STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G185	A. BUILDING _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DALMOOR DRIVE GROUP HOME	4400 DALMOOR DRIVE CHARLOTTE, NC 28212

(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 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to assure facility repairs or removal of furniture were conducted in a timely manner. The finding is: During observations in the group home on 7/30/24 - 7/31/24 revealed an oversized broken blue sofa chair with no seat cushion sitting near the window in client #1's bedroom. Interview with staff A on 7/31/24 revealed the oversized broken sofa chair was taken out of living room and placed in client #1's bedroom. Staff A was unaware if a work order was completed to have the chair removed or repaired. Continued interview with staff A revealed that he was unaware of how long the sofa chair was in client #1's bedroom and that client #1 was unable to sit and watch tv in his room. Interview with the Clinical Supervisor Residential Service (CSRS) on 7/31/24 verified that the broken oversized sofa chair should have not been placed in client #1's bedroom and that a work order will be completed to repair the chair.	W 104		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by:	W 130		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G185	A. BUILDING _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DALMOOR DRIVE GROUP HOME	4400 DALMOOR DRIVE CHARLOTTE, NC 28212

(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 130	Continued From page 1 Based on observation and interview, the facility failed to assure that privacy was maintained for 1 of 5 clients (client #1) during personal care. The finding is: Morning observations in the home on 7/31/24 at 6:42 AM revealed client #1 to be seated on the toilet nude with the bathroom door open to the extent client #1 could be observed from the hallway. Continued observation revealed client # 3 attempted to enter the bathroom to brush his teeth and staff A redirected client # 3 out the bathroom. The bathroom door remained completely open until 6:51AM and client #1 was observed to be visible on the toilet during the entire time. Further observation at 7:03AM revealed Staff B assisted client #1 out of the bathroom to his bedroom across the hall nude. Client #1 was visible to the hallway and dining room area. Staff B remained in the bedroom and the door remained open during the entire time client #1 was getting dressed. Interview with the Clinical Supervisor Residential Service (CSRS) on 7/31/24 verified that staff should be observing privacy during personal care by closing the bathroom and bedroom door.	W 130		
W 193	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure 1 of 5 clients	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G185	A. BUILDING _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DALMOOR DRIVE GROUP HOME	4400 DALMOOR DRIVE CHARLOTTE, NC 28212

(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 193	Continued From page 2 (client #1) received the needed interventions as identified in their behavior support plan (BSP) relative to prevention and proactive measures. The finding is: During morning observations on 7/31/24 revealed upon entering the home, a strong urine odor that was lingering in the dining room area, hallway, and client #1's bedroom. Continued observation revealed client #1 was lying down on the sofa in the living room while staff B was in client #1's bedroom pouring pet deodorizer powder onto a wet area near the left corner wall. Further observation revealed staff B returned to the bedroom with a bucket of water and a mop to clean the floor in client #1's bedroom. At no point did staff B prompt client #1 to help with cleaning the urine off the floor in his bedroom. Interview with the staff B revealed client #1 urinates on the floor and wall in the same corner of his bedroom every morning. Staff B stated that staff cleans the area every morning once client #1 awakes and exits the bedroom. Staff B was unaware if client #1 had an emergency toilet for his bedroom to possibly prevent client #1 from urinating on the floor and wall. Staff B stated that client #1 will not go to the bathroom when he wakes up in the morning and this has been an ongoing behavior. Record review on 7/30/24 revealed a current behavior support plan (BSP) dated 12/6/23. The BSP revealed target behaviors of agitation, PICA, inappropriate toileting, food seeking, and physical aggression. Further review of the BSP revealed strategies for handling client #1's inappropriate toileting as written staff were to prompt client #1 to help clean up the urine immediately and that	W 193		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G185	A. BUILDING _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DALMOOR DRIVE GROUP HOME	4400 DALMOOR DRIVE CHARLOTTE, NC 28212

(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 193	Continued From page 3 client #1 should have an emergency bedside commode in his room. Interview with the Clinical Supervisor Residential Service (CSRS) on 7/31/24 verified client #1 does have a current BSP that addresses his inappropriate toileting behavior. Further interview with the CSRS verified staff failed to follow the BSP.	W 193		
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. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that updated, written informed consents from the human rights committee (HRC) was secured for exterior and interior door chimes for 5 of 5 clients (#1, #2, #3, #4, and #5). The finding is: During observations on 7/30/24 and 7/31/24 at the facility revealed all exterior door alarms to ring upon clients, staff and surveyors entering and exiting the facility. Continued observation revealed an interior door alarm on client # 1's bedroom door. Review of the records for clients #1, #2, #3, #4, and #5 on 7/31/24 did not reveal an updated signed consent from HRC for the alarms on the exterior exit doors and client #1's bedroom door. Interview with the Clinical Supervisor Residential	W 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G185	A. BUILDING _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DALMOOR DRIVE GROUP HOME	4400 DALMOOR DRIVE CHARLOTTE, NC 28212

(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 4 Service (CSRS) revealed that the facility had not obtained HRC consents for clients #1, #2, #3, #4, and #5.	W 262		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure restrictive techniques were reviewed and approved by the legal guardians for 5 of 5 clients (#1, #2, #3,#4, and #5). The finding is: During observations on 7/30/24 and 7/31/24 at the facility, revealed all exterior door alarms to ring upon clients, staff and surveyors entering and exiting the facility. Continued observation revealed an interior door alarm on client # 1"s bedroom door. Review of the records for clients #1, #2, #3, #4, and #5 on 7/31/24 did not reveal an updated signed consent from the legal guardian for the alarms on the exteriors exit doors and client # 1's bedroom door. Interview with the Clinical Supervisor Residential Service (CSRS) revealed that the facility had not obtained guardian consents for clients #1, #2, #3, #4, and #5.	W 263		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure	W 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G185	A. BUILDING _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DALMOOR DRIVE GROUP HOME	4400 DALMOOR DRIVE CHARLOTTE, NC 28212

(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 371	Continued From page 5	W 371		

that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.
This STANDARD is not met as evidenced by:
Based on observation and interview, the system for drug administration failed to assure 3 of 3 clients (#3,#4 and #5) observed during medication administration were provided the opportunity to participate in medication self-administration or provided education related to name, purpose and side effects of medications administered. The findings are:

A. The system for drug administration failed to assure client #3 was provided the opportunity to participate in medication self-administration. For example:

During a medication administration observation on 7/31/24 at 6:30 AM revealed staff A to prepare medications for client #3 by punching the medications out the blister pack into the medication cup. Continued observation revealed staff A to hand client #3 the medication cup, he took all medications with a cup of water and the client exited the med room. Client #3 was not observed to receive any training during the medication pass or to participate beyond taking medications from staff A.

Interview with the facility nurse on 7/31/24 verified that client #3 had some level of independence to participate with the training and education during the medication administration.

B. The system for drug administration failed to assure client #4 was provided the opportunity to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G185	A. BUILDING _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DALMOOR DRIVE GROUP HOME	4400 DALMOOR DRIVE CHARLOTTE, NC 28212

(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 371	Continued From page 6	W 371		

participate in medication self-administration. For example:

During a medication administration observation on 7/31/24 at 6:36 AM revealed staff A to prepare medications for client #4 by punching the medications out the blister pack into the medication cup. Continued observation revealed staff A to hand client #4 the medication cup, he took all medications with a cup of water and the client exited the med room. Client #4 was not observed to receive any training during the medication pass or to participate beyond taking medications from staff A.

Interview with the facility nurse on 7/31/24 verified that client #4 had some level of independence to participate with the training and education during the medication administration.

C. The system for drug administration failed to assure client #5 was provided the opportunity to participate in medication self-administration. For example:

During a medication administration observation on 7/31/24 at 6:44 AM revealed staff A to prepare medications for client #5 by punching the medications out the blister pack into the medication cup. Continued observation revealed staff A to hand client #5 the medication cup, he took all medications with a cup of water and the client exited the med room. Client #5 was not observed to receive any training during the medication pass or to participate beyond taking medications from staff A.

Interview with the facility nurse on 7/31/24 verified that client #5 had some level of independence to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G185	A. BUILDING _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DALMOOR DRIVE GROUP HOME	4400 DALMOOR DRIVE CHARLOTTE, NC 28212

(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 371	Continued From page 7 participate with the training and education during the medication administration.	W 371		
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 interview, the facility failed to ensure medications remained locked except when being prepared for administration. This potentially affected all clients living in the home (#1, #2, #3, #4, and #5) The findings are: During a medication administration observation on 7/31/24 at 6:42 am, Staff A exited the medication room to retrieve a roll of paper towels from the supply closet. Further observation revealed staff A left the keys in the door and door remained unlocked until staff A returned with the paper towels. During an interview with the facility Nurse on 7/31/24 revealed staff A should not leave the door unlock and unattended.	W 382		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, record review, and interview the facility failed to ensure proper infection control procedures were followed in order to promote client health/safety and prevent	W 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G185	A. BUILDING _____ B. WING _____	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DALMOOR DRIVE GROUP HOME	4400 DALMOOR DRIVE CHARLOTTE, NC 28212

(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 454	Continued From page 8 possible cross-contamination. This potentially affected all clients (#1, #2, #3, #4,and #5) living in the home. The finding is During a dinner observation on 7/30/24 revealed client #5 exited the living room and walked into the kitchen to retrieve the dinnerware to set the dining table. Continued observations revealed client #5 rubbed sweat from his scalp, touched his arms, and the walls in the dining room. Further observation revealed client #5 picked up the utensils and cups by the mouth area and placed them on the table without washing his hands. At no point did staff prompt client #5 to wash his hands prior to setting the dining table. During a breakfast observation on 7/31/24 revealed client #5 exited his bedroom room to retrieve the dinnerware from the kitchen to set the dining table. Continued observations revealed client #5 did not wash his hands prior to placing the cups and utensils on the table by the mouth area. At no point did staff prompt client #5 to wash his hands prior to setting the dining table. During an interview on 7/31/24 with the facility Nurse revealed that staff should have prompted client #5 to wash his hands prior to meal times.	W 454		