STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G141	A. BUILDING _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROUP HOME	1101 FRANKLIN BLVD GASTONIA, NC 28054

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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		

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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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) was reviewed and/or updated at least biennially. The finding is: Review on 4/2/24 of the facility's EPP revealed that it was updated on 3/15/2021. Continued review of the EPP showed evidence of three out of five clients in the facility information. Interview on 4/3/24 with the qualified intellectual disabilities professional (QIDP) confirmed that the EPP reviewed was the current information. Continued interview with the QIDP confirmed that the EPP should be reviewed and updated.	E 004		
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, record review and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to assure facility repairs were conducted in a timely manner. The finding is: Observation of the group home during the 4/2/24 - 4/3/24 survey revealed a leather sofa and two	W 104		

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W 104	Continued From page 2 matching armchairs in the living room to have pealing leather, soiled arm rests and a missing seat cushion. Continued observation revealed client #3 to sit on each of the armchairs while participating in leisure activities. Further observation revealed one of the armchairs to have three pillows stacked in the place of the seat cushion. Interview with site home manager (HM) on 4/3/24 revealed she had no knowledge of the missing seat cushion, but she would report the condition of the furnishings to management. Continued interview with the HM revealed additional attention needs to be given to other areas of home to include replacement of stained/soiled bathroom floor mats, bathtubs, baseboards, and the areas around and under all appliances.. Interview with the qualified intellectual disabilities professional (QIDP) on 4/3/24 verified concerns with the condition of the furniture and cleanliness of group home. Continued interview with the QIDP revealed the two chairs will be replaced with new ones and the sofa will be repaired. Further interview with the QIDP revealed clarifications will be made to ensure deep cleaning is performed during the third shift.	W 104		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure that 5 of 5 clients (#1, #2, #3, #4	W 137		

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W 137	Continued From page 3 and #5) have the right to retain and use appropriate personal possessions. The finding is: Observation of the group home during the 4/2/24 - 4/3/24 survey revealed personal items to include a topical, deodorant, powders, and lotion on the counter in two separate resident bathrooms. Continued observation revealed the home manager (HM) to remove a topical, lotion and powder when questioned if client's items should be kept in common areas for public use. Further observation on 4/3/24 revealed a client's deodorant to remain on the counter in the smaller bathroom. Interview with the facility home manager (HM) confirmed each client's personal care items should be stored in their toiletry baskets for their private use. Continued interview with the HM verified personal care items should not be left in common areas such as on bathroom counters.	W 137		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure food was served in a form consistent with the developmental level of 2 of 5 clients (#1 and #4). The findings are: A. The facility failed to ensure diet consistency for client #1. For example: Observations in the group home on 4/2/24 at 5:07 PM revealed the dinner meal to include grill	W 474		

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W 474	Continued From page 4	W 474		

cheese, salad with dressing, tomato soup, and juice. Continued observations revealed staff cut client #1's grill cheese in half and did not provide her meal consistent to bite size. Further observations revealed client #1 to consume the dinner meal and a dessert brownie with no further assistance from staff.

Observations in the group home on 4/3/24 at 7:56 AM revealed the breakfast meal to include an omelet, whole wheat toast, grits, bacon slices, and coffee. Continued observations revealed staff sliced omelet not consistent to bite size. Further observations revealed client #1 consumed the breakfast meal with no further assistance from staff.

Review of records for client #1 on 4/3/24 revealed a nutritional assessment dated 11/3/23. Review of the nutritional assessment for client #1 indicates that the client is prescribed a regular no concentrated sweets diet, bite sized, low cholesterol, low fat, no seconds, and no grapefruit.

Interview with the qualified intellectual disabilities professional (QIDP) on 4/3/24 confirmed client #1's diet as current. Continued interview with the QIDP confirmed that staff should ensure clients receive prescribed diets.

B. The facility failed to ensure diet consistency for client #4. For example:

Observations in the group home on 4/3/24 at 5:48 PM revealed the breakfast meal to include an omelet, whole wheat toast with jelly, bacon slices, grits, and protein shake. Continued observations revealed staff to cut up omelet and toast to bite

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W 474	Continued From page 5 size with a rocker knife. Further observations at 8:20 AM revealed staff to feed client #4's bacon in whole consistency. Review of records for client #4 on 4/3/24 revealed a nutritional assessment dated 1/16/24. Review of the nutritional assessment for client #4 indicates that the client is prescribed a chopped diet, nectar thick liquid, may use straw, low cholesterol, low fat, no concentrated sweets, no seconds, simply thick to be used in liquid lactic milk. Interview with the QIDP on 4/3/24 confirmed client #4's diet as current. Continued interview with the QIDP confirmed that staff should have provided client #4 with a chopped diet.	W 474		