STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G210	A. BUILDING _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUCKASEEGEE GROUP HOME	5400 TUCKASGEE ROAD CHARLOTTE, NC 28208

(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 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Behavior Support Plan (BSP) for 2 of 3 audit clients (#1 and #3) was reviewed and revised as needed after completion of an objective. The findings are: A. Review on 4/3/24 of client #1's clinical record revealed a BSP dated 11/17/22 with a target date of 11/1/23 for target behaviors: property misuse and anxiety. No current BSP could be located. Interview on 4/3/24 with the qualified intellectual disabilities professional (QIDP) confirmed no current BSP for clients #1 was completed. B. Review on 4/3/24 of client #3's clinical record revealed a BSP dated 10/11/22 with a target date of 10/10/23 for target behaviors: physical aggression, SIB, and sleep disturbance. No current BSP could be located. Interview on 4/3/24 with the QIDP confirmed no current BSP for client #3 was completed.	W 255		
W 259	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.	W 259		

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 259	Continued From page 1 This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the comprehensive functional assessments (CFA) were reviewed annually and updated as needed. This affected 3 of 3 audit clients (#1, #3 and #4). The findings are: A. Review on 4/3/24 of client #1's record revealed no CFA was located in the chart. Interview on 4/3/24 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that he could not locate a copy of client #1's CFA in the computer system nor in client #1's record. B. Review on 4/3/24 of client #3's record revealed the CFA was last updated on 9/12/19. Interview on 4/3/24 with the QIDP revealed that he was unaware that the CFAs were to be reviewed or updated annually. He revealed that he was trained to do them every five years. C. Review on 4/3/24 of client #4's record revealed no CFA was located in the chart. Interview on 4/3/24 with the QIDP revealed that he could not locate a copy of client #4's CFA in the computer system nor in client #4's record.	W 259		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	W 260		

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W 260	Continued From page 2 failed to ensure the Individual Program Plan (IPP) was revised at least annually. This affected 2 of 3 audit clients(#1 and #3). The finding is: A. Review on 4/3/24 of client #1's record revealed an IPP dated 11/04/22. No current IPP was located. Interview on 4/3/24 with the qualified intellectual disabilities professional (QIDP) confirmed no current IPP for client #1 was available for review. B. Review on 4/3/24 of client #3's record revealed an IPP dated 10/11/22. No current IPP was located. Interview on 4/3/24 with the QIDP confirmed no current IPP for client #3 was available for review.	W 260		
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 observation, record review and interview, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 2 of 5 clients (#3 and #5). The findings are: Observations throughout the recertification survey period from 4/2/24 - 4/3/24 revealed exterior door alarms to chime as staff, clients and surveyors entered and exited the group home.	W 262		

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W 262	Continued From page 3 Review of client records on 4/3/24 for clients #3 and #5 revealed no signed consents from HRC relative to exit door alarms. Interview with the qualified intellectual disabilities professional (QIDP) on 4/3/24 revealed that signed consent forms could not be located during the survey. Continued interview with the QIDP verified HRC limitation consent forms for all clients should be updated and signed by the HRC annually.	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 interviews, the facility failed to ensure restrictive techniques were reviewed and approved by the legal guardians for 2 of 5 clients (#3 and #5). The findings are: Observations throughout the recertification survey period from 4/2/24 - 4/3/24 revealed exterior door alarms to chime as staff, clients and surveyors entered and exited the group home. Review of client records on 4/3/24 for clients #3 and #5 revealed no signed consents from the guardian relative to exit door alarms. Interview with the qualified intellectual disabilities professional (QIDP) on 4/3/24 revealed that signed consent forms could not be located during	W 263		

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W 263	Continued From page 4 the survey. Continued interview with the QIDP verified HRC limitation consent forms for all clients should be updated and signed by the legal guardian annually.	W 263		