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	34G123	A. BUILDING _____ B. WING _____	09/17/2024

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THE ATRIUM/THE RESPITE CENTER	101 HORIZONS LANE RURAL HALL, NC 27045

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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 that 4 clients (#7, #13, #27, #30) received a continuous active treatment program as identified in the Individual Program Plan (IPP) relative to proper provision and use of adaptive equipment and adherence to seizure guidelines. The findings are: A. The facility failed to ensure that client #7 was provided with hand and elbow splints. For example: During evening observations in the group home on 9/16/24, client #7 was observed to be seated in a wheelchair and alternately in a recliner. Continued observation revealed that client #7 was not wearing splints on either arm or either hand. During morning observations in the group home on 9/17/24, client #7 was observed at 7:00 AM to be seated in a wheelchair with an elbow splint on his left arm and a hand splint in a bag on the back of the wheelchair. Continued observation revealed that client #7 continued to wear the	W 249		

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

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elbow splint during a visit with his father at 9:25 AM, at which time the hand splint was still in the bag on the wheelchair.

Record review on 9/17/24 revealed an IPP dated 2/9/24 for client #7. Continued review of the IPP revealed a goal for client #7 to wear a hand splint daily, alternating every two hours with an elbow splint.

Interview with the qualified intellectual disabilities professional (QIDP) and the physical therapist (PT) on 9/17/24 confirmed that client #7 should wear the hand and elbow splints, alternating use every two hours, during all waking hours.

B. The facility failed to ensure that client #27 was provided with hand and elbow splints. For example:

During evening observations in the group home on 9/16/24, client #27 was observed to be seated in a wheelchair in the day room. Continued observation revealed that client #27 was not wearing splints on either arm or either hand.

Record review on 9/17/24 revealed an IPP dated 11/9/23 for client #27. Continued review of the IPP revealed a goal to offer client #27 to wear a hand splint daily, alternating every two hours with an elbow splint.

Interview with the QIDP and the PT on 9/17/24 confirmed that client #27 should wear the hand and elbow splints, alternating use every two hours, during all waking hours. Continued interview revealed that client #27's splints were damaged recently and needed to be reformed to the appropriate shape for client #27's hand and

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W 249	Continued From page 2 arm. C. The facility failed to ensure that proper seizure guidelines were followed for client #30. For example: During evening observations in the group home at 5:32 PM, client #30 was observed to begin having a seizure. Continued observation revealed staff B to check her watch and to make several attempts to gain client #30's attention. Further observation revealed a nurse to enter the room at 5:35 PM and for staff B to inform the nurse that client #30 had had 2 "mini-seizures" and for the nurse to comment that staff B should keep an eye on client #30 and notify the nurse of any further seizure activity. Record review on 9/17/24 revealed an IPP for client #30 dated 7/18/24 which includes specific seizure guidelines which indicate that staff should "Immediately page overhead for the nurse/paramedic/med tech on duty. DO NOT wait to see if the client comes out of the seizure." The guidelines further direct staff to "Document all seizure activity information in Therap immediately following the seizure." Interview with the QIDP on 9/17/24 confirmed that client #30's seizure guidelines are current and that there was no seizure activity noted for client #30 in Therap on 9/16/24. The QIDP further confirmed that staff should have notified nursing immediately upon witnessing the seizure and documented the seizure as soon as possible after it occurred. D. The facility failed to provide client #13's prescribed AFO's with shoes while in wheelchair.	W 249		

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W 249	Continued From page 3 For example: Observations in the facility on 9/16/24 at 4:45 PM revealed client #13 to be lifted from the bed located in the day room with a mechanical lift. Continued observations revealed client #13 to be wearing AFO's. Further observations revealed the client remained in the day room and staff administered client #13's feeding. At no time during the observations was staff observed to provide client #13 shoes. Subsequent observations at 5:38 PM revealed client #13 to enter the day room after taking a shower and to not wear his AFOs but only a pair of socks. Review of records on 9/17/24 revealed an IPP dated 10/14/23. Continued review of records for client #13 revealed a physical therapy evaluation dated 9/4/23 to state that client #13's footrests are equipped with foot straps, and it is recommended that the client wear AFO's and shoes while in his wheelchair. Interview with the QIDP on 9/17/24 confirmed that client #13's IPP and physical therapy evaluation are current. Continued interview with the QIDP confirmed that staff should provide client #13 with his prescribed AFO's with shoes while in his wheelchair.	W 249		
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 observation, record review and interview, the facility failed to ensure that all	W 369		

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drugs, including those that are self-administered, were administered without error for 2 of 30 clients (#7, #13). The findings are:

A. The facility failed to ensure that client #7 received all appropriate medications during the evening medication pass. For example:

Observation in the group home on 9/16/24 at 5:15 PM revealed client #7 to enter the hallway for medication administration. Continued observation revealed client #7 to receive Clonazepam .5 mg - ½ tablet. Further observation revealed staff A to crush the tablet, mix it with water and delivered it to client #7 through a feeding tube. When asked, staff A indicated that the Clonazepam is the only medication client #7 receives at the 6:00 PM medication pass.

Review of client #7's record on 9/17/24 revealed physician orders which indicated client #7 should receive the following medications during the 6:00 PM medication pass: Clonazepam .5 mg - ½ tablet, Tizanidine 2 mg - 1 tablet.

Interview with the qualified intellectual disabilities professional (QIDP) and the Director of Operations (DOO) confirmed that client #7 should have received the dose of Tizanidine during the 6:00 PM medication pass and that failing to administer this medication constituted a medication error.

B. The facility failed to ensure all drugs were administered without error for client #13. For example:

Observations in the facility on 9/17/24 at 8:27 AM revealed the facility nurse to obtain medications

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from drawers on a medication cart located in the hallway. Continued observations revealed the facility nurse to sanitize, to prepare syringes containing Metoclopramide 5MG/5ML sol and Levetiracetam sol. place and punch medications into a medicine cup, crush all medications, pour Polyethylene Glycol 3350 powder into a cup and add all crushed medications, add water to the cup, and put the contents of the cup into a syringe. Further observations at 8:39 AM revealed the nurse to place all syringes into a plastic zip bag which included a syringe of water for flushing while waiting for client #13 to exit the bathroom and for staff to place the client in the bed located in the day room. Subsequent observations at 8:46 AM revealed the facility nurse to administer client #13 all medications via syringe and flush with water.

Review of records for client #13 on 9/17/24 revealed physician orders dated 9/17/24. Review of the 9/17/24 physician orders revealed medications to administer to client #13 at 8:00 AM to be Clonazepam 0.5MG tab, Metoclopramide 5MG/5ML Solution, Multi-vitamin/minerals tab, Naproxen 375MG tab, Omeprazole 20MG DR tab (OTC), Senna Time 8.6MG tab, Transderm-SCOP 1MG/3dys PT72, Vitamin D3 2000 IU(50 MCG) tab, Fluticasone 50/MCG/ACT NS (RX), Iprat/Albuterol 0.5-3(2.5) MG/3ML, Ipratropium 0.03% Nasal Spray, Nebusal 3%, and Omeprazole 20MG DR tab (OTC) to be given 30 minutes before feeds. During survey medication administration observations, the facility nurse was observed to administer Omeprazole after client #13's 7:12 AM feeding. The nurse was not observed to administer Fluticasone 50/MCG/ACT NS (RX), Iprat/Albuterol 0.5-3(2.5) MG/3ML, Ipratropium

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W 369	Continued From page 6 0.03% Nasal Spray, and Nebusal 3%. Subsequent observations revealed the facility nurse administered client #13's 7:00 AM medications which consisted of Baclofen 10 MG and Levetiracetam Solution 100MG/ML. Additionally, the nurse administered client #13's 11:00 AM medication Polyethylene Glycol 3350 Powder. Interview on 9/17/24 with the DOO confirmed the 9/17/24 physician orders for client #13 to be current. Continued interview with the DOO revealed that the facility nurse should administer all medications as prescribed.	W 369		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on review of record and interview, the facility failed to show evidence quarterly fire drills were conducted with each shift of personnel. The finding is: Review of the facility fire drill reports from 9/23 through 8/24 revealed missing fire drills for the fourth quarter dates of 10/23, 11/23 and 12/23. There was no additional documentation available about conducting a drill on first, second, and third shifts for the fourth quarter during the review year. Interview with the director of operations (DOO) on 9/17/24 confirmed the facility fire drills should have been conducted quarterly for each shift. Continued interview with the DOO confirmed there was no additional documentation to reflect	W 440		

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W 440	Continued From page 7 the missing drills were conducted during the review year.	W 440		