

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

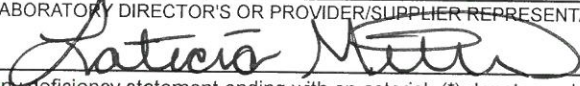
PRINTED: 06/06/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G219</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/05/2024</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>LITTLE RIVER GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4161 NC HWY 127 TAYLORSVILLE, NC 28681</b>
--	--

(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 125	<p><b>PROTECTION OF CLIENTS RIGHTS</b> CFR(s): 483.420(a)(3)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that 1 out of 6 clients (#5) was treated with dignity and respect regarding the use of incontinence padding. The finding is:</p> <p>During observations in the home on 6/4/24 at 4:15 PM, client #5 was observed sitting in a recliner in the living room of the group home with an incontinence pad clearly visible under the client's body.</p> <p>During observations in the home on 6/5/24 at 6:30 AM, client #5 was observed to sit in the living room recliner with an incontinence pad clearly visible under the client's body.</p> <p>Interview with the Ancillary Services Coordinator revealed that the purpose of the incontinence pads is to prevent damage to furniture and equipment from toileting accidents. Further interview confirmed that use of the incontinence pads violates the clients' right to dignity.</p>	W 125		8/14/24
W 249	<p><b>PROGRAM IMPLEMENTATION</b> CFR(s): 483.440(d)(1)</p> <p>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</p>	W 249	<p><b>RECEIVED</b> JUN 13 2024 DHSR-MH Licensure Sect</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>QP</b>	(X6) DATE <b>6/11/24</b>
---	--------------------	-----------------------------

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G219</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/05/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE RIVER GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4161 NC HWY 127 TAYLORSVILLE, NC 28681</b>	
(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	<p>Continued From page 1 and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure that 1 of 6 clients (#5) received a continuous active treatment program as identified in the Person-Centered Plan (PCP) relative to the use of adaptive equipment. The finding is:</p> <p>Observations in the group home on 6/4/24 at 4:30 PM revealed client #5 to be seated in a recliner in the living room of the home with a wheelchair folded and standing next to the recliner. Continued observation at 5:00 PM revealed client #5 to transfer to the wheelchair with the assistance of 2 staff and then to be pushed to the restroom. Further observation at 5:23 PM revealed staff to assist client #5 into his wheelchair and to push the wheelchair to the dining room table for his evening meal. At no time was a rolling walker present in the vicinity of client #5 nor offered by staff to client #5 to use for ambulation in the home.</p> <p>Observations in the group home on 6/5/24 at 6:50 AM revealed client #5 to exit the restroom while seated in the wheelchair and using his feet to propel the wheelchair. Continued observation revealed client #5 to propel the wheelchair into the medication room and to remain there until he exited the medication room and went to the dining room table. At no time was a rolling walker present in the vicinity of client #5 nor offered by staff to client #5 to use for ambulation in the</p>	W 249		8/4/24

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G219</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/05/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE RIVER GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4161 NC HWY 127 TAYLORSVILLE, NC 28681</b>		
(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 home.  Record review on 6/5/24 revealed a physical therapy (PT) evaluation dated 2/7/24 which recommends, "Continue gait training with rolling walker and assist." Continued record review revealed a PCP dated 2/7/24 which incorporated the recommendations of the physical therapist. Further record review revealed documentation of a staff in-service training on 11/7/23 which states, "Staff should assist client #5 to walk to the dining room for meals."  Interview with the qualified intellectual disability professional (QIDP) and the ancillary services coordinator confirmed that the PCP and PT evaluations are current and that staff should make a rolling walker available and offer it to client #5 for use in ambulating in the group home.	W 249			

## Protection of Clients Rights

W125

The facility will ensure that the rights of all clients are being met. The facility will treat all individuals with dignity and respect regarding the use of incontinence padding not being placed in the living room under the client's body. The facility will ensure that staff are trained on the protection of individuals rights. The QP and or designee will monitor through direct observation, on a weekly basis, within the home.

Completion Date: 8/4/24

## Program Implementation

W249

The facility will ensure that staff are trained on providing continuous active treatment as identified in the Person-Centered Plan related to the adaptive equipment. The facility will ensure that staff are trained on continued gait training with rolling walker and assist. The QP and or designee will monitor through direct observation, on a weekly basis, within the home.

Completion Date: 8/4/24