STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G206	A. BUILDING _____ B. WING _____	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSONVILLE GROUP HOME	**1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007**

(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
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		

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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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) was reviewed and/or updated at least biennially. The finding is: Review on 9/5/23 of the facility's emergency preparedness documentation revealed an undated EPP which was created for all of the Monarch properties as well as a document titled "Emergency Plan - Site Specific," which was dated 2/22/16. Continued review revealed that the facility's emergency binder contained outdated information about clients, including information about clients no longer residing in the facility and lacking information regarding clients presently residing in the facility. Interview on 9/6/23 with the Qualified Intellectual Disability Professional (QIDP) and the Home Manager (HM) revealed that the facility was unable to provide evidence of any updates to the EPP since 2016. Continued interview confirmed that the EPP needs to be updated to at least every two years and whenever there is a change in clientele in the facility.	E 004		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage	W 125		

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W 125	Continued From page 2 individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that 1 out of 6 clients (#4) was treated with dignity and respect regarding the use of incontinence padding. The finding is: During observations in the home on 9/5/23 at 4:40 PM, client #4 was observed sitting on a living room couch with an incontinence pad clearly visible under the client's body. During observations in the home on 9/6/23 at 6:50 AM, client #4 was again observed sitting on the living room couch on top of an incontinence pad while staff were present and supervising them. Interviews with the Qualified Intellectual Disability Professional (QIDP) and Home Manager (HM) on 9/6/23 revealed that the purpose of the incontinence pads is to prevent damage to furniture and equipment from toileting accidents. Further interview confirmed that use of the incontinence pads violates the clients' right to dignity.	W 125		
W 258	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iv) 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 being considered for training towards new objectives.	W 258		

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W 258	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and interviews. the facility failed to ensure that the Individual Program Plan (IPP) for 1 of 6 clients (client #5) was reviewed at least annually. The finding is: Record review on 9/5/23 revealed a Individual Program plan (IPP) for client #5 dated 10/18/21. Continued record review revealed no evidence that the plan has been reviewed since that date. Interview on 9/6/23 with the Qualified Intellectual Disability Professional (QIDP) an the Home Manager (HM) confirmed there is no IPP for client #5 dated later than 10/18/21.	W 258		
W 472	MEAL SERVICES CFR(s): 483.480(b)(2)(i) Food must be served in appropriate quantity. This STANDARD is not met as evidenced by: Based on observations, review of records and interview, the facility failed to assure food was served in the appropriate quantity for 5 of 6 clients (#1, #2, #3, #4 and #5). The finding is: Observation in the group home on 9/6/23 during the breakfast meal revealed clients to be served grits, turkey bacon, English muffins, butter, juice, milk and water. Continued observation of the morning meal revealed clients #1, #2, #3, #4 and #5 to be served large amounts of grits. The grits were served from a large bowl and the utensil used to serve the grits was a 1 cup scoop. Further observation revealed each client to eat all of the grits served to them. Subsequent observation revealed a daily menu indicating that	W 472		

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W 472	Continued From page 4 the appropriate portion size for grits is as follows: for a regular diet (1800 - 200 calories): 1/2 cup; for all other calorie categories: 1/3 cup. Review of records on 9/6/23 for all clients revealed that clients #1, #2, #3, and #4 are prescribed a regular (1800 - 2000 calorie) diet and that client #5 is prescribed a weight loss diet (1200 calorie) and that clients #1 and #5 have a specific order reading, "no seconds except non-starchy vegetables." Interview on 9/6/23 with the Qualified Intellectual Disabilities Professional (QIDP) and Home Manager (HM) verified that the prescribed diets for client #1, #2, #3, #4 and #5 are current. Continued interview with the QIDP and HM verified that clients #1, #2, #3, #4 and #5 did not receive the appropriate quantity of food items.	W 472		