STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G110	A. BUILDING ______ B. WING ______	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSS II GROUP HOME	**1615-B MOSS SPRINGS ROAD** **ALBEMARLE, NC 28001**

(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 000	INITIAL COMMENTS A complaint survey was completed on 4/24/24 for intake #NC00215155. The complaint was substantiated. No deficiencies were cited.	W 000		
W 190	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' developmental, This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure direct care staff were adequately trained with regard to privacy. This affected 2 of 6 clients (#1 and #6). The findings are: A. The facility failed to provide privacy for client #1. For example: Observations in the group home on 4/24/24 at 7:23 AM revealed client #1 to enter the bedroom. Continued observations at 7:25 AM revealed the client to exit the bedroom and enter the bathroom to urinate in the toilet with the door open. Further observations revealed the client to exit the bathroom and staff C to prompt client #1 to wash his hands. At no time was staff observed to assist client #1 with providing privacy while in the bathroom by closing the bathroom door. Interview on 4/24/24 with the ICF Director confirmed that all clients should be provided with privacy. Continued interview with the ICF Director revealed that staff should assist clients while using the bathroom by closing the doors. B. The facility failed to provide privacy for client #6. For example:	W 190		

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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	34G110	A. BUILDING ______ B. WING ______	C 04/24/2024

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W 190	Continued From page 1 Observations in the group home on 4/24/24 at 7:29 AM revealed client #6 to enter the bathroom and sit on the toilet with the door open. Continued observations at 7:31 AM revealed another client to walk past the opened door while client #6 was using the toilet. Further observations revealed staff B to walk past the open door, prompt another client, and they both left the area. Subsequent observations revealed client #6 to make loud moaning sounds and staff C to walk to the bathroom door and ask the client if she needed anything. Additional observation at 7:33 AM revealed staff C to leave the area to obtain wet wipes and return to the bathroom, provide wipes, and close the bathroom door to assist client #6. Interview on 4/24/24 with the ICF Director confirmed that all clients should be provided with privacy. Continued interview with the ICF Director confirmed that staff should have provided client #6 with privacy by closing the bathroom door.	W 190		
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:	W 249		

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W 249	Continued From page 2	W 249		

Based on observations, record review and interview, the facility failed to ensure 2 of 6 clients (#5 and #6) received a continuous active treatment program consisting of needed interventions as identified in the person-centered plan (PCP). The findings are:

A. The facility failed to implement training objectives for client #5. For example:

Observation throughout the 4/23-24/24 survey revealed client #5 to participate in a dinner and breakfast meal. Continued observations revealed client #5 was never prompted to pour his beverage into his cup at mealtime.

Review of records for client #5 revealed a PCP dated 12/5/23 which indicated a training objective to pour his beverage in his cup at mealtime with three physical prompts, 85% of the time for 12 consecutive months.

Interview with the ICF director on 4/24/24 verified client #6's training goals to be current. Continued interview confirmed client's training objective should be supported at all opportunities.

B. The facility failed to implement training objectives for client #6. For example:

Observation throughout the 4/23-24/24 survey revealed client #6 to participate in a dinner and breakfast meal. Continued observations revealed client #6 was never prompted to wipe her area after each meal.

Review of records for client #6 revealed a PCP dated 12/5/23 which indicated a training objective to wipe her area after meals daily with two verbal

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	34G110	A. BUILDING ______ B. WING ______	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSS II GROUP HOME	**1615-B MOSS SPRINGS ROAD ALBEMARLE, NC 28001**

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W 249	Continued From page 3 prompts at 85% accuracy. Interview with the ICF director on 4/24/24 verified client #6's training goals to be current. Continued interview confirmed client's training objective should be supported at all opportunities.	W 249		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure 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 interview, the facility failed to ensure all drugs were administered without error for 1 of 6 clients (#6) during medication administration. The finding is: Observation in the group home on 4/24/24 at 7:00 AM revealed staff A and client #6 to both sanitize hands. Continued observation revealed staff A to obtain medications from the medication cart and bins. Further observation revealed staff A to sanitize hands and apply gloves, sanitize the client's hands, punch medications, prepare MiraLAX in water, give nasal spray, and give eye drops. Subsequent observations revealed staff A to give client #6 all medications in medicine cup to take with Sucralfate 10 ml and MiraLAX. Review of records for client #6 on 4/24/24 revealed physician orders dated 1/4/24. Review of the 1/4/24 physician orders revealed medications to administer to client #6 at 8:00 AM to be adult multivitamin gummies chew, Align Cap 4 MG, Fluticasone 50 MCG Spray, Low-Ogestrel Tab, Methimazole Tab 5 MG, Nasal	W 369		

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MOSS II GROUP HOME	**1615-B MOSS SPRINGS ROAD ALBEMARLE, NC 28001**

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W 369	Continued From page 4 Decongestant Tab 10 MG, Olopatadine 0.2% SOL, Pantoprazole Tab 40 MG one tablet by mouth twice daily before meals ***Do Not Crush***, Polyethylene Glycol Powder 238 GM, Risperidone Tab 1 MG, SF 5000 Plus Cream 1.1%, Sucralfate SUS 1 GM/10 ML take by mouth three times daily 2 hours after meals, and Vitamin D3 50 MCG (2000IU). During survey medication administration observation of staff, staff A was observed to administer all medications for client #6 after breakfast which included the medication Pantoprazole Tab 40 MG that should have been administered before breakfast and Sucralfate SUS 1 GM/10 ML that should have been taken by mouth 2 hours after meals. Interview with the facility nurse on 4/24/24 confirmed the 1/4/24 physician orders for client #6 to be current. Continued interview with the facility nurse revealed that staff should administer all medications as prescribed.	W 369		
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 observation and interview, the system for drug administration failed to assure 2 of 2 clients (#1, and #6) observed during medication administration were provided the opportunity to participate in medication self-administration or provided teaching related to name, purpose and side effects of medication administered. The	W 371		

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	34G110	A. BUILDING ______ B. WING ______	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSS II GROUP HOME	**1615-B MOSS SPRINGS ROAD** **ALBEMARLE, NC 28001**

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W 371	Continued From page 5 findings are: A. The system for drug administration failed to assure client #1 was provided the opportunity to participate in medication self-administration. For example: Observation in the group home 4/24/24 at 7:46 AM revealed staff A to prepare medications for administering for client #1 by the client punching the medications into the medication cup with some assistance from staff. Continued observation revealed staff A to hand client #1 the medication cup, the client to take all medications with bottled water, sanitize hands, and the client to exit the medication area. Client #1 was not observed to receive any training during medication pass or to participate beyond taking medications from staff A and drinking bottled water. Interview with the facility nurse on 4/24/24 verified that staff should train and educate all clients during medication administration. Continued interview with the facility nurse revealed that staff are provided a list of medications and side effects located in the medication room. B. The system for drug administration failed to assure client #6 was provided the opportunity to participate in medication self-administration. For example: Observation in the group home 4/24/24 at 7:00 AM revealed staff A to remove medications for client #6 from medication cart and prepare medications for administering by punching them into the medication cup with the exception of two medications that were punched by client #6.	W 371		

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W 371	Continued From page 6 Continued observation revealed staff A to hand client #6 a medication cup and the client to take all medications. Further observation revealed staff A to hand client #6 Sucralfate 10 ml in a medicine cup and client to drink. Subsequent observation revealed staff A to hand the client MiraLAX in a small cup of water and the client to drink it. Client #6 was not observed to receive any training during medication pass or to participate beyond taking medications from staff A. Interview with the facility nurse on 4/24/24 verified that staff should train and educate all clients during medication administration. Continued interview with the facility nurse revealed that staff are provided a list of medications and side effects located in the medication room.	W 371		
W 374	DRUG ADMINISTRATION CFR(s): 483.460(k)(7) The system for drug administration must assure that drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure all drugs were packaged in accordance with state law. This affected 1 of 6 clients (#6). The finding is: Observation in the group home on 4/24/24 at 7:00 AM during medication administration, staff A was observed to punch client #6's evening medication Bromocriptine Mesylate 2.5 MG tab into a medicine cup. Continued observations revealed staff A to catch the mistake and remove the pill from the medicine cup. Further observations revealed staff A to place the pill back into the	W 374		

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	34G110	A. BUILDING ______ B. WING ______	C 04/24/2024

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MOSS II GROUP HOME	1615-B MOSS SPRINGS ROAD ALBEMARLE, NC 28001

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W 374	Continued From page 7 bubble packet and place a piece of tape on the back and return the packet to the medicine cart. Subsequent observations revealed that the staff continued to administer all of client #6's medication. Interview with the facility nurse on 4/24/24 revealed that staff did not notify nursing that client #6's medication was punched in error. Continued interview with the facility nurse revealed that staff should have placed the medication in a baggy, label the baggy, place it in the disposal box, and notify nursing so a replacement order can be made for the client.	W 374		
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 6 clients (#5, #6). The findings are: A. The facility failed to ensure diet consistency for client #5. For example: Observations in the group home on 4/23/24 at 6:05 PM revealed the dinner meal to include sloppy joe's, cooked carrots, salad with dressing, fruit cup, milk, and juice. Continued observations revealed client's #5 to receive and consume a sloppy joe that was cut into quarter pieces. Review of records for client #5 on 4/24/24 revealed a nutritional evaluation dated 3/31/24.	W 474		

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W 474	Continued From page 8 Review of the evaluation indicated the client's diet order as regular, food cut into small bite size pieces, seconds as desired. Interview with the ICF director on 4/24/24 verified the diet order for client #5 is current. Continued interview confirmed staff are responsible for ensuring clients receive their diet orders as prescribed. B. The facility failed to ensure diet consistency for client #6. For example: Observations in the group home on 4/23/24 at 6:05 PM revealed the dinner meal to include sloppy joe's, cooked carrots, salad with dressing, milk, and juice. Continued observations revealed client's #6 to receive and consume a sloppy joe that was cut into quarter pieces. Observations in the group home on 4/24/24 at 6:45 AM revealed the breakfast meal to include scrambled eggs, grits, toast, milk, and juice. Continued observations revealed client's #6 to receive and consume the toast in whole form. Review of records for client #6 on 4/24/24 revealed a nutritional evaluation dated 3/31/24. Review of the evaluation indicated the client's diet order as 1400 calories, staff to cut her food into bite size pieces, prompt to slow down. Interview with the ICF director on 4/24/24 verified the diet order for client #6 is current. Continued interview confirmed staff are responsible for ensuring clients receive their diet orders as prescribed.	W 474		