STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G222	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JADE TREE	6501 JADE TREE LANE RALEIGH, NC 27615

(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 conducted on 5/2/24 for intake #NC00214803. The complaint was substantiated with deficiencies cited.	W 000		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were sufficiently trained to provide monitoring for client #3 as indicated. This affected 1 of 4 audit clients. The finding is: Review on 5/2/24 of client #3's record and Individual Program Plan (IPP) dated 3/14/24 revealed client #3 had experienced a fall in December 2023 and was hospitalized and later received rehab for a broken hip from January 2024 until February 2024. Interview on 5/2/24 with Staff A (3rd shift) revealed client #3 had fallen in his room before she began working in the home in January '24. Additional interview indicated she checks on client #3 in his bedroom "every hour" throughout the night. Interview on 5/2/24 with the Program Director revealed after client #3's fall in his bedroom, staff had been told to increase their overnight checks on him from "every hour to every 30 minutes". Additional interview indicated these checks are documented on client #3's sleep check sheet which is completed by staff on a daily basis.	W 189	W189 A review of systems revealed that staff did not follow directives by the Program Director to increase bed checks to every 30 minutes. To correct this deficiency, the PD will retrain all staff to do bed checks q 30 minutes on client #3 and to document 30 minute bed checks until such time that the treatment team determines that we can decrease the bed checks to every one hour. The PD will retrain staff and will monitor the documentation monthly to assure that 30 minute bed checks are completed and to assure that this deficiency doesn't occur again. 7-1-24	

RECEIVED
MAY 20 2024
DHSR-MH Licensure Sect

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alyse Shirey, MHA, BSW QIDP	CEO	5-16-24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G222	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JADE TREE	6501 JADE TREE LANE RALEIGH, NC 27615

(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 189	Continued From page 1 Review on 5/2/24 of client #3's sleep check sheet for 2/25 - 5/2/24 revealed only hourly checks had been completed for the client throughout the night.	W 189		
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 observations, record reviews, and interviews, the facility failed to ensure 4 of 4 audit clients (#1, #2, #3 and #4) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of meal preparation, dining and behavior plan implementation. The findings are: A. Upon arrival to the home on 5/2/24 at 6:00am, Staff B was observed in the kitchen beginning to prepare food items for the breakfast meal. No clients were in the kitchen at this time. Additional observations from 6:00am - 7:05am, the staff continued to perform various meal preparation tasks to prepare grits, ham, bacon, bagels with creme cheese and apple slices. After preparing the breakfast meal, Staff A proceeded to place	W 249	W249 - A review of systems revealed that a new employee did not understand her training regarding a consumer's IPP in meal prep and dining and the implementation of behavior plans. To correct this issue, the Program Director and the QP will re-train the staff in following the IPP regarding all issues, but especially as it concerns meal prep and dining. Additionally, the Program Director with the QP will also re-train the new employee on ways to implement a client's behavior plan. To prevent this from occurring again, the Program Director (or designee, like lead staff) on a monthly basis will monitor the new employee to assure she is following meal prep and dining and other IPP issues. The QP (or designee) will monitor the correct implementation of the behavior plan to assure these issues do not occur again.	7-1-24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G222	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JADE TREE	6501 JADE TREE LANE RALEIGH, NC 27615

(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	Continued From page 2 food items on individual plates in the kitchen before taking the plates to the table for the breakfast meal. At 7:10am, Staff A began packing lunches for clients to take to the workshop. Immediate interview with Staff A revealed they had made the sandwiches for the client's lunches and put fruit into individual containers. Although several clients sat unengaged in living room during this time, no clients were prompted or encouraged to assist with preparing food items, setting the table, serving themselves or preparing/packing their lunches. Interview on 5/2/24 with Staff B revealed she had worked in the home for 3 or 4 weeks and had been trained on how things work in the home by the home's supervisor. The staff indicated she had not been told she should not prepare client's plates for them or cook meals without their participation. Review on 5/2/24 of client #1's IPP dated 2/22/24 revealed she "participates in all parts of meal preparation including cooking, setting the table and cleaning up." Additional review of the plan noted she can serve herself from a bowl/platter, mix beverages, prepare simple snacks/meals and identify kitchen appliances. Review on 5/2/24 of client #3's IPP dated 3/14/24 indicated he has strengths to prepare simple drinks, do simple meal prep, participate in cooking skills using the microwave, stovetop and oven, serve himself from a bowl/platter and participate in setting the table. Additional review of the plan included an objective to participate in weekly meal preparation with no more than 3 verbal prompts at least 25% of the time.	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G222	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JADE TREE	6501 JADE TREE LANE RALEIGH, NC 27615

(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	Continued From page 3 Review on 5/2/24 of client #4's IPP dated 1/24/24 revealed needs in the areas of using a knife for spreading, making simple snacks, preparing a beverage and setting the table without prompts. Additional review of the client's Adaptive Behavior Inventory (ABI) dated 11/30/23 indicated the client has partial independence with all meal preparation tasks. Interview on 5/2/24 with the Program Director confirmed all clients should be involved with meal preparation tasks in the home. B. During morning observations in the home on 5/2/24 from 6:30am - 8:01am, client #1 and client #4 sat in the living room unengaged. With the exception of eating breakfast, the clients were not prompted or encouraged to complete any other tasks. During this time, client #4 entered the dining room area on two occasions and was immediately prompted by staff to return to the living room until breakfast was ready. No activities were offered to the clients. Interview on 5/2/24 with Staff A revealed clients in the home participate in leisure activities in the evenings on second shift. Additional interview indicated in the mornings they complete chores before going to the day program. Review on 5/2/24 of client #1's IPP dated 2/22/24 revealed she likes watching TV, putting puzzles together and spending time in her room. Review on 5/2/24 of client #4's IPP dated 1/24/24 revealed he needs "several prompts to complete a task...enjoys engaging in activities, especially outdoors...enjoys looking at books and magazines..."	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G222	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JADE TREE	6501 JADE TREE LANE RALEIGH, NC 27615

(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	Continued From page 4 Interview on 5/2/24 with the Program Director confirmed staff should be assisting the clients with getting involved with activities in the morning. C. During morning observations in the home on 5/2/24 from 6:30am - 7:30am, client #2 was slamming the clothes dryer door and cursing and staff redirected client #2 to his bedroom. Further observation client #2 came out of his room ran down the hallway to the kitchen area and staff redirected him back to his bedroom. Client #2 was in his bedroom slamming doors, banging on the dresser and cursing when staff redirected him to calm down and stay in his bedroom. Review on 5/2/24 of client #2's behavior intervention plan (BIP) dated 2/16/24 revealed for target behaviors client #2 will have 10 minutes of "contingent observations", Client #2 is not to be in his room during contingent observation. Interview on 5/2/24 of staff A revealed she had witnessed other staff directing client #2 to go to his room when he had a behavior, and she did the same as what she had witnessed. Interview on 5/2/24 with the Program Director confirmed staff should follow the BIP.	W 249		
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.	W 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G222	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JADE TREE	6501 JADE TREE LANE RALEIGH, NC 27615

(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 262	Continued From page 5 This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the constituted committee reviewed, approved and monitored the use of a device which violated client #3's right to privacy. This affected 1 of 4 audit clients. During observations in the home on 5/2/24, a video camera was mounted in client #3's bedroom and pointed towards his bed. A monitor located on a table in the living room of the home showed a live stream of client #3's bedroom. Interview on 5/2/24 with Staff A revealed the facility had placed the camera in client #3's bedroom to better monitor him after he had gotten out of bed and fallen a few months ago. The staff indicated they view the monitor periodically to see if he is getting out of bed. Review on 5/2/24 of client #3's record revealed consent dated 2/26/24 had been obtained from client #3's guardian for the video monitoring system to address his getting up at night; however, the record did not include written consent from the constituted committee to incorporate the use of the camera. Interview on 5/2/24 with the Program Director confirmed client #3's guardian had given written consent for the camera in the client's bedroom; however, no consent had been obtained from their constituted committee.	W 262	W262 - A review of systems revealed that while the guardian approved the monitor for the consumer, the HRC did not approve the monitor. To correct this issue, the monitor was taken out of the consumer's room, and a "motion sensor" device has been ordered to replace the monitor which does not show any pictures of the consumer. To prevent this from occurring again, the HRC has approved the use of the motion sensor and we are awaiting the arrival of the device and approval from the guardian to utilize the motion sensor device.	7-1-24
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client	W 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G222	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JADE TREE	6501 JADE TREE LANE RALEIGH, NC 27615

(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 288	Continued From page 6 behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a technique to manage client #3's behavior was included in an active treatment program. This affected 1 of 4 audit clients. The finding is: During observations in the home on 5/2/24, a video camera was mounted in client #3's bedroom and pointed towards his bed. A monitor located on a table in the living room of the home showed a live stream of client #3's bedroom. Interview on 5/2/24 with Staff A revealed the facility had placed the camera in client #3's bedroom to better monitor him after he had gotten out of bed and fallen a few months ago. The staff indicated they view the monitor periodically to see if he is getting out of bed. Review on 5/2/24 of client #3's record revealed consent dated 2/26/24 had been obtained from client #3's guardian for the video monitoring system to address his getting up at night; however, the record did not include a formal program to incorporate the use of the camera. Interview on 5/2/24 with the Program Director confirmed client #3's guardian had given consent for the camera in the client's bedroom; however, the device was not incorporated into a formal plan.	W 288	W288- A review of systems revealed that the use of the monitor in the client's room was not added as an addendum or incorporated into in the client's IPP or formal plan. To correct this issue and to prevent it from occurring again, ASI removed the monitor. It is being replaced by a motion sensor device that does not show any pictures of the client in question. Usage of the motion sensor device has been approved by the Human Rights Committee, and the QP will incorporate this as an addendum to the client's IPP or formal plan.	7-1-24
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G222	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JADE TREE	6501 JADE TREE LANE RALEIGH, NC 27615

(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 340	Continued From page 7 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 record reviews and interviews the facility failed to ensure the staff were sufficiently trained to implement appropriate health and hygiene methods and were competent in medication administration procedures. This affected 2 of 4 audit clients (#2 and #3). The findings are: A. Review on 5/2/24 of client #2's physician orders dated 2/29/24 revealed blood sugars taken weekly every Sunday of the month. Further review of client #2's medication administration record revealed blood sugars were not documented on April 24th, 22nd or the 28th. The month of March was unavailable to be reviewed. The month of February were not taken on the 22th and 25th for 2024. B. Review on 5/2/24 of client #3's physician orders dated 4/20/24 revealed blood sugars taken three times a day and insulin given on the sliding scale. The month of February 23-29, 2024 blood sugars were not taken one time a day and no insulin given per the sliding scale. The month of March was unavailable to be reviewed. Interview on 5/2/24 with the nurse revealed she visits the home twice a month and reviews the medication administration records when in the home. The nurse revealed she had trained the new staff in the home earlier this week. However, unable to provide training documentation. The nurse confirmed that client #2's blood sugar	W 340	W340 - A review of systems revealed that ASI's RN did not have appropriate documentation on the client's blood sugar. To correct this issue, the RN will retrain all staff and assure that she has written documentation of such training. To prevent this from occurring again, the RN will monitor client's blood sugar documentation by the DSP's on a monthly basis and document such monitoring to assure that the blood sugars of all clients are taken and documented correctly. In that month of monitoring the documentation, if she should find any employee either not taking blood sugars accurately or not documenting blood sugars accurately, she will immediately re-train that employee who will not be allowed to work until she is satisfied that the employee knows the proper way to take blood sugars and document them. Written monitoring by the RN should be sent to the Clinical Director/QP to become a part of client's Treatment Team file.	7-1-24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G222	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JADE TREE	6501 JADE TREE LANE RALEIGH, NC 27615

(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 340	Continued From page 8 should be taken weekly and recorded. The nurse confirmed that client #3's blood sugars were taken incorrectly in the month of February.	W 340		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure physician's orders were being followed. This afftect 2 of 4 audit clients (#2 and #3). The findings are: A.Review on 5/2/24 of client #2's physician orders dated 2/29/24 revealed blood sugars taken weekly every Sunday of the month. Further review of client #2's medication administration record revealed blood sugars were not documented on April 14th, 21st or the 28th. The month of March was unavailable to be reviewed. The month of February were not taken 11th and 25th for 2024. B. Reviw on 5/2/24 of client #3's physician orders dateed 4/10/24 revealed blood sugars taken three times a day and insulin given on the sliding scale. The month of February 23-29, 2024 blood sugars were not taken one time a day and no insulin given per the sliding scale. The month of March was unavailable to be reviewed. The month of April 2024, when blood sugars are less than 100 no insulin should be given 14 times blood sugars were below 100 and 5 units of insulin was given. Interview on 5/2/24 with the nurse revealed she visits the home twice a month and reviews the	W 368	W368 - A review of systems revealed that the RN could not substantiate that blood sugars were taken accurately on certain dates in February and April, and she didn't provide documentation for March. In conjunction with TAG W340, to correct this issue, the RN will retrain all staff and assure that she has written documentation of such training. To prevent this from occurring again, the RN will monitor client's blood sugar documentation by the DSP's on a monthly basis and document such monitoring to assure that the blood sugars of all clients are taken and documented correctly. In that month of monitoring the documentation, if she should find any employee either not taking blood sugars accurately or not documenting blood sugars accurately, she will immediately re-train that employee who will not be allowed to work until she is satisfied that the employee knows the proper way to take blood sugars and document them. Written monitoring by the RN should be sent to the Clinical Director/QP to become a part of client's Treatment Team file. 7-1-24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G222	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JADE TREE	6501 JADE TREE LANE RALEIGH, NC 27615

(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 368	Continued From page 9 medication administration records when in the home. The nurse confirmed that client #2's blood sugar should be taken weekly and recorded. The nurse confirmed that client #3's blood sugars were taken incorrectly in the month of February.	W 368		
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 observations, record review, and interviews, the facility failed to ensure all medications were administered without error. This affected 2 of 4 audit clients (#2). The finding is: Review on 5/2/24 of client #2's physician orders dated 2/29/24 revealed Dorzolamide Hcl/Timolol 2-0-.5% Instill 2 drop in both eyes twice daily. Interview on 5/2/24 with staff A revealed she did not give client #2 eye drops this morning because she forgot. Staff A confirmed client #2 should have gotten eye drops this morning. Interview on 5/2/24 with the nurse confirmed client #2 should have received eye drops this morning. The nurse also confirmed she was unaware of client #2 not receiving his eye drops.	W 369	W369 - A review of systems revealed that a staff did not administer eye drops for client #2. To correct this issue, the staff who did not administer the eye drops will be retrained in medication administration and will not be allowed to pass meds until such time as the RN feels the staff is sufficiently trained and passes all tests to be able to pass meds accurately. To prevent this from occurring again, the RN will monitor all medication records for medication errors at least twice a month. if the RN finds there is a medication error, she will immediately pull that staff from passing medication and will retrain them in medication administration before being allowed to pass medication again.	7-1-24