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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G060	A. BUILDING _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH STREET HOME	112 SMITH STREET CLEVELAND, NC 27013

(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 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to assure the interior and exterior of the facility was sanitary and orderly. The finding is: Observations throughout the 6/27/23-6/28/23 revealed several items in the rear patio area of the facility. Continued observations revealed the items: a shower curtain, a pair of used gloves, 2 office chairs, 2 small trash cans, a cooler full of water and a large bag of lawncare mixture, several metal pipes on top of a weathered cardboard box, a wooden plank fixated on a wooden pole with rusted nails protruding outward, and 2 window screens removed from the windows and propped against the facility. Further observations revealed a broken window in client #4's room, a large hole in the sofa cushion in the living room, damaged blinds hanging in client #3's room, and no blinds in client #6's room. Review of facility documentation on 6/28/23 revealed a work order dated 6/19/23 for the broken window in client #4's room. Review of an emailed dated 4/25/23 revealed a new sofa was needed for the facility. Continued review of the facility documentation did not reveal work orders for the damaged blinds and window screens. Interview with staff in the facility on 6/28/23 revealed they were unsure how long client #4's window had been broken. Interview with the	W 104	W 104 The Program Manager will in-service the QP on ensuring work orders are completed and turned in a timely manner. The clinical team will complete environmental assessments bi-weekly for a period of 30 days and then on a routine basis to ensure the facility is kept in good standing. In the future, the QP will ensure work orders are turned into maintenance and completed.	8/27/23

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

Regional Admin 8/10/23

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 104	Continued From page 1 qualified intellectual disabilities professional (QIDP) on 6/28/23 verified that the window screens may have been removed by client #3 and #6 relative to AWOL and property destruction behaviors. Continued interview with the QIDP revealed that the items in the backyard should be thoroughly cleaned and removed due to clients that have SIBs and aggressive behaviors. Interview with the QIDP also revealed that maintenance requests have not been addressed in a timely manner for the facility. Further interview with the QIDP revealed that the staff should have kept the exterior of the facility clean and free of debris that could be used as a weapon or would cause harm to the clients. Interview with the QIDP also revealed the large metal pieces were from a trampoline that was never installed. Additional interview with the QIDP verified all facility staff have been trained to keep the exterior of the facility clean and to report any repairs as soon as possible.	W 104		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a continuous	W 249	W 249 The behavior analyst will in-service all staff and the RTL on ensuring gates are locked and secured at all times. The clinical team will complete interaction assessments 1x a week for a period of 30 days and then on a routine basis to ensure BSPs are followed as written. In the future, the behavior analyst will ensure all staff are trained on BSPs and ensuring they are followed as written.	8/27/23

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W 249	Continued From page 2 active treatment program consisting of needed interventions were implemented as identified in the person-centered plan (PCP) for 3 of 6 sampled clients (#1, #4, #6). The findings are: A. The facility failed to ensure behavior supports were in place for clients #1, #4 and #6 relative to an exterior gate locking system. For example: Observations throughout the 6/27/23-6/28/23 survey revealed a locking mechanism on the front and sides of the chained link fence surrounding the facility. Continued observations revealed the locks in all gate entries to have a key in the lock in the unlocked position. At no point during the observation did staff secure the gated entries by locking the gates and removing the keys. Review of the record for client #1 on 6/28/23 revealed a revealed a behavior support plan (BSP) dated 12/3/21 which indicated the following target behaviors: physical aggression, self-injurious behavior (SIBs), darting, property disruption, inappropriate food acquisition, invading privacy, inappropriate self-stimulation and feces behavior. Additional review of the 12/2021 BSP indicated that client #1 has exhibited elopement and the client has "gone out windows, entered neighbors' houses and run from placements". Review of the BSP for client #1 did not include a gate locking system, cameras, and door alarms (i.e. behavior supports) as additional behavior interventions to decrease elopement attempts. Review of the record for client #4 revealed a BSP dated 9/10/21 which indicated the following target behaviors: habilitation activity refusal, inappropriate self-stimulation, SIBs, PICA	W 249		

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W 249	Continued From page 3 behaviors, aggression, tantrum behavior, AWOL and inappropriate toileting. Continued review of the 9/2021 BSP for client #4 did not reveal the use of behavior supports relative to AWOL behaviors. Review of the record for client #6 revealed a BSP dated 11/2/22 revealed the following target behaviors: activity refusal, inappropriate touch, inappropriate self-stimulation, inappropriate urination, minor physical aggression, property disruption/destruction, seat belt removal, AWOL, untrue statements, SIBs, invading personal space, loud vocalizations, and pulling or leading staff and other persons. Continued review of the 11/2022 BSP revealed client #6 has "a history of AWOL and will exit any window in the group home. Due to his AWOL attempts and to ensure the client's safety all windows will have alarms placed on them to help staff identify the area he is attempted to flee". Further review of the BSP for client #4 also revealed a more secure locking system was installed and there is a lock on all fence exits due to the client's AWOL behaviors. Interview with the qualified intellectual disabilities professional (QIDP) on 6/28/23 revealed that staff are to ensure the locking system is secured at all times. Continued interview with the QIDP also revealed that the locking mechanism on all fence entries were installed to ensure the safety of clients #1, #4 and #6 and to minimize AWOL attempts. B. The facility failed to ensure communication training objectives were implemented as prescribed for client #1. For example: Observation in the group home on 6/27/23 from 4:45 PM through 5:45 PM revealed client #1 to	W 249		

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W 249	Continued From page 4 participate in a leisure activity. Further observation revealed client #1 to participate in the dinner meal, fix his dinner plate, pour his drinks and take his dishes to the kitchen. Continued observations revealed client #1 to return to his room. Subsequent observations revealed staff to verbally prompt client #1 to transition from one activity to another. At no time during observation did staff implement client #1's communication training objective. Observation in the group home on 6/28/23 from 7:00 AM through 8:30 AM revealed client #1 to participate in a leisure activity. Further observation revealed client #1 to participate in the breakfast meal, fix a bowl of cereal, pour his drinks and take his dishes to the kitchen. Continued observations revealed client #1 to return to his room, enter the living room and then pace between his bedroom doorway and living/dining area. Subsequent observations revealed client #1 to participate in a leisure activity at the dining table, then back to the living room. Additional observation revealed client #1 to get into both surveyors personal space and staff to verbally redirect him to another area. At no time during observation did staff implement client #1's communication training objective. Review of records for client #1 on 6/28/23 revealed a person centered plan (PCP) dated 12/27/22. Further review of the PCP for client #1 revealed training objective goals to include: privacy, bathe, put on clothes, clean work area, communication and oral hygiene. Continued review of the communication training objective revealed the following: When asked the sign for a targeted word, client will independently demonstrate the sign with 90% accuracy over two	W 249		

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W 249	Continued From page 5 consecutive months. This goal should be taught continuously and at naturally occurring times throughout the day. For example, signing medicine when it's time for his medication. Staff should ask client to demonstrated each sign one at a time. (i.e., "show me the sign for _____"). Interview with the qualified intellectual disabilities professional (QIDP) on 6/28/23 revealed all training objectives are current for client #1. Further interview with the QIDP verified client #1 communication objectives should be implemented as written to increase communication skills.	W 249		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to furnish adaptive equipment as prescribed for 1 of 6 clients (#2). The finding is: Observation in the group home on 6/27/23 at 5:10 PM revealed staff A to assist client #2 to transfer from his bedroom to the dining table wearing a gait vest to participate in the dinner meal. Further observation revealed staff to remove the gait vest while the client completed his dinner meal. Continued observation revealed staff to assist client #2 to the bathroom and then the living room	W 436	W 436 The qualified professional will in-service all staff and the RTL on ensuring adaptive equipment is used as prescribed. The clinical team will complete interaction assessments 1x a week for a period of 30 days and then on a routine basis to monitor for adaptive equipment being used as prescribed. In the future, the qualified professional will ensure all staff are trained on People Supported's adaptive equipment and use of it.	8/27/23

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W 436	Continued From page 6 to sit on the sofa without the use of a gait vest. Subsequent observations did not reveal the use of a helmet while ambulating. Observation in the group home on 6/28/23 revealed staff A to assist client #2 to transfer from his bedroom to the dining table to participate in the breakfast meal. Further observation revealed staff to transfer client #2 to the bathroom, medication room, then the livingroom to sit on the sofa. Continued observation did not reveal the use of a gait vest or helmet while ambulating. Review of records for client #2 on 6/28/23 revealed a person centered plan (PCP) dated 7/27/22. Continued review of the 7/22 PCP revealed the following adaptive equipment: gait vest, shirt protector, mug with straw, high sided dish, noise monitor, and helmet. Further review of the PCP for client #2 revealed the gait vest to assist with ambulation, helmet (safety while ambulating due to seizure activity) wears at all times of ambulation except while bathing, eating and/or sleeping. Subsequent review revealed a physical therapy (PT) evaluation dated 8/5/22. Additional review of the PT evaluation revealed the following recommendations: "client must wear his helmet when up standing/walking. Medical staff may want to consider posture/back brace for positioning and alignment if his medical team feels it is necessary. Consistent use of his gait vest". Interview with the qualified intellectual disabilities professional (QIDP) on 6/28/23 revealed the 8/5/22 PT evaluation is current. Continued interview with the QIDP revealed client #2 must	W 436		

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W 436	Continued From page 7 wear all adaptive equipment as prescribed.	W 436		