PRINTED: 06/18/2024 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIEN CIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |         |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|--|--|---------|---|-------------------------------|----------------------------|
|  |  | 34G094   | B. WING                                |         |   | 06/                           | 18/2024                    |
|  | PROVIDER OF SUPPLIER   |  |  | 5713 NE | ADDRESS, CITY, STATE, ZIP COI<br>EWTON STREET<br>MILLS, NC 28348                                  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                     |         | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE                      | (X5)<br>COMPLETION<br>DATE |
| W 249  | formulated a client'<br>each client must re<br>treatment program<br>interventions and s<br>and frequency to se   | erdisciplinary team has a significant sign | W 2                                    | 49      |   |                               |                            |
|  | objectives identified plan.  This STANDARD is Based on observareview, the facility for received a continuous consisting of needed identified in the Indithe area of adaptivity 1 of 3 audit clients.  During observation the home throughout 6/18/24, client #1 with strap under his chirobserved to be remarked to be remarked.  Interview on 6/18/2 #1 wears the helmout she thinks they when he is in the bright Review on 6/17/24 Plan (BSP) dated 4/2 plan (B | is not met as evidenced by: tions, interviews and record failed to ensure each client ous active treatment program ed interventions and services lividual Program Plan (IPP) in e equipment use. This affected (#1). The finding is: as at the day program and in out the survey on 6/17 - vore a soft helmet secured by a n. At no time was the helmet noved from client #1's head. observed to attempt to remove   |  |         |   |                               |                            |
| LABORATOR'   | ·  | when ambulating or out of his DER/SUPPLIER REPRESENTATIVE'S SIGN   | NATURE                                 |         | 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.

Event ID: V6XW11

Facility ID: 944881

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|   | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   | G  | COMPL   |                            |
|---|---|---|---|--|---------|----------------------------|
|   |   | 34G094  | B. WING _   |  | 06/18   | 3/2024                     |
| NAME OF PROVIDER OR SUPPLIER  HOPE MILLS HOME |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE  5713 NEWTON STREET  HOPE MILLS, NC 28348 |  |         |                            |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| W 249   | wheelchair. The he (1) hour and fifty (5 removed from his will remain off for the should be reminded helmet is placed or removed from his assist and monitor wheelchair." Additionally dated 3/3/24 noted to keep his helmed encourage to take combative, he may and 50 at a time."  Interview on 6/18/2 and Qualified Intel (QIDP) confirmed | elmet should be worn for one 50) minutes and then will be head. The protective helmet en (10) minute intervals. Staff ed to document when the in his head and again when head. 1:1 staff will always him when he is out of the fonal review of the client's IPP d, "Sometimes [Client #1] wants on when sitting, staff should off, if [Client #1] becomes y wear it but no longer than 1 hr | W 24  | 9  |         |                            |
| W 303   | hour and 50 minut QIDP confirmed cremoved for 10 minut PHYSICAL RESTICFR(s): 483.450(c) A record of restraikept. This STANDARD Based on observations, the facility restrictive helmet indicated. This affinding is:  During observation the home through 6/18/24, client #1 strap under his ch  | tes with 10 minutes off. The<br>lient #1's helmet should be<br>inute breaks.<br>RAINTS  | W 30  | 3  |         |                            |

PRINTED: 06/18/2024 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLI<br>A. BUILDING  | E CONSTRUCTION      |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|---|---------------------|--|-------------------------------|----------------------------|
|  |   | 34G094  | B. WING             |  | 06                            | /18/2024                   |
|  | PROVIDER OR SUPPLIER  |   | 57                  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>713 NEWTON STREET<br>OPE MILLS, NC 28348                       |                               |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHI<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |
| W 303  | The client was not the helmet.  Interview on 6/18/2 #1 wears the helm but she thinks they when he is in the bedocument the use indicated not on he it on".  Review on 6/17/24 Plan (BS P) dated has a history of fall placed on his head wheelchair. The he (1) hour and fifty (fremoved from his will remain off for should be reminded helmet is placed or removed from his assist and monitor wheelchair." Addit Individual Program "Sometimes [Clier on when sitting, stoff, if [Client #1] be wear it but no long Further review of documentation she last documented on 6/18/2 and Qualified Interview on 6/18/2 and Interview on | observed to attempt to remove 24 with Staff A revealed client at "at all times" on their shift by take it off on 2nd shift and bed. When asked if they of his helmet, the staff ar shift "because he always has  I of client #1's Behavior Support 4/17/24 revealed, "[Client #1] II and a protective helmet will be d when ambulating or out of his elmet should be worn for one 50) minutes and then will be head. The protective helmet ten (10) minute intervals. Staff and to document when the an his head and again when head. 1:1 staff will always ar him when he is out of the ional review of the client's an Plan (IPP) dated 3/3/24 noted, at #1] wants to keep his helmet aff should encourage to take ecomes combative, he may ger than 1 hr and 50 at a time."  Client #1's helmet use eets revealed the helmet was an 8/26/23.  24 with the Behavior Specialist llectual Disabilities Professional | W 303               |  |                               |                            |
|  | hour and 50 minut   | client #1 wears his helmet for 1 tes with 10 minutes off. w indicated staff should be   |                     |  |                               |                            |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |         | IPLE CONSTRUCTION   | (X3) DATE<br>COMF  | (X3) DATE SURVEY COMPLETED |  |
|---|--|---|---------|---|--|----------------------------|--|
|   |  | 34G094  | B. WING |   | 06/1   |                            |  |
| NAME OF PROVIDER OR SUPPLIER  HOPE MILLS HOME       |  |   |         | STREET ADDRESS, CITY, STATE, ZIP CODE  5713 NEWTON STREET  HOPE MILLS, NC 28348 |  |                            |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICI   | S JIMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG C |         | (EACH CORRECTIVE ACTIO  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>PROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                            |  |
| W 303   | The second secon | n page 3 ecord for the use of his helmet.   | W 3     | 03  |  |                            |  |
|   |  |   |         |   |  |                            |  |
|   |  |   |         |   |  |                            |  |
|   |  |   |         |   |  |                            |  |
|   |  |   |         |   |  |                            |  |
|   |  |   |         |   |  |                            |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: V6XW11

Facility ID: 944881

If continuation sheet Page 4 of 4

Shemicka Monwe 6.21.2024

**HOPE MILLS** 

#W249

The facility will ensure that all clients 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.

Behavior Specialist will re-Inservice all DSA staff on person supported #1 use of adaptive

equipment, helmet, as ordered on the physician's orders.

Behavior Specialist will conduct Interaction Assessments 2x a month for three consecutive

months to ensure Person Supported adaptive equipment is being utilized per physician order

**TARGET DATE: AUGUST 17, 2024** 

#W303

The facility will ensure Person Supported #1's restricted helmet and all Persons Supported

adaptive equipment use is documented as indicated.

Behavior Specialist will re-Inservice all DSA staff on person supported #1 use of adaptive

equipment documentation, as ordered on the physician's orders.

Behavior Specialist will conduct Interaction Assessment 2 x a month for three consecutive

months to ensure Person Supported adaptive equipment documentation is being utilized and documented per physician order.

**TARGET DATE: AUGUST 17, 2024**