STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G305	A. BUILDING ______ B. WING ______	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKWOOD	**313 EAST BROOKWOOD AVENUE** **LIBERTY, NC 27298**

(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 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 5 of 6 clients (#1, #2, #4, #5, #6). The findings are: Observations throughout the recertification survey period from 3/19/24 - 3/20/24 revealed exterior door alarms to chime as staff, clients and surveyors entered and exited the group home. Review of client records on 3/20/24 for clients #1, #2, #4, #5 and #6 revealed no signed consents from HRC relative to exit door alarms. Interview with the qualified intellectual disabilities professional (QIDP) on 3/20/24 revealed that signed consent forms could not be located during the survey. Continued interview with the QIDP revealed that she was unaware that all clients needed consents signed by HRC.	W 262		
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 observations, record review and	W 263		

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 263	Continued From page 1 interviews, the facility failed to ensure restrictive techniques were reviewed and approved by the legal guardians for 5 of 6 clients (#1, #2, #4, #5, #6). The findings are: Observations throughout the recertification survey period from 3/19/24 - 3/20/24 revealed exterior door alarms to chime as staff, clients and surveyors entered and exited the group home. Review of client records on 3/20/24 for clients #1, #2, #4, #5 and #6 revealed no signed consents from the guardian relative to exit door alarms. Interview with the qualified intellectual disabilities professional (QIDP) on 3/20/24 revealed that signed consent forms could not be located during the survey. Continued interview with the QIDP revealed that she was unaware that all clients needed consents signed by the guardian.	W 263		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the system for drug administration failed to assure 2 of 6 clients (#2 and #3) were provided the opportunity to participate in medication self-administration or provided teaching relative to name, purpose, and side effects of medications administered. The findings are:	W 371		

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W 371	Continued From page 2	W 371		

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A.The system of drug administration failed to assure client #2 was provided the opportunity to participate in medication self-administration.

Observation on 03/20/24 between 8:02 a.m. -8:14 a.m. revealed DCS A administered Levoner-ETH, Gabapentin, Olanzapine, Vitamin B-6, Acetaminophen ER, Levetiracetam, One-Daily Vitamin, Clonidine, Escitalopram, and Lithium ER to client #2. Further observation revealed client #2 took the medication with a cup of water and walked out of the med room. Client #2 was not observed to have received any medication education or participated beyond receiving medications from Staff A.

Interview with the qualified intellectual disabilities professional (QIDP) on 03/20/24 verified client #2 should have participated in the medication administration.

B. The system of drug administration failed to assure client #3 was provided the opportunity to participate in medication self-administration.

Observation on 03/20/24 between 8:15 a.m. -8:20 a.m. revealed DCS A administered Clearlax, Benztropine, and Dapagliflozin to client #3. Further observation revealed client #3 took the medication with a cup of water and walked out of the med room. Client #3 was not observed to have received any medication education or participated beyond receiving medications from Staff A.

Interview with the QIDP on 03/20/24 verified client #3 should have participated in the medication administration.

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W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure fire evacuation drills were conducted at least quarterly on each shift. This potentially affected all clients residing in the home. The finding is: Review on 03/19/24 of the fire drill records for the facility from 01/23-12/23 revealed fire drills conducted for: Quarter 1: Jan 23(01/10/23 1st shift), Feb 23 (02/17/23 1st shift) Mar 23 (none) Quarter 2: April 23(04/12/23 1st shift), May 23(none), June23(06/06/23 3rd shift) Quarter 3: Jul 23 (none), Aug 23(none), Sept 23(09/06/23 3rd shift) Quarter 4: Oct 23(10/10/23 1st shift), Nov 23(11/05/23 1st shift), Dec 23(12/18/23 1st shift) Further review revealed that there were no start and end times documented for 11 of 12 fire drills. Interview on 03/20/24 with the home manager (HM) and the qualified intellectual disabilities professional (QIDP) revealed that they could not locate any of the missing drills. The HM stated that fire drills should have been conducted during all three shifts, one shift each month in a quarter and included start and end times.	W 440		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by:	W 454		

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W 454	Continued From page 4	W 454		

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Based on observation and interviews the facility failed to ensure proper infection control procedures were followed in order to promote client health/safety and prevent possible cross-contamination. This potentially affected 1 of 6 clients (#2) residing in the home. The findings are:

Observation on 03/20/24 during the medication administration, Staff A was observed assisting client # 2 with taking her medications from an individual wrapped packaging into a small cup. Further observation revealed Staff A dropped one orange pill onto the floor and she retrieved the pill, wiped it with a paper towel, and prompted client #2 to take the pill. Subsequent observation revealed client #2 took the pill with a cup of water and walk out of the med room.

Interview on 3/20/24, the qualified intellectual disabilities professional (QIDP) revealed client #2 should have not been given a pill that fell onto the floor. The QIDP stated that the staff should have gave her another pill and reported it to the Nurse.