STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G045	A. BUILDING _____ B. WING _____	C 07/21/2023

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W 000	INITIAL COMMENTS An unannounced complaint survey was conducted on 7/20/23-7/21/23 for intakes #NC00203153 and #NC00204500. Allegations were substantiated with deficiencies.	W 000		
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 reviews and interviews, the qualified intellectual disabilities professional (QIDP) failed to monitor client's active treatment programs and revise as necessary. This affected 1 of 4 audit clients (#4). The findings is: Review on 7/21/23 of client #4's Behavior Support Plan dated 12/19/22 revealed he had an objective to display physical aggression and self-injurious behavior on no (0) occasions for 6 consecutive months. Review on 7/21/23 of client's #4 quarterly behavior note revealed January 2023 client # 4 had 13 documented physical aggression behaviors. Interview with Interim QIDP confirmed that there was no documentation since January 2023 due to the QIDP leaving the position. The Interim QIDP stated she was also aware of the documentation not being current.	W 159		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with	W 189		

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

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W 189	Continued From page 1 initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure their staff were sufficiently trained in behavior management recommendations and safe transfer guidelines. This affected 1 of 4 audit clients (#1). The finding is: During observations at the vocational center on 7/20/23 at 11:30 AM Staff A identified that she was a new staff and along with Staff B, was hired two weeks ago. Staff B went to other classrooms looking for help to supervise other clients so that client #1 could be transported to the restroom. Staff A had indicated that he needed his teeth brushed after lunch and that he was taken to the bathroom every two hours. The vocation center manager (VCM) and the occupational therapy assistant (OTA) arrived at 12:00 PM and rolled a sleeping client #1 to the restroom using his reclined geri chair. In the bathroom, the OTA pushed the geri chair to the threshold of the staff and locked the brakes. The OTA stood next to the chair and held onto client #1's gait belt. The VCM stood by client #1 and raised him out of his chair, on a count of 3. Together the OTA and VCM entered the staff and sat client #1 on the toilet. Client #1 kept his ankles crossed during the transfer and maintained a stooped, slouching position and did not take steps to get closer to the toilet. The VCM placed a seatbelt on him once he was on the toilet seat. The toilet had side rails on both side of the toilet. The VCM remained inside the staff with client #1. The bathroom observation continued and at	W 189		

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W 189	Continued From page 2	W 189		

12:20 PM, the OTA entered the stall with client #1 and the VCM to get him off the toilet. The VCM uncrossed him ankles, giving client #1 verbal prompts to keep feet apart. On a count of three, both staff lifted client #1 to a standing position, holding his gait belt. Client #1 was able to stand straight up with support. Staff realized there was no toilet paper in the staff and client #1 was sat back on the toilet. The OTA re-entered the stall and helped the VCM lift client #1 from the toilet again. The VCM used one hand to help hold client #1 while she used the second hand to wipe his buttock. The OTA offered most of the physical support, and then let go with one hand, as she stooped to pull up client #1's incontinent brief and shorts. Both staff held onto client #1's gait belt and tried to lift him as they pivot him to sit in his geri chair, parked in front of the stall, with the brakes still locked. As staff tried to lower client #1 into the geri chair, which was in a sitting position, client #1's knees started to buckle and the VCM and OTA could not support his weight. Client #1 was not fully sitting on the cushion and was sliding from the chair, when the VCM told the OTA to help lower him to the floor, in a sitting position. The OTA was told to summon the nurse.

The observation continued with the nurse entering the bathroom at 12:25 PM. She assessed client #1 and he had no visible injuries. The nurse attempted to lift client #1 with staff but could not. The behavioral specialist entered the bathroom. He helped the nurse and VCM lift client #1 from a sit to stand position while the OTA stood behind the geri chair to prevent it from rolling. Client #1 was successfully transferred to the geri chair at 12:30 PM.

Record review on 7/21/23 of client #1's revised

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W 189	Continued From page 3	W 189		

Transfer Guidelines dated 1/24/23 revealed he was diagnosed with a medial tibial fracture on his left knee and required a change in his transfers due to his weight bearing status restrictions. As of 1/24/23 his weight bearing restrictions were lifted and he could resume full weight bearing. Client #1's primary method of transfer wil be stand-pivot transfer:

One to Two-person squat pivot transfer.
Position the wheelchair to a 45 degree angle.
Lock wheelchair brakes.
Apply the gait belt around client #1's waist.
Position his feet as flat on the surface as possible with his legs spread apart.
The staff should assist client #1 with moving forward in the wheelchair in preparation for transferring. Ask him to scoot forward in his wheelchair but not falling off the surface.
When client #1 is positioned close to the edge of the surface, staff are ready to transfer him.
Continue to keep both of his feet placed on the floor with maintaining your hands in contact with his trunk to provide support to reduce him from losing balance off the surface.
Please face client #1 at this time or slightly to one side of him. -

Record review on 7/21/23 of a therapy progress note dated 6/23/23 revealed client #1 demonstrates impaired tolerance for sit to stand and impaired ability to tolerate weight shifting at this time. Unable to perform any ? (not legible) 1/0 min right lower extremity and requires maximum x 2 person sit to stand. Will continue to monitor.

Interview on 7/21/23 with Staff A and Staff B revealed they started working in the classroom

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W 189	Continued From page 4 with client #1 on 7/17/23 and have not received formal training on transferring him. Interview on 7/21/23 with the Habilitation Specialist revealed she had training originally scheduled for Staff A and Staff B on 7/18/23 but it has been rescheduled because clinical staff have been needed to work in the homes due to staffing shortages. Interview on 7/21/23 with the Physical Therapist (PT) revealed client #1 was a 2 person transfer. The PT stated that when toileting client #1 he required a staff to stand on each side of him, supporting him, holding a gait belt. A third staff should stand to assist with wiping and removing or re-applying his clothes. The PT also acknowledged it was important for client #1's ankles to not be crossed when transferring him or getting him to stand. Interview on 7/21/23 with the Regional Administrator (RA) revealed staff should be training on safe transfers before working with clients. The RA believed that Staff A and Staff B received training on safe transfer techniques on 7/17/23 but she did not have an attendance sheet to show that they participated.	W 189		
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by:	W 257		

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W 257	Continued From page 5 Based on record review and interview, the facility failed to ensure the Behavior Support Plan (BSP) for 1 of 4 audit clients (#4) were revised after client failed to progress towards identified objective. The finding is: Review on 7/21/23 of client # 4 BSP dated 1/12/23 client #4 will display a combined total of (0) episodes of physical aggression and self-injurious behavior for 6 consecutive months. Review on 7/21/23 of client #4's incident reports dated between 2/3/23 -7/7/23 revealed 25 physical aggression behaviors toward staff and 10 physical aggression behaviors toward peers. Interview on 7/21/23 the Behavior Specialist confirmed he was unable to find note of "mini teams" or any documentation to address clients' behaviors and redirections of what had been done to address client's behaviors.	W 257		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on record review and interviews the facility failed to provide training to staff to meet the behavioral needs of 1 of 4 audited client (#4). The finding is: Observation at 11:32am at the day program lunchroom client #4 was grabbing at Staff A's chest. Staff A walked away from client #4. Client #4 then attempted to grab Staff B chest she	W 288		

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W 288	Continued From page 6 redirected client #4 and stated "good touch [client #4]". Review of training for Staff A and Staff B revealed no training on client #4's BSP. Interview on 7/21/23 the Behavior Specialist confirmed that Staff A and Staff B had not been trained on client #4's BSP. Staff A and B had started a week prior, and he had planned on completing a training for them	W 288		