

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

PRINTED: 07/19/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G277	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/12/2023
NAME OF PROVIDER OR SUPPLIER MASON STREET			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 2 of 4 audit clients (#4 and #5) received a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of meal guidelines to promote safe eating. The findings are:</p> <p>A. During dinner observations at a restaurant on 7/11/23 at 6:00 pm, the Home Manager (HM) sat next to client #4. Client #4 ordered a cheeseburger sandwich for dinner. Client #4 was observed taking quick bites from his burger, overstuffing his mouth. There were no observations of staff at the table, prompting client #4 to slow his eating pace. Client #4 finished his meal, without incident.</p> <p>Review on 7/11/23 of the nutritional evaluation from 10/18/22 revealed client #4 was on a regular diet and should eat bite size pieces at a safe rate.</p> <p>B. During dinner observations at a restaurant on 7/11/23 at 6:00 pm, revealed client #5 ordered</p>	W 249			
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 249	<p>Continued From page 1</p> <p>grilled skinless chicken, prepared bite size pieces for dinner. Client #5 was observed to quickly filled his mouth with food. There were no observations of staff at the table, prompting client #5 to slow his eating pace. No problems were noted with ingestion.</p> <p>A breakfast observation on 7/12/23 at 7:15 am in the home, revealed Staff D permit client #5 to remove 3 whole pancakes from a bowl. Client #5 hurriedly ate one pancake in 3 large bites. The HM prompted Staff D to get the bowl with the bite sized pancakes, and then client #5 was given an extra pre-cut pancake. Client #5 ate all of the pancakes without incident. Client #5 was observed with two large cups; one clear cup was filled to the rim with water and the fluid level could not be determined in the opaque gray cup.</p> <p>Review on 7/11/23 of the occupational therapy evaluation from 4/14/23 revealed staff should fill cup halfway or offer two cups half-filled to decrease aspiration risks. Staff should pre-cut foods as needed in the kitchen due to client #5 eating at fast paced.</p> <p>Interview on 7/12/23 with the HM revealed Staff D normally did not work the morning shift or assist with meal supervision and required some prompting.</p> <p>Interview on 7/12/23 with the Program Director revealed client #5 likes to eat very fast and meal guidelines need to be followed.</p>	W 249			
W 369	<p>DRUG ADMINISTRATION CFR(s): 483.460(k)(2)</p> <p>The system for drug administration must assure</p>	W 369			

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W 369	<p>Continued From page 2</p> <p>that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure all medications were administered without error. This affected 1 of 4 audit clients (#3). The finding is:</p> <p>During observations of medication administration in the home on 7/11/23 at 4:30 pm, Staff A placed two drops of Brimonidine Sol 0.2% OP in the left eye of client #3 plus one drop of Polyvinyl AL SOL 1.4% OP in the right and left eye. An additional observation revealed client #3 received these oral medications: Levetiraceta 750 MG, Stimulant Lax 8.6-50 MG, Baclofen 10 MG and Carvedilol Tab 3.125 MG. No other medication was observed ingested.</p> <p>Review on 7/11/23 of the eye drop medication package labels revealed instructions to place 1 drop of Brimonidine Sol 0.2% OP into the left eye. On further review, it revealed there were two boxes of the identical prescription of Polyvinyl AL Sol 1.4% dated for April 2023 and July 2023. The instructions were to place one drop into the right eye of client #3. There was no box of Polyvinyl AL Sol 1.4% to instill in the left eye. An additional review on 7/12/23 of client #3's Physician Orders signed 6/26/23 revealed there was a prescription for Kristalose PAK 10 GM that was not observed given on 7/11/23 between 4:22 PM and 4:45 PM.</p> <p>Interview on 7/11/23 with Staff A revealed she placed Polyvinyl AL Sol 1.4% into client #3's right and left eye and did not realize it was a duplicate prescription, only for the right eye. Staff A did not offer an explanation for giving client #3 an extra</p>	W 369			

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W 369	Continued From page 3 drop of Brimonidine Sol 0.2% OP in his left eye. Staff A called the nurse on 7/11/23 at 4:50 PM to notify her of her error. Interview on 7/12/23 with the Program Director (PD) revealed the old medication should have been discarded. The PD also revealed staff should have had the physical medication administration record (MAR) available while dispensing meds, to review all orders.	W 369			