client #5's IPP dated 2/15/22 revealed the client to have a communication program to model the manual sign for "more." Further observations revealed no training of this objective or use of any other manual signs by staff during the survey. In addition, review of program progress for this objective revealed no data since 9/22 has been available to evaluate the client's progress with this objective. The facility failed to assure a continuous active treatment program regarding the client's communication needs has been implemented.	W 249	B. The facility will ensure that staff are trained on active treatment and on the implementation of communication programs and the documentation of all programs. The QP and designee will monitor through direct observation on a weekly basis within the home.	3-31-23

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

February 2, 2023

Ms. Paige Anderson, Administrator
ComServ Inc.,
2419 Norwood St., SW
Lenoir, NC 28645

Re: Recertification Completed 1/30-31/23
Chesterfield Group Home-Morganton
Provider Number 34G301
MHL# 012-051
E-mail Address: paigea@comserve.org

Dear Ms. Anderson:

Thank you for the cooperation and courtesy extended during the recertification survey completed 1/30-31/23. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is 3/31/23.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call me at 828-750-4895.

Sincerely,

Steven C. Yost

Steven C. Yost, MSW, QDDP
ICF-IID Branch Manager
Mental Health Licensure & Certification Section

Enclosures

Cc: QM@partnersbhm.org
dhhs@vayahealth.com