STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G144	A. BUILDING _____ B. WING _____	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILDCAT GROUP HOME	208 WILDCAT ROAD DEEP GAP, NC 28618

(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
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.	E 037		

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

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E 037	Continued From page 1 (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	E 037		

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E 037	Continued From page 2 policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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E 037	Continued From page 3 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 4 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide and maintain documentation of annual staff training on the Emergency Preparedness Plan (EPP). The finding is: Review of facility documentation on 6/18/24 revealed an EPP dated 3/2024. Continued review of the 3/2024 EPP did not reveal evidence of an annual staff in-service training. Interview with the qualified intellectual disabilities professional on 6/18/24 verified that evidence of the facility EPP in-service training could not be located during the survey. Continued interview with the QIDP verified that the EPP in-service training should be completed and documented annually, and updates are conducted as needed.	E 037		
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	W 249		

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W 249	Continued From page 5 objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the person-centered plan (PCP) in the areas of leisure activities, program implementation, and adaptive equipment use. This affected 10 of 11 audit clients (#2, #3, #4, #5, #7, #9, #10, #12, #13 and #14). The findings are: A. During observations in the home on 6/17/24 from 4:15pm until 6:15pm (a total of 120 minutes), clients #2, #3, #4, #5, #7, #9, #12, #13 and #14 were observed to sit in the living room of the home with the same movie playing repeatedly. During the observations, the clients sat unengaged by staff, with the exception of client #3 who would ask staff questions, and they would respond. Subsequent observations in the facility on 6/17/24 from 4:20 PM - 5:25 PM revealed client #10 to sit in the dining room area holding a magazine in his hand. Continued observations revealed client #10 to repeatedly tear pieces of paper from the magazine. Further observations revealed staff to pick up the torn pieces of paper and provide client #10 with another magazine to continue tearing the pages. Additional observations revealed client #10 to sit in the dining room area for 65 minutes of unengaged and unstructured time.	W 249		

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W 249	Continued From page 6 Further observations in the home on 6/18/24 from 6:15am until 6:43am (a total of 28 minutes) revealed client #2 to sit at the piano in the dining room, unengaged by staff. Interview on 6/18/24 with the qualified intellectual disabilities professional (QIDP) verified staff should be engaging clients in leisure activities during down time and when not completing training. B. During observations in the home on 6/17/24 from 4:15pm until 6:15pm, client #2 was observed to repeatedly hit himself in the face and put his hand in his mouth. At no time during the observations were interventions implemented by staff to redirect client #2. Review on 6/17/24 of client #2's person-centered plan (PCP) dated 8/15/23 revealed client #2 is supported with a behavior support plan(BSP). Review on 6/18/24 of client #2's BSP dated 9/25/23 revealed target behaviors including self-injurious behavior (SIB) including hitting himself on the chin, face and head, as well as mouthing hands. Continued review of the BSP revealed for him hitting himself on the chin, face or head, staff should apply wrist weights and leave them on for 3 - 5 minutes. If client #2 continues to hit himself, add weight and leave on for an additional 5 minutes. For hand mouthing, staff should routinely apply mitts/gloves. Interview on 6/18/24 with the QIDP confirmed staff should follow client #2's BSP as written to redirect the target behaviors. C. During observations in the home on 6/17/24	W 249		

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W 249	Continued From page 7	W 249		

from 4:15pm until 6:15pm, client #2 was observed to sit in his wheelchair. At no time during the observations was client #2 offered to sit in the recliner.

During additional observations in the home on 6/18/24 from 6:15am until 7:45am, client #2 was observed to sit in his wheelchair. At no time during the observations was client #2 offered to sit in the recliner.

Review on 6/17/24 of client #2's PCP dated 8/15/23 revealed a health service goal to prevent skin breakdown due to incontinence, "Reposition frequently and allow for sufficient out of wheelchair time."

Interview on 6/18/24 with the facility nurse and QIDP confirmed staff should offer client #2 time out of his wheelchair.

D. During observations in the home on 6/17/24 from 4:15pm until 6:15pm, client #9 was observed to sit in his wheelchair. Continued observations on 6/17/24 client #9 was observed to sit in his wheelchair in the suite's common area. At no time during the observations was client #9 wearing his AFO's.

Review on 6/17/24 of client's #9 PCP dated 8/30/23 revealed client's adaptive equipment to include a wheelchair with pin release seatbelt, rifton pacer gait trainer, hospital bed low to the ground with standard mattress, floor mat, chest harness and AFO's to be worn during awake hours.

Interview on 6/18/24 with the facility nurse confirmed client #9 should be wearing his AFO's

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W 249	Continued From page 8 during awake hours as prescribed.	W 249		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) 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 clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure staff were sufficiently trained in health needs and maintenance. This affected 1 of 11 audit clients (#7). The finding is: During observations in the home on 6/17/24 from 4:15pm until 6:15pm, client #7 was observed laying in his bed, on his back, with his left arm propped up on a pillow. At no point during the observations was client #7 repositioned. Additional observations in the home on 6/18/24 from 6:15am until 7:45am, client #7 was observed laying in his bed, on his back, with his left arm propped up on a pillow. At no point during the observations was client #7 repositioned. Review on 6/18/24 of client #7's record revealed client #7 has a history of pressure sores. Continued review revealed he is currently on bed rest due to pressure sores, and should be up only for meals and showers. Continued review revealed repositioning guidelines for client #7 to be repositioned every 2 hours, from right, back, to left.	W 340		

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W 340	Continued From page 9 Interview on 6/18/24 with the facility nurse revealed client #7 moved to the facility on 5/17/24 from a sister home. The facility nurse stated client #7 should be repositioned every 2 hours per his guidelines. However, the facility nurse stated she has not formally trained the staff on these guidelines.	W 340		
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 and interviews, the facility failed to assure all medications and biologicals remained locked except when being prepared for medication administration for 2 sampled clients (#4 and #9). The finding is: Observations throughout the recertification survey from 6/17/24-6/18/24 revealed various prescribed topical's in client #4's shower bin located in an unlocked cabinet in the bathroom. Continued observations revealed a prescribed medicated shampoo for client #9 in his shower bin located in an unlocked cabinet in the bathroom. Interview with the facility nurse on 6/18/24 revealed staff have been trained to keep prescribed topical's locked when they are not being administered. Continued interview with the facility nurse revealed all prescribed medications should be locked in the medication room when they are not being used for the clients.	W 382		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii)	W 474		

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W 474	Continued From page 10 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 reviews, and interviews, the facility failed to ensure liquids were served in a form consistent with the developmental level for 2 of 11 audit clients (#13 and #14). The findings are: A. During observations in the home on 6/17/24 at 5:50pm revealed two 8 ounce cups of water on the table in front of client #13. Staff E was observed to pump 8 pumps of Simply Thick Easy Mix thickener into both cups of water and stir the mixture. Subsequent observations revealed Staff C to spoon feed client #13's liquids to him. Review on 6/17/24 of client #13's diet order posted in the dining room of the home revealed client #13 liquids should be nectar thick. Continued review revealed a handwritten note for 6 pumps of thickener to be added into each serving of liquid. Review on 6/18/24 of the Simply Thick Easy Mix container revealed for 8 ounces of liquids, two pumps of thickener should be added, and stirred briskly for 30 seconds. Interview on 6/18/24 with the facility nurse and qualified intellectual disabilities professional (QIDP) confirmed staff should thicken client #13's liquids as directed on the thickener container. B. During observations in the home on 6/17/24 at 5:48pm revealed client #14 sitting at the dining room table. There were two empty 8 ounce cups on the table in front of client #14. Staff E was	W 474		

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W 474	Continued From page 11 observed to pump two pumps of Simply Thick Easy Mix thickener into both cups. At 5:51pm, Staff C was observed to pour water into both cups, place the lid on them, and client #14 was observed to drink his liquids. At no time during the observation was client #14's liquids stirred prior to him being served. Review on 6/17/24 of client #14's diet order posted in the dining room of the home revealed client #14 is on nectar thick liquids. Review on 6/18/24 of the Simply Thick Easy Mix container revealed for 8 ounces of liquids, two pumps of thickener should be added, and stirred briskly for 30 seconds. Interview on 6/18/24 with the facility nurse and QIDP confirmed staff should thicken client #14's liquids as directed on the thickener container.	W 474		