STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G268	A. BUILDING ______ B. WING ______	C 08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORE COUNTY HOME FOR AUTISTIC ADULTS	**1112 DEVONSHIRE TRAIL ABERDEEN, NC 28315**

(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 000	INITIAL COMMENTS A complaint survey was completed on 8/7/23 for intake #NC00205513. The allegations were unsubstantiated however a deficiency related to the allegation was cited.	W 000		
W 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) 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 direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on record review and interviews, staff failed to demonstrate the ability to recognize signs and symptoms of seizure activity. This affected 1 of 4 audit clients (#4). The finding is: Review on 8/7/23 of a seizure chart for client #4 revealed the following activities: On 7/23/23 at 5:30AM client #4 had seizure for 6 seconds; rolled off couch and had muscle spasms. On 7/31/23 at 6:25PM client #4 had seizure for 35 seconds; fell out of chair, onto the floor. On 8/1/23 at 9:13AM client #4 had seizures for 10 seconds; eyes rolled and he started making noises. On 8/1/23 At 9:45AM client #4 had seizure for 31 seconds; laid on floor shaking. On 8/1/23 At 10:40AM client #4 had seizure for 35 seconds, laying on living room floor, shaking. On 8/1/23 At 11:41 AM client #4 had seizure for 30 seconds, laying on floor, shaking.	W 342		

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 342	Continued From page 1	W 342		

Interview on 8/7/23 with Staff A revealed that she had worked with client #4 for years, whereas Staff B had worked in the home for about six months. On 8/1/23, Staff A arrived to work at 8:00AM and saw client #4 laying on the living room floor. Staff A explained that she automatically suspected that client #4 had a seizure and asked Staff B who had worked overnight with client #4. Staff B responded that he did not see client #4 have a seizure. Staff A revealed she could not get client #4 off the floor, because he was lethargic and could not assist. Staff A stated she got a blanket and pillow for client #4, called the home manager and began to monitor him, as he had additional brief seizures for several hours. Staff B revealed she called 911 emergency services after client #4 had his third seizure that morning. Client #4 remained in the hospital.

Interview on 8/7/23 with Staff B confirmed he worked the night shift on 7/31/23 and was relieved by Staff A on 8/1/23. Staff B revealed he was the only staff on duty and had showered and dressed client #4 at 7:00AM on 8/1/23. After the shower, Staff B walked with client #4 to the living room to sit down, so he could complete bathing other clients. Staff B returned to the living room at 7:15AM and found client #4 out of the chair, on the floor. Staff B acknowledged that he could not get client #4 off the floor by himself and he was not following verbal prompts to put on his socks. Staff B revealed client #4 was "not a big guy, but was dead weight." Staff B said he propped client #4 against the living room chair instead. Staff B acknowledged that he was asked by Staff A if client #4 had a seizure, but said no. Staff B said he never saw client #4 stare off, have body movements or slurred speech so he did not

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W 342	Continued From page 2 consider him to have had a seizure on 8/1/23. Interview on 8/7/23 with the home manager (HM) revealed she arrived to work on 8/1/23 at 9:30AM and supervised client #4 as he had seizure activity that morning. The HM notified the nurse and doctor when she arrived at work of client #4's seizures and he was sent to the hospital after he continued to have seizures. The HM revealed she visited client #4 this morning at the hospital and that he had to be sedated due to continuous seizure activity. The HM revealed she was new in her role as HM, starting her position in June. Interview on 8/7/23 with the qualified intellectual disabilities professional (QIDP) revealed there had been six classes on seizures training in the last year. The QIDP did not have access to the attendance sheet of staff participating, but stated, all shifts were required to attend the training. The QIDP confirmed Staff B only worked in the home since the beginning of this year.	W 342		