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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G277	A. BUILDING ______ B. WING ______	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASON STREET	306 N MASON STREET APEX, NC 27502

(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: Based on observations, record review and staff interviews, the facility failed to ensure 1 of 3 audit clients (#2) received a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of safety interventions in the behavior support plan (BSP) to prevent opportunities to elope. The findings is: During observations in the home throughout the survey 8/1/22-8/2/22, the front door had a door chime in place but it was not turned on to activate the alarm. The front door was opened repeatedly by staff and clients when exiting the home for activities and failed to sound to alert staff. Review on 8/2/22 of client #2's BSP dated 8/1/22, revealed he would display 0 episodes of elopement per month for 12 consecutive months. Standard door chimes are on the front and back doors. The chimes will inform staff if anyone is entering or leaving the home, which included client #2's attempts to leave.	W 249	W.249 This deficiency will be corrected by the following actions: A. All ISP's will be reviewed and revised as needed to ensure objectives are met. B. All BSP's will be reviewed. C. All proper techniques will be used to manage behaviors. D. All staff will be in-serviced on all Behavior Support Plans and proper documentation. E. All staff will ensure the door chime is working properly. F. Site Supervisor will monitor one time a week G. Qualified Professional will monitor one time a week.	09/30/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marika Whack KJK	Executive Director	8/18/2022

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 249	Continued From page 1 Interview on 8/2/22 with the site supervisor (SS) revealed he was aware that client #2 was tall enough to turn off the door chime and had deactivated it before. Interview on 8/2/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that client #2 remained an elopement risk and the door chimes should remain on at all times. The QIDP told the SS that when he became aware that client #2 turned off the door chime, he must ensure that it is turned back on.	W 249		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, nursing services failed to ensure that staff who were not vaccinated for COVID-19 wore the required Personal Property Equipment (PPE) while on duty. This had the potential to affect all clients (#1, #2 and #3). The findings is: During mooring observations in the home on 8/1/22 at 9:30am, Staff A and Staff B, answered the door to screen surveyors wearing a single surgical mask. Clients #1, #2 and #3 had interacted with Staff A and Staff B sitting on the porch, did Zumba inside of the home and worked on puzzles at the dining room table. At 11:12am, it was observed that Staff A and Staff B had switched over to KN95 masks.	W 340	W.340 This deficiency will be corrected by the following actions: A. RN will in-service all staff on Infectious diseases. B. COVID disaster plan will be updated as needed: C. KN95 mask will be provided by management. D. Staff will be in-services on COVID protocol. E. Staff will be trained on the importance of face coverings. F. RN will monitor monthly. G. Site Supervisor will monitor two time a week. H. Qualified Professional will monitor two times a week.	09/30/2022

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W 340	Continued From page 2 Review on 8/1/22 of the Vaccination Policy, dated 1/28/22 revealed all unvaccinated or not fully vaccinated staff providing care in an intermediate care facility (ICF) home will wear a National Institute for Occupational Safety and Health (NIOSH) approved KN95 mask at all times unless eating or drinking. Interview on 8/2/22 with Staff A revealed that yesterday she forgot to put on the KN95 mask when she arrived at work. Staff A revealed that when the Qualified Intellectual Disabilities Professional (QIDP) arrived to the facility, she advised them to put on the KN95 mask. Staff A acknowledged that the KN95 mask had been available in the house. Interview on 8/2/22 with the facility's nurse revealed their protocol required all unvaccinated staff must wear KN95 masks.	W 340		
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #3 received a comprehensive dental examination at least annually. This affected 1 of 3 audit clients. The finding is: Review on 8/2/22 of client #3's record revealed his last dental examination was completed on 10/22/20. Additional review of the dental report	W 352	W. 352 This deficiency will be corrected by the following actions: A. The Qualified Professional will ensure that all assessments, appointments and annual examinations are scheduled and completed. B. The comprehensive dental diagnostic service mentioned in the statement of deficiencies will be scheduled or completed. Any issues with non-compliance are to be documented. C. The Site Supervisor will monitor and document monthly. D. The Qualified Professional will monitor and document monthly.	09/30/2022

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W 352	Continued From page 3 dated 10/22/20 noted, "Exam prophy, 4 bitewings xrays. Please return for filling on #30 and #4." Further review of the record did not reveal a current dental examination report. Interview on 8/2/22 with the facility's nurse indicated client #3 was scheduled for a dental visit in November 2021; however, the appointment was canceled. The nurse confirmed client #3 has not had a comprehensive dental examination since 10/22/20.	W 352	E. The Nurse will ensure these appointments are completed documented monthly.	
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered without error. This affected 1 of 2 audit clients observed receiving medications (#1). The finding is: During observations of medication administration in the home on 8/2/22 at 6:58am, client #1 ingested Vitamin D3, Prozac, Depakote, Zyrtec, Abilify and Flonase. No other medications were ingested. Review on 8/2/22 of client #1's physician's orders dated 6/14/22 revealed an order for Miralax 3350 powder (17gm), mix 1 capful (17gms) as directed and take by once daily, 7:00am - 8:00am. Interview on 8/2/22 with the facility's nurse confirmed client #1 should have received Miralax powder during his morning medication	W 369	W. 369 This deficiency will be corrected by the following actions: A. All medication orders will be reviewed. B. All medication will be dispensed as prescribed. C. All physicians' orders will be current and updated. D. RN will monitor once a month. E. Site supervisor will monitor one time a week. F. Qualified Professional will monitor one time a week.	09/30/2022

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W 369	Continued From page 4 administration.	W 369		
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. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to furnish eyeglasses for 1 of 3 audit clients (#1). The finding is: During observations throughout the survey on 8/1/22 and 8/2/22, client #1 was observed to never wear eyeglasses. Review on 8/2/22 of client #1's vision consultation revealed on 10/29/20, the practioner diagnosed him with Refractive Error, with compound myopic astigmatism in the right and left eyes. It was recommended that client #1 wear eyeglasses and follow up annually. An invoice from this appointment documented that a claim was initiated with the insurance to purchase single vision eyeglasses. Review on 8/2/22 of client #1's Individual Program Plan (IPP) dated 4/18/22 revealed that eyeglasses were listed as adaptive equipment to be worn daily to increase vision. The IPP was reviewed and signed by the Qualified Intellectual Disabilities Professional (QIDP) on 4/18/22. Interview on 8/2/22 with the Site Supervisor (SS) revealed that he had worked at the home for less	W 436	W.436 This deficiency will be corrected by the following actions: A. All adaptive equipment will be discussed in a team meeting. B. All people served will be in-services on their adaptive equipment and the importance of wearing/using their adaptive equipment. C. All adaptive equipment will be accessible to the person served needing the equipment. D. Formal training will be completed for the use of adaptive equipment-glasses. E. All people served will be assessed for the use of adaptive equipment. F. Qualified professional will implement a formal goal. G. All staff will be in-serviced of the use of adaptive equipment. H. Site Supervisor will monitor one time a week. I. Qualified Professional will monitor one time a week.	09/30/2022

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W 436 Continued From page 5 W 436

than a year and never knew that client #1 required eyeglasses.

Interview on 8/2/22 with the QIDP revealed that she had not observed client #1 wearing eyeglasses before and unaware where they were stored.

W 443 EVACUATION DRILLS
CFR(s): 483.470(i)(1)(ii) W 443

The facility must hold evacuation drills to ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features.
This STANDARD is not met as evidenced by:
Based on observations, record review and staff interviews, the facility failed to follow fire safety procedures during a fire emergency. This had the potential to affect all clients (#1, #2 and #3). The finding is:

During morning observations in the home on 8/2/22 at 6:30am, Staff A was at the stove in the kitchen assisting client #3 prepare grits. A saucepan with water and uncooked grits was on the front left burner. There was smoke coming from the burner with an odor that resembled the smell of a grilled cheese sandwich. Staff A stood at the stove and continued to stir the contents in the pan, dismissing the smoking coming from the burner. At 6:32am, the smoke became an orange flame and spilled out from underneath the pot. Staff A continued to stir the grits in the pot, with the presence of flames.

Staff A instructed client #3 to leave the kitchen and client #3 stood in the dining room. At 6:33am, the Site Supervisor (SS) entered the kitchen and instructed Staff A to turn off the heat source to the

Provider's Plan of Correction:

W.443
This deficiencies will be corrected by the following actions: — 09/30/2022

A. All staff will be in-services on fire drills and fire safety.
B. The Emergency Procedure for fire safety will be reviewed.
C. All fire drills will be conducted in the home monthly.
D. Site Supervisor will monitor once a weekly.
E. Qualified Professional will monitor once a week.

Note: QIDP did not comment on being aware that fire extinguisher needing to be in kitchen.

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W 443	Continued From page 6	W 443		

front burner. Staff A moved the saucepan to the front right burner and turned on the heat, to boil the water. The flame continued to rise from the front left burner, with a black smoke created from the top of the flame. The kitchen became hazy from the smoke and there was a mild odor coming from the flames which reached approximately 6-8" in height.

The SS instructed Staff A to pour salt on the flames. The SS told client #1 and #3 to exit the house and commented that he was going to count the evacuation as an actual fire drill. Staff A stood at the stove and it took 4 handfuls of salt dropped over the flames to extinguish the fire. The smoke detector in the living room did not activate. There was no visible fire extinguisher in the kitchen or adjoining dining room. When the flames were out, Staff A took the Emergency Plan (EP) binder and exited the home.

The SS supervisor re-entered the home at 6:36am and went to the medication room and informed Staff E, the 2nd surveyor and client #2 that he was conducting a fire drill and they need to evacuate from the home. Staff, clients and surveyors stood away from the home in the backyard. At 6:38am, the surveyor made the SS aware that the home was evacuated without all burners turned off. The SS immediately re-entered the home and turned off the stove, then returned to the yard. The SS gave clearance to re-enter the home at 8:45am.

Review on 8/2/22 of the facility's Emergency Procedures for Fire Safety Procedures, revealed the RACE method for fires.

R Rescue persons in immediate danger.

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W 443	Continued From page 7 A Activate Fire Alarm. Should fire or heavy smoke be discovered, immediately activate the nearest fire pull station. C Confine fire, call fire department and other emergency response personnel. E Evacuate people supported to a safe area and remaining available staff should extinguish the small fire. Fighting the Fire: It is recommended that you remove all of the people supported from the building to a safe area before attempting to fight a fire. Interview on 8/2/22 with Staff A revealed that this was the first time since she was hired three years ago, that she saw a fire in the home and admitted she did not know what to do. Staff A also acknowledged she was aware there was a spill on the burner. Interview on 8/2/22 with the SS revealed the clients just moved back into the home last month, after moving out to have it remodeled. When the home was remodeled, the fire extinguisher was removed from the kitchen and not re-installed. The SS acknowledged that they were all nervous and he quickly thought to use salt on the flames. The SS stated that he notified the fire alarm monitoring company and contacted the Qualified Intellectual Disabilities Professional (QIDP) about the fire. The SS acknowledged that he saw the burner left on, with an unattended stove when he re-entered the home after they evacuated for the fire drill and turned it off. The SS confirmed that there were fire extinguishers available in the home, which should have been used to extinguish the fire.	W 443		

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W 443	Continued From page 8 Interview on 8/2/22 with the QIDP acknowledged she was aware the kitchen did not have a fire extinguisher installed when they moved back in the home. The QIDP produced an attendance sheet from a 2/15/22 fire drills in-service sheet that Staff A attended and stated that staff were also trained last month on fire drills.	W 443		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 2 of 3 audit clients (#2 and #3) received their specially-prescribed diet as indicated. The findings are: A. During lunch observations in the home on 8/1/22 at 12:30pm, client #2 was served tuna salad with boiled egg, pasta, dill pickle, 6 Club crackers and a desert cup of ice cream. Client #2 quickly ate his pasta and crackers and attempted to reach for the box of crackers several times to get more. Staff C supervised client #2 as he ate, and the Qualified Intellectual Disabilities Professional (QIDP) was present in the dining room and suggested to the Site Supervisor (SS) that client #2 be offered an apple. The SS presented an apple and client #2 began eating it. The QIDP asked the SS how many crackers did client #2 receive and was told 6. The QIDP gave client #2 four additional crackers, which he consumed. Client #2 had not attempted to eat the	W 460	W.460 This deficiency will be corrected by the following actions: A. Nutritionist will complete assessment on consumers. B. Recommendations will be added based upon assessments. C. Nutritional assessments will be conducted to ensure proper food consistency. D. All people served will receive a nourishing, well-balanced diet including modified and specially prescribed diets. E. All staff will be in-serviced on food consistency orders. F. Site Supervisor will monitor one time a week. G. Qualified Professional will monitor one time a week.	09/30/2022

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W 460	Continued From page 9	W 460		

tuna salad and was never encouraged to eat it before he was given extra servings of crackers.

During dinner observations on 8/1/22 at 4:40pm at a restaurant, client #2 received an average size piece of pizza with cheese and meat along with a bowl of salad. It was cut into 1-2" size pieces. Client #2 quickly consumed his pizza when the QIDP noticed that he finished before the other clients. The QIDP suggested to Staff C that she could request that kitchen prepare vegetarian pizza for him since he was allowed second portions of vegetables. The QIDP placed an order for more pizza and when she returned to the table, client #2 was encouraged to eat his untouched salad, that he began to consume. Client #2 was observed to quickly consume the vegetarian pizza once it was cut into bite sized pieces without incident.

During morning observations in the home on 8/2/22 at 7:00am, the SS assisted client #2 cut his muffin into 6, 1" pieces. Client #2 ate his muffin, grits, grapes and yogurt for breakfast, without incident.

Review on 8/1/22 of client #2's IPP dated 4/18/22 revealed staff should encourage him to eat at a safe rate and take bite sized pieces. Client #2 was permitted to have non-starchy 2nd servings of vegetables and fruits. In addition there were dietary orders dated on 7/18/22 posted on the dining room wall, that confirmed client #2 remained on a bite size diet with no 2nd servings unless non-starchy fruits and vegetables.

Review on 8/1/22 of the nutritional facts on the box of Club Crackers revealed a serving size equaled 4 crackers.

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W 460	Continued From page 10 Interview on 8/2/22 with the SS revealed that he acknowledged client #2 did not receive bite size pieces of the muffin for breakfast. Interview on 8/2/22 with the QIDP revealed that she was aware that client #2 should not receive 2nd servings of food that were starchy. Interview on 8/2/22 with the nurse revealed client #2 had a tendency to eat his food too fast so it was recommended that he receive bite sized pieces. The nurse stated that even though the dietary orders did not specify the measurement for bite size pieces, a muffin cut into 6 portions became finger foods servings. The nurse also stated that client #2 should have not receive extra crackers for lunch or vegetables served on a 2nd slice of pizza. The nurse stated that both crackers and pizza dough were full of carbohydrates. B. During breakfast observations in the home on 8/2/22 at 7:05am, client #3 consumed his breakfast meal with orange juice and milk. The client did not consume any other beverages at breakfast. Review on 8/1/22 of a list dated 7/18/22 posted in the dining room of the home included each client's current diet. Client #3's diet noted he should receive "Prune juice 4 oz daily at breakfast." Interview on 8/2/22 with the QIDP and SS confirmed the posted diet for client #3 was the most current and continues to receive prune juice at breakfast.	W 460		
W 473	MEAL SERVICES	W 473		

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W 473	Continued From page 11 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 foods were served at appropriate temperature. This affected 3 of 3 audit clients (#1, #2 and #3). The finding is: During morning observations in the home on 8/2/22 at 6:30am, two containers of peach yogurt and two containers of strawberry yogurt were placed on the dining room table. Clients #1, #2 and #3 did not sit down to eat breakfast until 7:00am. At 7:10am, Clients #1 and #2 begin to eat the peach yogurt after they consumed their grits and muffin. At 7:12am, the Site Supervisor (SS) was asked to check the temperature on the remaining unopened container of strawberry yogurt. The SS used a thermometer to check the yogurt and recorded a food temperature of 60 degrees. Review on 8/2/22 of an email from the facility's nurse to the Qualified Intellectual Disabilities Professional (QIDP) dated 8/2/22 confirmed that cold foods needed to be kept at 40 degrees or below before serving. Interview on 8/2/22 with the SS revealed that he did not know the minimum temperature allowed for cold foods served. The SS stated that in order to maintain the proper temperature, the yogurt could have remained in the refrigerator until served or placed in a bowl with ice and left on the table up to 15 minutes.	W 473	W. 473 This deficiency will be corrected by the following actions: A. All food will be served at appropriate food temperature. B. All staff will be in-serviced on appropriate food temperature. C. Site Supervisor will monitor once a week. D. Qualified Professional will monitor once a week.	09/30/2022