STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G138	A. BUILDING _____ B. WING _____	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PARK	1900 LAKE DRIVE LAURINBURG, NC 28352

(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 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, record review and interviews, the facility failed to ensure 1 of 4 audit clients (#5) received a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the area of application of elbow splint. The finding is: During observation in the home on 4/1/24 from 5:15pm to 7:45pm and on 4/2/24 from 7:00am to 8:45am, revealed client #5 had a contracted right wrist and did not wear a splint on right arm, extending to her elbow. On 4/2/24 at 7:15am, a light blue fabric splint was observed laying across equipment; client #5 was sitting in her wheelchair in the living room. Record review on 4/1/24 of the IPP dated 3/5/24 revealed client #5 should wear a hard splint on right arm daily. Interview on 4/2/24 with the home manager (HM) revealed the light blue splint in client #5's room was supposed to be applied in the morning and removed by 2nd shift. The HM returned the splint	W 249		

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

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W 249	Continued From page 1 to the room and did not ensure that client #5 had it on before leaving for the vocational center. Interview on 4/2/24 with the nurse revealed she was new to the home, however nursing monitors the adaptive equipment worn by clients.	W 249		
W 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure med techs were proficiently trained in medication administration procedures. This affected 2 of 4 audit clients (#5 and #6). The findings are: A. During evening observations of medication administration in the home on 4/1/24 at 5:40pm, Staff A measured 30 cc of Lactulose and 25 ml of Levetiraceta Solution into small medication cups. The medications were then transferred to a cup of milk and stirred. There was noticeable residue of the liquid medication in the smaller medication cup that was not gathered before discarded in the trash. Client #5 initially refused to swallow her medications, but drunk it in her bedroom 10 minutes later. Staff A retrieved the cup of milk that was not entirely drunk. Staff A threw the disposable cup with an ounce of milk into the trash can.	W 342		

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W 342	Continued From page 2	W 342		

Interview on 4/2/24 with Nurse B revealed she was new to the home and did not have the opportunity to conduct any refresher training with med techs. The nurse affirmed if staff noticed the liquid medication sticking to the side of the medication cup, it should be turned over to ensure all of it was given. In addition, the nurse revealed staff should ensure that clients drink all of the fluid that the medication was placed in, otherwise you cannot determine how much medicine they consumed.

B. During morning observations of medication administration in the home on 4/2/24 at 7:50am, revealed Staff F was supervising client #6 take her 8 medications. Client #8 was observed to carry her medication cup approximately 10 feet away from the med room and stood in front of the trash can by the kitchen door. Client #8 was turned sideways and put the cup of medication to her mouth, shook the contents in her mouth, threw away the cup and then drunk her water. Staff F was watching client #6 from the inside of the medication room. Staff F was not observed to ask client #6 to show her the medication cup before discarding or to stick out her tongue. The contents of the cup could not be determined at that distance.

Interview on 4/2/24 with Staff F revealed client #6 liked to take her medication at the trash can and Staff F determined client #6 swallowed all of her pills.

Interview on 4/2/24 with Nurse B revealed med techs were expected to stand by clients when they took their medications or to have them stick out tongue to check mouth for pills. The nurse

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W 342	Continued From page 3 stated they must make sure they take meds before walking away.	W 342		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure medications were secured when staff not present. This had the potential to effect 1 of 4 audit clients (#6). The finding is: Observations of medication administration in the home on 4/2/24 at 7:50am, revealed Staff F brought client #6 to the medication room, which was not in a closed office. Staff F unlocked the medication cabinet, removed 8 blister packs of medications and scanned them to the electronic medication administration record (EMAR). Afterward, Staff F placed the blister packs back in the cabinet, clicked the padlock but left the keys inserted in the lock. Staff F walked to the kitchen pantry to retrieve something, before returning to the medication cabinet to unlock and get the packs. Client #6 stood in front of the medication table during this activity. Review on 4/2/24 of the facility's Medication Policy dated October 2018 revealed medications will not be left unattended in the presence of a person. Interview on 4/2/24 with Staff F revealed she went to the kitchen pantry to get several medication cups. Staff F revealed she thought she placed the	W 382		

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W 382	Continued From page 4 keys in her pocket when she stepped away from the medication cabinet. Interview on 4/2/24 with Nurse B revealed she was new to the home and have not been involved in any medication policy procedures yet with staff. Nurse B revealed the medication key should be stored on the med tech at all times.	W 382		
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 review and interview, the facility failed to ensure 3 of 4 audit clients (#1, #2 and #5) received the proper modified diet. The findings are: A. During morning observations in the home on 4/2/24 at 7:13am, a deli meat and cheese sandwich was in a bag on the counter with client #1's name on it. The sandwich was cut into 20 pieces; it had the smallest size pieces of sandwich compared to the five bags for the other clients. It was packed in a cooler and placed on the van with the clients at 8:45am. Record review on 4/2/14 of the diet list from 5/23/23 was inside a kitchen cabinet. It revealed client #1 was on a regular calorie diet of 1/2" to 1" consistency and that finger foods were allowed. Interview on 4/2/24 with the home manager (HM), after examining the contents of the packed	W 460		

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W 460	Continued From page 5	W 460		

sandwiches for lunch, revealed client #1 received larger pieces of bread then the other two clients on a more restricted diet.

B. During dinner observation in the home on 4/1/14 at 7:30pm, revealed Staff C prepared dinner. Staff A was observed telling Staff C to modify the food for client #2 in the kitchen. The lasagna was very hot and soft as Staff C attempted to cut it into smaller pieces. Client #2 received a plate of lasagna that was cut into 2 inch pieces, dinner roll torn into 1 inch pieces and tossed salad with chunky raw tomatoes. Client #1 was observed to eat the food without incident.

C. During dinner observations in the home on 4/1/24 at 7:30pm, revealed Staff C prepared dinner. Staff C cut the lasagna for client #5 into pieces that were larger then 1/4 inch, the roll was torn into 1 inch pieces, the tossed salad had chunky tomato wedges and the fruit cocktail was larger than 1/4 inch. Client #5 ate the meal without incident.

An additional observation on 4/2/14 at 7:13am, revealed 2 prepared lunch meat and cheese sandwiches for clients #2 and #5 already on the kitchen counter. Their bags had sandwiches cut into 12 pieces, larger then 1/4 inch pieces. The sandwich was packed in a cooler and put on the van with the clients at 8:45am.

Interview on 4/2/24 with the HM, revealed the sandwich prepared for client #2 and #5 exceeded 1/4 inch consistency and would need to be cut into small pieces once they arrived at the vocational center.

Interview on 4/2/24 with Nurse B revealed on

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W 460	Continued From page 6 3/29/24 she received a call from staff at the home during the afternoon that client #5 was coughing and had brown emesis. The nurse acknowledged client #5 had a diagnosis of dysphagia and was treated at the emergency room for pneumonia. Nurse B revealed the incident with client #5 was not referred to as aspirated pneumonia but she was awaiting a copy of her hospital discharge summary to review. Client #5 would get a follow-up chest x-ray in two weeks.	W 460		