| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G277 | A. BUILDING _____ B. WING _____ | 07/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MASON STREET | 306 N MASON STREET APEX, NC 27502 |

| (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 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>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.<br><br>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 2 of 4 audit clients (#4 and #5) received a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of meal guidelines to promote safe eating. The findings are:<br><br>A. During dinner observations at a restaurant on 7/11/23 at 6:00 pm, the Home Manager (HM) sat next to client #4. Client #4 ordered a cheeseburger sandwich for dinner. Client #4 was observed taking quick bites from his burger, overstuffing his mouth. There were no observations of staff at the table, prompting client #4 to slow his eating pace. Client #4 finished his meal, without incident.<br><br>Review on 7/11/23 of the nutritional evaluation from 10/18/22 revealed client #4 was on a regular diet and should eat bite size pieces at a safe rate.<br><br>B. During dinner observations at a restaurant on 7/11/23 at 6:00 pm, revealed client #5 ordered | W 249 | This deficiency will be corrected by the following actions:<br>A. Nutritionist will assess all dietary needs of the people we serve.<br>B. All people served will be afforded food options within their dietary needs or restrictions.<br>C. Occupational Therapy will assess the needs people served<br>D. ISP will be update modified to meet the current dietary needs ( as needed)<br>E. All people served will be in service on their diets and food choices<br>F. All staff will be in-service on their diets and food choices<br>G. All staff will be in-service on any adaptive equipment based on Occupational therapy assessment<br>H. Site Supervisor/designee will monitor one time a week.<br>I. Qualified Professional/designee will monitor one time a week | 09.10.2023 |

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

Marika Mack RN Executive Director 7/21/2023

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 249 | | W 249 | Continue from page 1 | |

Continued From page 1

grilled skinless chicken, prepared bite size pieces for dinner. Client #5 was observed to quickly filled his mouth with food. There were no observations of staff at the table, prompting client #5 to slow his eating pace. No problems were noted with ingestion.

A breakfast observation on 7/12/23 at 7:15 am in the home, revealed Staff D permit client #5 to remove 3 whole pancakes from a bowl. Client #5 hurriedly ate one pancake in 3 large bites. The HM prompted Staff D to get the bowl with the bite sized pancakes, and then client #5 was given an extra pre-cut pancake. Client #5 ate all of the pancakes without incident. Client #5 was observed with two large cups; one clear cup was filled to the rim with water and the fluid level could not be determined in the opaque gray cup.

Review on 7/11/23 of the occupational therapy evaluation from 4/14/23 revealed staff should fill cup halfway or offer two cups half-filled to decrease aspiration risks. Staff should pre-cut foods as needed in the kitchen due to client #5 eating at fast paced.

Interview on 7/12/23 with the HM revealed Staff D normally did not work the morning shift or assist with meal supervision and required some prompting.

Interview on 7/12/23 with the Program Director revealed client #5 likes to eat very fast and meal guidelines need to be followed.

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| W 369 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(2)<br><br>The system for drug administration must assure | W 369 | | |

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| W 369 | Continued From page 2<br>that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure all medications were administered without error. This affected 1 of 4 audit clients (#3). The finding is:<br><br>During observations of medication administration in the home on 7/11/23 at 4:30 pm, Staff A placed two drops of Brimonidine Sol 0.2% OP in the left eye of client #3 plus one drop of Polyvinyl AL SOL 1.4% OP in the right and left eye. An additional observation revealed client #3 received these oral medications: Levetiraceta 750 MG, Stimulant Lax 8.6-50 MG, Baclofen 10 MG and Carvedilol Tab 3.125 MG. No other medication was observed ingested.<br><br>Review on 7/11/23 of the eye drop medication package labels revealed instructions to place 1 drop of Brimonidine Sol 0.2% OP into the left eye. On further review, it revealed there were two boxes of the identical prescription of Polyvinyl AL Sol 1.4% dated for April 2023 and July 2023. The instructions were to place one drop into the right eye of client #3. There was no box of Polyvinyl AL Sol 1.4% to instill in the left eye. An additional review on 7/12/23 of client #3's Physician Orders signed 6/26/23 revealed there was a prescription for Kristalose PAK 10 GM that was not observed given on 7/11/23 between 4:22 PM and 4:45 PM.<br><br>Interview on 7/11/23 with Staff A revealed she placed Polyvinyl AL Sol 1.4% into client #3's right and left eye and did not realize it was a duplicate prescription, only for the right eye. Staff A did not offer an explanation for giving client #3 an extra | W 369 | This deficiency will be corrected by the following actions:<br>A. RN will assess all orders.<br>B. All physician orders will be reviewed for accuracy.<br>C. All staff will be in-serviced on medication procedure and following the guidelines for measuring and dispensing all medications.<br>D. All medication will be dispensed within the designated time frame<br>E. All assessment will be reviewed, and recommendations discussed in core team, quarterly, or ISP.<br>F. Staff will be in service on Medication Administration procedures<br>G. RN will monitor monthly<br>H. Site Supervisor/designee monitor one time a week.<br>I. Qualified Professional/designee will monitor monthly | 09.10.2023 |

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| W 369 | Continued From page 3 drop of Brimonidine Sol 0.2% OP in his left eye. Staff A called the nurse on 7/11/23 at 4:50 PM to notify her of her error.<br><br>Interview on 7/12/23 with the Program Director (PD) revealed the old medication should have been discarded. The PD also revealed staff should have had the physical medication administration record (MAR) available while dispensing meds, to review all orders. | W 369 | | |