STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G324	A. BUILDING _____ B. WING _____	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT GILEAD CHILDREN'S HOME	205 EAST INGRAM AVENUE MOUNT GILEAD, NC 27306

(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 complaint survey NC # 00222810 was completed during the recertification survey 10/15/2024 - 10/16/2024. The complaint survey was unsubstantiated, but did result in two deficiencies. Additionally, the recertification survey resulted in deficiency practices..	W 000		
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: Based on observation, record review and interview, the facility failed to ensure that privacy was maintained for 1 of 6 clients (#3). The finding is: Observations in the home on 10/15/24 from 5:34 PM - 5:45 PM revealed client #3 being assisted by staff E in the bathroom with self-care. Continued observation revealed client #3 to have all his clothing removed by staff E while the bathroom door remained open. Further observation revealed client #3 to be walked out of the bathroom, down the hallway to the kitchen by staff E in only his attends'. Subsequent observation revealed staff E to return client #3 back to the bathroom leaving the door fully opened and another staff closed the door. Additonal observation revealed the bathroom door was reopened and client #3 was observed having two attends placed on then was completely dressed with the bathroom door fully opened. At no point did staff E close the bathroom door to provide privacy for client #3 during the self-care routine.	W 130	• Residential Team Leader will retrain all staff on privacy by 11/13/2024. • Residential Team Leader and Residential Manager will complete shift observations 2X weekly for 6 weeks. • Residential Team Leader will document observations on shift observation form and turn into ICF Director weekly. Target Completion Date: 12/13/2024 RECEIVED NOV 6 2024 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kevin Clark, Statewide ICF Director | TITLE | (X6) DATE: 11/01/2024

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.

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W 130	Continued From page 1 Review on 10/16/24 of client #3's person-centered plan (PCP) dated 8/2/24 revealed client #3 requires 1:1 supervision during wake hours. Interview on 10/16/24 with the Statewide ICF Director confirmed that when client #3 is in the bathroom, staff should close the door for him to maintain his privacy. Continued interview with the director confirmed staff should not walk any of the clients through the home with no clothing on.	W 130		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure clients were provided opportunities for choice and self-management and not for the convenience of staff relative to mealtimes for 3 of 6 clients (#1, #3, #5). The finding is: Morning observations in the facility on 10/16/24 at 6:20AM revealed client #3 to sit at the dining table and participate in the breakfast meal. Further observation revealed staff to interrupt the breakfast meal and prompt client #3 to come to the medication room to participate in medication administration. Additional observations revealed staff to give client #3 a cup with pills and a cup with water. Subsequent observations at 6:45AM revealed staff to interrupt client #1 from participation in the	W 247	• Residential Team Leader will retrain all staff on providing each client with opportunities for choice and self-management not for the convenience for staff relative to mealtimes by 11/13/2024. • Residential Team Leader and Residential Manager will complete meal observations 2X weekly for 6 weeks. • Residential Team Leader will document observations on shift observation form and turn into ICF Director weekly. Target Completion Date: 12/13/2024	

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W 247	Continued From page 2 breakfast meal and prompt the client to come to the medication room for medication administration. Continued observation revealed staff to pick up client #1's plate from the table and take it with her to the medication room. Further observation revealed staff to hand client #1 a cup with pills that have already been placed in a cup. Observations also revealed staff to hand client #1 the cup and water. Additional observations at 6:50AM revealed staff to enter into the dining area and interrupt the breakfast meal while prompting client #5 to come to the medication room for medication administration. Continued observation revealed staff to pick up client #5's bowl of food and take it to the medication room. Observations also revealed staff to provide medication administration to client #5 with the door remaining open. Interview with the I/DD State Coordinator on 10/16/24 revealed staff should have either prompted the clients before the breakfast meal or waited for them to complete their meal prior to medication administration. Continued interview with the I/DD Coordinator revealed staff should not have taken clients' food into the medication room to encourage the clients to participate in medication administration for the convenience of staff.	W 247		
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	W 249		

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W 249	Continued From page 3 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 review and interviews, the facility failed to ensure that a continuous active treatment program consisting of needed interventions were implemented as identified in the person-centered plan (PCP) for 6 of 6 clients (#1, #2, #3, #4, #5, #6). The findings are: A. The facility failed to incorporate program interventions relative to medication administration for two clients (#2, #3). For example: Morning observations from 6:15AM-7:00AM revealed clients to participate in various activities to include medication administration, participate in the breakfast meal and prepare for school. Continued observations at 6:25AM revealed staff to assist client #3 to the medication room to prepare for medication administration. Further observations revealed med tech staff to hand client #3 a cup with medications and prompt the client to take his medication with water. Additional observations revealed staff to prompt the client to leave the medication room. At no point during the observation did staff provide medication education or assist the client with popping the pills and placing them in the cup. Subsequent observations at 6:35AM revealed staff to escort client #2 to the medication room for medication administration. Continued	W 249	• Residential Team Leader will retrain all staff all person centered plans and active treatment by 11/13/2024. • Residential Team Leader and Residential Manager will complete meal observations 2X weekly for 6 weeks. • Residential Team Leader will document observations on shift observation form and turn into ICF Director weekly. Target Completion Date: 12/13/2024	

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W 249	Continued From page 4 observations revealed staff to have already popped the pills and placed them into the cup. Further observations revealed staff to hand client #2 the cup and prompt him to take his medication with water. At no point during the observation did staff prompt client #2 to assist with popping pills or provide medication education to the client during medication administration. Review of the record for client #3 revealed a person centered plan (PCP) dated 8/2/24 which indicated the client has the following program goals: bathing goal, toileting schedule, handwashing, toothbrushing goal, choose a sensory activity, and medication administration goal. Review of the record for client #2 revealed a PCP dated 5/6/24 which indicated the client has the following program goals: bathing goal, toileting schedule, toothbrushing goal, participate in a sensory activity, and a medication participation goal. Interview with the I/DD State Coordinator on 10/16/24 revealed that client #2 and #3's goals are current. Interview with the I/DD State Coordinator also revealed staff have been trained to provide medication education with all clients, along with encouraging participation during medication administration. Continued interview with the I/DD State Coordinator revealed staff should follow clients medication administration goals as required. B. The facility failed to engage 6 of 6 clients (#1, #2, #3, #4, #5 and #6) in planned structure activities:	W 249		

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W 249	Continued From page 5 Observations in the group home on 10/15/24 from 4:45 PM - 6:00 PM revealed all clients to walk around the homes living room and dining room areas continuously with no engagement in structured activities. Further observation revealed clients to hover over the pony wall while the staff prepared the dinner meal while others continued to pace the floor. Subsequent observation revealed clients to cling to staff and surveyors and at no point were clients offered structures activity to occupy their time. Interview with the I/DD State Coordinator confirmed that the clients should have been offered and engaged in a structured activity. Continued interview with the director confirmed that staff should have been offered structured activities.	W 249		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure 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, record review and interviews, the system for drug administration failed to assure 1 of 6 clients (#2) observed during medication administration were provided the opportunity to participate in medication self-administration or provide medication education. The finding is: Morning observations on 10/16/24 at 6:30AM revealed staff to prompt client #2 to come to the	W 371	• RN will conduct a medication administration course with all staff by 11/13/2024. • Residential Team Leader and Residential Manager will complete medication administration observations 2X weekly for 6 weeks. • Residential Team Leader will document observations on medication observation form and turn into ICF Director weekly. Target Completion Date: 12/13/2024	

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W 371	Continued From page 6 medication room for medication administration. Continued observations revealed client #2 to enter the medication room and staff to hand the client a cup of pills and water. Observations revealed client #2 to receive the following medications in a cup: Vyvanse 40mg, Levetiracetam 250mg, Ziprasidone 20mg, and Flintstones' Complete vitamin. Further observation revealed staff to prompt the client to take his medications and exit the medication room. At no point during the medication administration did staff prompt client #2 to assist with popping his pills into a cup and providing medication administration. Review of the record for client #2 revealed a person centered plan (PCP) dated 5/6/24. Continued review of the PCP for client #2 revealed the following program goals: bathing goal, getting dressed, toileting, toothbrushing, participate in sensory routine, and participate in medication administration. Interview with the IDD State Coordinator revealed that all of the goals for client #2 are current. Continued interview with the IDD State Coordinator revealed that staff should have provided medication education with client #2 and provided the opportunity for assisting with 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 interviews, the facility	W 382		

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W 382	Continued From page 7 failed to assure all medications and biologicals remained locked except when being prepared for medication administration for 1 non-sampled client (#3, #5). The finding is: Observations on 10/16/24 at 6:25AM revealed staff to prompt client #3 to enter the medication room for medication administration. Continued observations revealed staff to have already punched out the medications and placed them in a cup on the counter. Further observations revealed staff to exit the medication room with the medication remaining on the counter and the medication cabinet remaining unlocked. Additional observations revealed staff to leave the surveyor in the room with the medications on the counter. Subsequent observations at 6:50AM revealed staff to prompt client #5 to enter the medication room to prepare for medication administration. Continued observations revealed staff to leave the medication cup on the counter and to exit the medication room with the medication door remaining open and the medication cabinet to remain unlocked. Interview with Nursing Services and IDD Coordinator on 10/16/24 revealed that staff have been trained to close and secure the medications when they are not being administered. Continued interview with the IDD Coordinator verified that all medications should be locked in the medication administration room when it is not in use.	W 382	• RN will conduct a medication administration course with all staff by 11/13/2024. • Residential Team Leader and Residential Manager will complete medication administration observations 2X weekly for 6 weeks. • Residential Team Leader will document observations on medication observation form and turn into ICF Director weekly. Target Completion Date: 12/13/2024	
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the	W 474		

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W 474	Continued From page 8 developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to serve food in a form consistent with the developmental levels and prescribed diets ensure 3 of 6 clients (#1, #2, and #3) The findings are: A. The facility failed to ensure the prescribed diet for client #1. For example: Observations in the group home on 10/15/24 at 5:23 PM revealed the dinner meal to be Manwich sandwiches on a bun, sweet potato fries, green peas, canned orange slices, canned cubed pears, and favored water. Continued observations revealed staff to serve the Manwich sandwich to be served quartered and all other food items served in whole consistency. Further observation revealed client #1 to consume 100% of his dinner meal without staff cutting or modifying it in any manner. Observations in the group home on 10/16/24 at 6:45 AM revealed the breakfast to be two toaster waffles, three sausage links, canned fruit cocktail, and juice. Continued observation revealed staff to serve the two waffles cut into bite size pieces, the three-sausage links served in whole consistency, the canned fruit cocktail was served in whole consistency and client #1 to consume all food items served to him. Further observation revealed client #1 to consume 100% of his meal. Record review on 10/16/24 revealed a nutritional evaluation for client #1 dated 9/12/24 stating that the client is currently on a regular chopped diet. B. The facility failed to ensure the prescribed diet	W 474	• Residential Team Leader will retrain all staff on all person supported's diet orders by 11/13/2024. • Residential Team Leader and Residential Manager will complete meal observations 2X weekly for 6 weeks. • Residential Team Leader will document observations on meal observation form and turn into ICF Director weekly. Target Completion Date: 12/13/2024	

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W 474	Continued From page 9 for client #2. For example: Observations in the group home on 10/15/24 at 5:23 PM revealed the dinner meal to be Manwich sandwiches on a bun, sweet potato fries, green peas, canned orange slices, canned cubed pears, and favored water. Continued observations revealed staff to serve the Manwich sandwich to be served quartered and all other food items served in whole consistency. Further observation revealed client #2 to consume 100% of his dinner meal without staff cutting or modifying it in any manner. Observations in the group home on 10/16/24 at 6:45 AM revealed the breakfast to be two toaster waffles, three sausage links, canned fruit cocktail, and juice. Continued observation revealed staff to serve the two waffles cut into bite size pieces, the three-sausage links served in whole consistency, the canned fruit cocktail was served in whole consistency and client #2 to consume all food items served to him. Further observation revealed client #2 to consume 100% of his meal. Record review on 10/16/24 revealed a nutritional evaluation for client #2 dated 9/12/24 stating that the client is currently on a regular chopped diet C. The facility failed to ensure the prescribed diet for client #3. For example: Observations in the group home on 10/15/24 at 5:23 PM revealed the dinner meal to be Manwich sandwiches on a bun, sweet potato fries, green peas, canned orange slices, canned cubed pears, and flavored water. Continued observations revealed staff to serve the Manwich sandwich quartered and all other food items served in	W 474		

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W 474	Continued From page 10 whole consistency. Further observation revealed client #1 to consume 100% of his dinner meal without staff cutting or modifying it in any manner. Observations in the group home on 10/16/24 at 6:45 AM revealed the breakfast to be two toaster waffles, three sausage links, canned fruit cocktail, and juice. Continued observation revealed staff to serve the two waffles cut into bite size pieces, the three-sausage links served in whole consistency, the canned fruit cocktail was served in whole consistency and client #3 to consume all food items served to him. Further observation revealed client #3 to consume 100% of his meal. Record review on 10/16/24 revealed a nutritional evaluation for client #3 dated 9/12/24 stating that the client is currently on a chopped, soft foods diet. Interview with the I/DD State Coordinator on 10/16/24 confirmed the diet orders are current, and each client should have had their food served in a consistency appropriate to their needs as set forth in their respective nutritional orders.	W 474		