STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G243	A. BUILDING _____ B. WING _____	R 07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTSIDE RESIDENTIAL	**467 SOUTH CREEK ROAD ORRUM, NC 28369**

(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 revisit was conducted on July 29, 2024 for all previous deficiencies cited on April 23, 2024. Some deficiencies were corrected and some were recited.	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 observation, documentation and interviews, the facility failed to ensure staff were sufficiently trained in the usage of rollator for 1 of 5 audited clients (#1). The findings are: During afternoon observations in the home on 4/22/24 at 12:00pm, client #1 received a telephone call. She got up from the couch and walked into the other room without using her walking. Staff B was sitting on the rollator and revealed client #1 will take phone calls in her bedroom. Client #1 returned to the living room area after the phone call walking without her rollator. Staff B remained sitting on the rollator once client #1 returned to the couch. Further observation on 4/22/24 at 3:00pm, staff B was sitting on client #1 rollator while client #1 sat on the couch. Review of the doctor's consultation dated 2/2024 the order of a rollator for Ataxic gait and referral to physical therapy. Interview on 4/22/24 staff B revealed client #1 received the rollator about a month ago. She had	{W 189}		

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

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{W 189}	Continued From page 1 not received any training for the rollator. Interview on 4/23/24 the Licensed Practical Nurse (LPN) revealed client #1 received the rollator from a doctor's visit due to an unsteady gait. LPN confirmed there has been no training on the use of the rollator for the staff at the group home. The follow up survey completed on 7/29/24 revealed: Review on 7/29/24 of the facility's Plan Of Correction (POC) dated 6/20/24 revealed the Nurse, Qualified Intellectual Disabilities Professional (QIDP) and Program Manager would monitor weekly for compliance of the use of the rollator by client #1 and staff and an in-service with staff would be completed. Review of in-service sheets on 7/29/24 revealed staff were in-serviced on the usage of rollator. However, the in-service was not clear on what information was reviewed by staff. An interview on 7/29/24 with the QIDP revealed that the facility had not done any monitoring. Therefore, the facility remains out of compliance.	{W 189}		
{W 252}	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by:	{W 252}		

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{W 252}	Continued From page 2	{W 252}		

Based on observations, record reviews and interviews, the facility failed to ensure data relative to the accomplishment of objective criteria was documented in measurable terms. This affected 2 of 5 audit clients (#4 and #6). The findings are:

A. Review on 4/22/24 of client #6's Individual Program Plan (IPP) dated 5/10/23 revealed formal training programs for exercise, applying lotion, toothbrushing, washing upper body, wearing hearing aid, identifying value of coin combinations and correctly interacting with peers.

Review on 4/23/24 of client #6's program plan data sheets for March 2024 and April 2024 of goals that are run in the home revealed the client was on home visit from 4/8/24 - 4/22/24. No data was collected for any of those goals for the month of March or April.

Review on 4/23/24 of client #6's program plan data sheets for March 2024 and April 2024 of goals that are run at the day program revealed data was completed April 8 - April 11, 2024 when client was said to be on home leave.

B. Review on 4/22/24 of client #4's IPP dated 11/10/23 revealed formal training programs for hygiene, and money management.

Review on 4/23/24 of client #4's program data sheets for March 2024 and April 2024 of goals that are scheduled for the home revealed data was collected for 8 days, schedule for 31 days in March 2024. Data documented for 5 days in the month of April 2024 scheduled frequency for the goal was daily.

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{W 252}	Continued From page 3 Interview on 4/23/24 with the habilitation specialist confirmed the goals were not being completed as written. She had planned to schedule an inservice for the staff at the home since a lot of them were new. The follow up survey completed 7/29/24 revealed: Review on 7/29/24 of the facility's Plan of Correction dated 6/20/24 revealed that the Program Manager and Qualified Intellectual Disabilities Professional (QIDP) would monitor documentation submitted for compliance. Review on 7/29/24 of client #4's program data sheets for July of goals that are scheduled for the home revealed data was collected for 4 days. Review on 7/29/24 of client #6's program data sheets for July of goals that are scheduled for the home revealed data was collected for 10 days. Interview on 7/29/24 with the QIDP revealed she was aware that data was still not being taken as prescribed. Therefore, the facility remains out of compliance.	{W 252}		
{W 287}	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a technique to manage inappropriate behavior was not used for the convenience of staff for 1 of 5 audit clients (#2).	{W 287}		

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{W 287}	Continued From page 4 The finding is: During observations in the home on 4/22/24 from 11:25 and through 12:35pm, client #2 was noted to ambulate using a walker. Further observations on 4/22/24 from 2:30pm through 5:00pm, client #2 was noted to be in a wheelchair. Observations on 4/23/24 from 6:30am through 8am, client #2 was noted to ambulate using a walker. Interview on 4/22/24 with staff D revealed nursing instructed staff to keep client #2 in a wheelchair to keep him from walking around because he likes to get into things and go in other clients rooms. Staff D also revealed that client #2 tries to ambulate often without using the walker. Interview on 4/23/24 with the facility's registered nurse (RN) revealed client #2 was admitted 4/16/24 and has not been evaluated by physical therapy yet. However, the RN revealed staff were trained to have client #2 ambulate in the home using a walker and that the client could use a wheelchair for long distances. The RN confirmed client #2 should be allowed to ambulate as independently as possible and should be using a walker in the home. The follow up survey completed on 7/29/24 revealed: Review on 7/29/24 of the facility's Plan of Correction dated 6/20/24 revealed that the nurse will ensure client #2 had been evaluated by physical therapy (PT) and staff would be	{W 287}		

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{W 287}	Continued From page 5 in-serviced on use of adaptive equipment. Review of in-service sheets on 7/29/24 revealed staff were in-serviced on the usage of adaptive equipment. However, the in-service was not clear on what information was reviewed by staff. Interview on 7/29/24 with the nurse revealed PT had evaluated the client. However, no evaluation could be located. Therefore, the facility remains out of compliance.	{W 287}		
{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 observations, record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 1 of 5 audit clients (#3). The finding is: A. During afternoon observations in the home on 4/22/24 at 4:14pm, staff D was observed administering Artificial Tears, Olanzapine and Lorazepam to client #3. Record review 4/23/24 of client #3's physician's orders dated 2/26/24 revealed an order for "Refresh Instill 1 drop in each eye three times daily at 8am, 2pm and 8pm". Interview on 4/23/24 with the facility's licensed practical nurse (LPN) confirmed client #3 should not have received eye drops at 4:14pm. The LPN	{W 368}		

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{W 368}	Continued From page 6 revealed medications can be given 1 hour before or 1 hour after the time a medication is ordered. B. During morning observations in the home on 4/23/24 at 8:14am, staff A was observed administering Cetaphil, Lorazepam, Amlodipine, Naproxen, Silodosin, Vitamin B12, Olanzapine, Dutastenide, Multivitamin, Lubiprostone, Metoprolol, Quetiapine to client #3. Record review on 4/23/24 of client #3's physician's orders dated 2/26/24 revealed an order for "Refresh Instill 1 drop in each eye three times daily at 8am, 2pm and 8pm". Interview on 4/23/24 with the LPN revealed client #3 should have received eye drops at 8am medication pass. The follow up survey completed 7/29/24 revealed: Review on 7/29/24 of the facility's Plan of Correction (POC) dated 6/20/24 revealed that the nurse, program manager and/or Qualified Intellectual Disabilities Professional (QIDP) would conduct weekly med pass observations and staff would be in-serviced on medication administration. Review of in-service sheets on 7/29/24 revealed staff were in-serviced on medication administration. However, the in-service was not clear on what information was reviewed by staff. Interview on 7/29/24 with the facility nurse confirmed there was no documentation of weekly med pass monitoring. Therefore, the facility remains out of compliance.	{W 368}		

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{W 382} {W 382}	Continued From page 7 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 observations and interview, the facility failed to ensure all medications remained locked except when being administered. The findings are: During observations in the home on 4/22/24 at 4:07pm, staff D is unable to find the medication room key. Staff D went outside to stop staff A as she was leaving for the day to ask where the keys were. Staff A came back inside, walked into the unlocked medication room and got the keys for staff D. For an unspecified amount time, the medication room was left unlocked with the keys inside and no locks on the cabinets that contained medications. During observations in the home on 4/23/24 at 6:56am, staff F revealed that medication room keys are in a box on the wall in the hallway by the medication room. Surveyor observed the box to be unlocked and opened. Interview on 4/23/24 with staff A revealed that the medication room key is supposed to be on the person assigned to medications at all times and should not be left in the box in the hallway. Interview on 4/23/24 with the facility's registered nurse (RN) revealed the medication room key should be in a safe location at all times such as a locked key box or on the staff that is assigned to medications for that shift. The RN confirmed the	{W 382} {W 382}		

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{W 382}	Continued From page 8 medication room should never be left unlocked where anyone has access to the room nor should the key be left in the box in the hallway. The follow up survey completed on 7/29/24 revealed: Review on 7/29/24 of the facility's Plan of Correction (POC) dated 6/20/24 revealed the nurse, program manager and/or Qualified Intellectual Disabilities Professional (QIDP) would monitor weekly to ensure compliance and staff would be in-serviced on ensuring medication room is locked. Review of in-service sheets on 7/29/24 revealed staff were in-serviced on medication administration. However, the in-service was not clear on what information was reviewed by staff. Interview on 7/29/24 with the QIDP revealed there was no documentation of monitoring. Therefore, the facility remains out of compliance.	{W 382}		
{W 383}	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure only authorized persons have access to the keys to the drug storage area. The finding is: During observations in the home on 4/22/24 at 4:07pm, staff D is unable to find the medication room key. Staff D went outside to stop staff A as she was leaving for the day to ask where the keys	{W 383}		

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{W 383}	Continued From page 9	{W 383}		

were. Staff A came back inside, walked into the unlocked medication room and got the keys for staff D.

During observations in the home on 4/23/24 at 6:56am, staff F revealed that medication room keys are in a box on the wall in the hallway by the medication room. Surveyor observed the box to be unlocked and opened.

Interview on 4/23/24 with staff A revealed that the medication room key is supposed to be on the person assigned to medications at all times and should not be left in the box in the hallway.

Interview on 4/23/24 with the facility's registered nurse (RN) revealed the medication room key should be in a safe location at all times such as a locked key box or on the staff that is assigned to medications for that shift. The RN confirmed the medication room should never be left unlocked nor should the key be left in the box in the hallway.

The follow up survey completed on 7/29/24 revealed:

Review on 7/29/24 of the facility's Plan of Correction dated 6/20/24 revealed the nurse, program manager and/or Qualified Intellectual Disabilities Professional (QIDP) would monitor weekly to ensure compliance and staff would be trained on ensuring medication room key is secured.

Review of in-service sheets on 7/29/24 revealed staff was in-serviced on the medication administartion review. However, the in-service was not clear on what information was reviewed

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{W 383}	Continued From page 10 by staff. Interview on 7/29/24 with the QIDP revealed there was no documentation of monitoring. Therefore, the facility remains out of compliance.	{W 383}		