STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G125	A. BUILDING _____ B. WING _____	R 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANDLER ROAD	**342 CHANDLER ROAD DURHAM, NC 27707**

(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 revisit was conducted on 10/31/23 for all previous deficiencies cited on 8/8/23. All deficiencies were not corrected and no new non-compliance was found. The facility is not in compliance with all regulations surveyed.	W 000		
{W 210}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to obtain an initial Physical Therapy (PT) Evaluation assessment for 1 of 4 audit clients (#6). The finding is: Review on 8/7/23 of client #6's record revealed he had not received a PT evaluation. Further review revealed client #6 was admitted to the facility on 8/9/22. During an interview on 8/8/23, the Administrator confirmed client #6 had not received his intial PT evaluation. A follow up was conducted on 10/31/23: Review on 10/31/23 of client #6's record revealed he still has not received a PT evaluation. During an interview on 10/31/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6 still has not received a PT evaluation.	{W 210}		

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 217}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 4 audit clients (#6) received an initial Nutritional assessment. The finding is: Review on 8/7/23 of client #6's record revealed there was no Nutritional assessment. Further review revealed client #6 was admitted to the facility on 8/9/22. During an interview on 8/9/23, the Administrator revealed client #6 did not have a initial Nutritional assessment. A follow up visit was conducted on 10/31/23: Review on 10/31/23 of client #6's record revealed he still has no Nutritional assessment. During an interview on 10/31/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6 still has not received his Nutritional assessment.	{W 217}		
{W 220}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include speech and language development. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure 1 newly admitted client (#6) received his initial speech/language assessments within 30 days of admission. The finding is:	{W 220}		

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{W 220}	Continued From page 2 Review on 8/7/23 of client #6's record revealed he had not received his initial speech/language assessment within 30 days of admission. Further review revealed client #6 was admitted to the facility on 8/9/22. During an interview on 8/8/23. the Administrator revealed client #6 did not have a speech/language assessment. A follow up visit was conducted on 10/31/23: Review on 10/31/23 of client #6's record revealed he still has no speech/language assessment. During an interview on 10/31/23, the Qualified Intellectual Disabilities Professional confirmed client #6 still does not have a speech/language assessment.	{W 220}		
{W 221}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include auditory functioning. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure an auditory examination for 1 of 4 audit clients (#6). The finding is: Review on 8/7/23 of client #6's record revealed he had not received an auditory examination. Further review revealed client #6 was admitted to the facility on 8/9/22. During an interview on 8/8/23, the Administrator confirmed client #6 had not received his auditory examination.	{W 221}		

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{W 221}	Continued From page 3 A follow up visit was conducted on 10/31/23: Review on 10/31/23 of client #6's record revealed he still had not received his auditory examination. During an interview on 10/31/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6 still had not received his auditory examination.	{W 221}		
{W 263}	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 3 of 4 audit clients (#2, #5 and #6). The findings are: During observations in the home on 8/7/23, the surveyor noticed there were separate locks on the refrigerator, freezer and cabinets in the kitchen. During an interview on 8/7/23, Staff B revealed there is a client who will come into the kitchen and eat items which do not follow his diet consistency and that is why there are locks on the refrigerator, freezer and cabinets. A. Review on 8/7/23 of client #2's Individual Program Plan (IPP) dated 7/19/22 did not include a signed consent allowing for the refrigerator, freezer and cabinets to be locked.	{W 263}		

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{W 263}	Continued From page 4 B. Review on 8/7/23 of client #5's IPP dated 1/23/23 did not include a signed consent allowing for the refrigerator, freezer and cabinets to be locked. C. Review on 8/7/23 of client #6's record did not include a signed consent allowing for the refrigerator, freezer and cabinets to be locked. During an interview on 8/7/23, the Behaviorist confirmed there were no signed consents from the legal guardians of clients #2, #5 and #6. A follow up visit was conducted on 10/31/23: A. Review on 10/31/23 of client #2's Individual Program Plan (IPP) dated 7/19/22 still does not include a signed consent allowing for the refrigerator, freezer and cabinets to be locked. B. Review on 10/31/23 of client #5's IPP dated 1/23/23 still does not include a signed consent allowing for the refrigerator, freezer and cabinets to be locked. C. Review on 10/31/23 of client #6's record still does not include a signed consent allowing for the refrigerator, freezer and cabinets to be locked. During an interview on 10/31/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients #2, #5 and #6 IPP's still do not include a signed consent allowing for the refrigerator, freezer and cabinets to be locked.	{W 263}		
{W 455}	INFECTION CONTROL CFR(s): 483.470(l)(1)	{W 455}		

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{W 455}	Continued From page 5 There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of possible infection and prevent possible cross-contamination. This potentially affected 2 of 6 clients (#1 and #3) in the home. The finding is: During breakfast observations in the home on 8/9/23 at 8:35am, client #1 took a bowl with scrambled eggs that was sitting in front of client #3 and began to eat from it. Further observations revealed Staff A took the bowl of eggs and gave it back to client #3 for which the eggs were meant for. Additional observations revealed client #3 then put the eggs in his plate and began to eat them. At no time was client #3 redirected not to eat the eggs until after the surveyor began asking questions. During an interview on 8/9/23, Staff A revealed he should not have given the bowl of eggs back client #3 who they were meant for. Further interview revealed the eggs should have been thrown out. During an interview in 8/9/23, the Administrator stated client #1 who began eating the eggs should have been allowed to finish eating the eggs and more eggs should have just been made for client #3 who they were meant for in the first place. A follow up visit was conducted on 10/31/23:	{W 455}		

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{W 455}	Continued From page 6 Review on 10/31/23 of the facility's Plan of Correction (POC) revealed no in-service was conducted in reference to cross-contamination during meal times. During an interview on 10/3/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed no in-services where conducted by themselves and the Habilitation Specialist.	{W 455}		
{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 reviews and interviews, the facility failed to ensure each client received a nourishing, well balanced diet including modified specially prescribed diet as prescribed. This affected 1 of 4 audit clients (#3). The finding is: During breakfast observations in the home on 8/8/23 at 8:38am, client #3 picked up a whole muffin and bit into it. Further observations revealed 2 staff were standing directly behind client #3 when he bit into the muffin; but he was not redirected. During an interview on 8/8/23, Staff C revealed client #3's diet consistency is ground. Review on 8/8/23 of client #3's Nutritional Evaluation (no date) stated, "all foods should be	{W 460}		

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{W 460}	Continued From page 7 modified to a ground consistency". Review on 8/8/23 of client #3's Physicians Orders revelaed his diet is a ground consistency. During an interview on 8/9/23, the Administrator revealed client #3's diet is a ground consistency and all his food should be served this way. A follow up visit was conducted on 10/31/23: Review on 10/31/23 of the facility's Plan of Correction (POC) revealed there were no in-services conducted in reference to diet consistencies.	{W 460}		