STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G222	A. BUILDING _____ B. WING _____	C 10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JADE TREE	**6501 JADE TREE LANE RALEIGH, NC 27615**

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W 000	INITIAL COMMENTS A complaint investigation was conducted during the recertification survey for intake #NC00222684. The complaint was not substantiated; however, the deficiencies were cited during the recertification survey.	W 000		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the Individual Program Plan (IPP) included specific information to support each client's independence regarding the use of adaptive equipment. This affected 1 of 3 audit clients (#2). The findings are: A. During observations in the home throughout the survey on 10/21 - 10/22/24, client #2 wore a large baseball type helmet with a wire shield covering his head and face. The client was assisted to remove the helmet at meals. At other times, client #4 periodically wore the helmet while ambulating or while seated in the home. However, the helmet was not always worn by the client. Interview on 10/22/24 with Staff C revealed client #2 should wear his helmet all the time, except when eating. Interview on 10/22/24 with the Home Manager indicated client #2 wears his helmet to protect his head due to falls and should wear it all the time, except when eating.	W 240		

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

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W 240	Continued From page 1 Review on 10/21/24 of client #2's IPP dated 2/16/24 revealed no information regarding his helmet or it's use. Interview on 10/22/24 with the Program Director indicated client #2 wears the helmet due to seizures and his potential for falls. The Director confirmed no information regarding the helmet and it's use were included in the client's IPP.	W 240		
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 interview, the facility failed to ensure written informed consent was obtained from the guardian for the use of restrictive devices. This affected 1 of 3 audit clients (#2). The finding is: During observations in the home on 10/21 - 10/22/24, two of three bathrooms in the home did not contain toilet paper and/or paper towels. Various clients were noted to consistently use both bathrooms without the availability of paper products. Interview on 10/22/24 with Staff C and Home Manager revealed paper products are kept out of the bathrooms due to client #2's obsession with the brown rolls containing the toilet paper and paper towels. The staff noted he will remove all of the paper to get to the roll underneath.	W 263		

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W 263	Continued From page 2 Review on 10/22/24 of client #2's Behavior Support Plan (BSP) dated 4/1/24 revealed an objective to display 30 or fewer target behaviors for 6 out of 12 months. Additional review of the BSP did not include removing paper products from bathrooms to address client #2's inappropriate behaviors. Additional review of the record did not include written informed consent from client #2's guardian for the device. During an interview on 10/22/24, the Program Director did not indicate consent for the door chime had been obtained from client #2's guardian.	W 263		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure techniques to address client's inappropriate behaviors were included in a formal active treatment program. This affected 2 of 3 audit clients (#2 and #6). The findings are: A. During observations in the home on 10/21 - 10/22/24, two of three bathrooms in the home did not contain toilet paper and/or paper towels. Various clients were noted to consistently use both bathrooms without the availability of paper products. Interview on 10/22/24 with Staff C and Home Manager revealed paper products are kept out of	W 288		

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W 288	Continued From page 3	W 288		

the bathrooms due to client #2's obsession with the brown rolls containing the toilet paper and paper towels. The staff noted he will remove all of the paper to get to the roll underneath.

Review on 10/22/24 of client #2's Behavior Support Plan (BSP) dated 4/1/24 revealed an objective to display 30 or fewer target behaviors for 6 out of 12 months. Additional review of the BSP did not include removing paper products from bathrooms to address client #2's inappropriate behaviors.

Interview on 10/22/24 with the Program Director (PD) confirmed client #2 likes the rolls underneath the paper products; however, these products should not be removed from the bathroom as a way of address his behavior.

B. During observations in the home on 10/21 - 10/22/24, a door chime was mounted on client #2's bedroom door.

Review on 10/21/24 of client #2's BSP dated 4/1/24 revealed an objective to display 30 or fewer target behaviors for 6 out of 12 months. Additional review of the BSP did not include the use of a door chime.

Interview on 10/22/24 with the PD indicated the door chime was in place due to client #2's tendency to go into other client's bedrooms at night. The PD confirmed the door chime was not included in client #2's BSP.

C. During observations on 10/21/24 - 10/22/24, a door chime rang out each time client #6 entered or exited his bedroom.

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W 288	Continued From page 4 Review of client #6's Behavior Intervention Plan (BIP) dated 10/14/24 did not identify the door chime as an approved behavioral intervention for client #6. During interview on 10/22/24, the PD revealed the door chime was implemented because client #6 would leave his room and go into the rooms of other clients. She further advised that this intervention was not documented in client #6's BIP, and because it is being used, it should have been documented in client #6's BIP plan.	W 288		
W 303	PHYSICAL RESTRAINTS CFR(s): 483.450(d)(4) A record of restraint checks and usage must be kept. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a record of use and checks for restraints was kept as indicated. This affected 1 of 3 audit clients (#2). The finding is: During observations in the home throughout the survey on 10/21 - 10/22/24, client #2 periodically wore a baseball type helmet containing a wire face shield. The client was assisted to remove and apply the helmet. Interview on 10/22/24 with Staff C revealed client #2 should wear his helmet all the time, except when eating. Additional interview indicated use of the helmet should be documented on sheets in his training book. Interview on 10/22/24 with the Home Manager indicated client #2 wears his helmet to protect his	W 303		

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W 303	Continued From page 5 head due to falls and should wear it all the time, except when eating. Review on 10/22/24 of client #2's training book included sheets to document the helmet's use. The sheets noted, "Staff will remove helmet every 2 hours for 30 minutes." It also included spaces for "on/off" times to be recorded each day for his helmet from 6am - 10pm. Further review of the sheets revealed no documentation of the helmet's use during the month of October '24 (up to and including 10/22/24). Interview on 10/22/24 with the Program Director confirmed use of client #2's helmet should be documented as indicated on the sheets in his training book	W 303		
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that client #6 received an annual physical examination. This affected 1 of 3 clients. The findings is: Review on 10/22/24 of client #6's record revealed his last physical examination was on 8/3/23. Interview on 10/22/24 with the Program Director revealed client #6's last physical examination was on 8/3/23 with no future examination scheduled. She further confirmed that client #6 should have received an annual physical examination.	W 322		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i)	W 323		

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W 323	Continued From page 6 The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that client #6 received an annual visual examination. This affected 1 of 3 clients. The findings is: Review on 10/22/24 of client #6's record revealed his last visual examination was dated 10/31/21 with a 10/22/22 follow-up exam recommendation. Interview on 10/22/24 with the Program Director confirmed client #6's last visual examination was on 10/31/21 and he should have had an annual evaluation.	W 323		
W 336	NURSING SERVICES CFR(s): 483.460(c)(3)(iii) Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure nursing assessments were completed at least quarterly. This affected 2 of 3 audit clients (#2 and #6). The findings are: A. Review on 10/22/24 of client #2's record revealed a nursing assessment had been completed on 4/18/24. No other nursing assessments could be located. Interview on 10/22/24 with the facility nurse	W 336		

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W 336	Continued From page 7 confirmed nursing assessments should be completed on a quarterly basis and she was in the process of completing them for all of the clients. The nurse indicated she had been working at the facility for approximately two months. B. Review on 10/22/24 of client #6's record revealed there were no quarterly nursing evaluations from 2021 to 2024. Interview with the Nurse on 10/22/24 revealed that she has been in her position two months, and she had no access to previous nursing evaluations.	W 336		
W 364	DRUG REGIMEN REVIEW CFR(s): 483.460(j)(3) The pharmacist must prepare a record of each client's drug regimen reviews and the facility must maintain that record. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the pharmacist reviewed each client's drug regimen at least quarterly. This affected 2 of 3 audit clients (#2 and #6). The findings are: A. Review on 10/22/24 of client #2's record revealed a pharmacy review had been completed on 10/2/23 and 4/2/24. No other pharmacy drug reviews could be located. Interview on 10/22/24 with the Program Director (PD) confirmed the pharmacist should complete a drug review on a quarterly basis for each client. B. Review on 10/22/24 of client #6's record	W 364		

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W 364	Continued From page 8 revealed a pharmacy review had not been completed. No quarterly pharmacy drug reviews could be located. Interview with the facility nurse on 10/22/24 revealed the quarterly pharmacy drug reviews were not on site and the pharmacist was unable retrieve and provide the information for client #6 during the survey.	W 364		