STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G093	A. BUILDING _____ B. WING _____	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKWOOD HOME	1254 BROOKHAVEN DRIVE LINCOLNTON, NC 28092

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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 observation, interviews, and record review, the facility failed to assure a continuous active treatment program identified as an individual need was implemented for 3 of 6 clients (#2, #3, and #5) relative to a program goal and mealtime adaptive equipment. The findings are: A. The facility failed to implement a goal and provide mealtime adaptive equipment for client #5. For example: Observations during survey 12/10-12/11/24 revealed client #5 to consume the entire dinner meal and breakfast meal. Continued observations revealed client #5 to eat all meals at a fast pace and the staff was observed to prompt the client verbally two times to slow while eating during the dinner meal. Further observations revealed that client #5 is prescribed a small spoon and high sided dish for mealtime adaptive equipment. At no time during the mealtime observations was client #5 prompted to rest her eating utensil after every few bites of the dinner meal and breakfast meal. Additionally, client #5 was provided by staff with individual bowls for the breakfast meal	W 249	W249: Staff Will be in serviced trained on adaptive equipment needs and implementation of adaptive equipment during mealtimes. RECEIVED DEC 30 2024 DHSR-MH Licensure Sect	12/20/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joshua Butler — TITLE: IDD Admn — (X6) DATE: 12/20/24

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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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W 249	Continued From page 1 instead of the client's prescribed high sided dish. Review of the record on 12/11/24 for client #5 revealed a person-centered plan (PCP) dated 11/11/24. Review of the PCP revealed a goal implemented 10/29/22 for client #5 to rest her utensil after every few bites at an appropriate rate of eating being 90% accurate for two consecutive progress periods. Continued review of records revealed a physician's orders (P.O.) dated 9/30/24 to prescribe client #5 with a small spoon and a high sided divided dish. Interview on 12/11/24 with the qualified intellectual disability professional (QIDP) and the facility nurse verified that client #5's PCP and P.O. was current. Continued interview with the QIDP revealed that the staff should have implemented the rate of eating goal for client #5. Further interview with the facility nurse confirmed that client #5 should have been provided with her prescribed high sided dish. B. The facility failed to provide mealtime adaptive equipment for client #2. For example: Morning observations in the group home on 12/11/24 at 7:50 AM revealed client #2 at the dining room table eating her breakfast meal. The breakfast meal for client #2 consisted of the following: toast, sausage, strawberries, and a cup of orange juice. Continued observations revealed that client #2 was provided with the following adaptive equipment: an elevated meal tray. Further observations revealed client #2 consumed most of the breakfast meal. At no point during the observation period was client #2 provided with her prescribed rocker knife during the breakfast meal.	W 249	W249: Staff Will be in serviced trained on adaptive equipment needs and implementation of adaptive equipment during mealtimes.	12/20/24

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W 249	Continued From page 2 Review of records on 12/11/24 for client #2 revealed a P.O. dated 9/30/24. Continued review of the P.O. revealed that the client is prescribed the following adaptive equipment: elevated meal tray and a rocker knife. Interview on 12/11/24 with the facility nurse verified that client #2's P.O.'s was current. Continued interview confirmed that staff should have provided the client with prescribed rocker knife. C. The facility failed to provide mealtime adaptive equipment for client #3. For example: Morning observations in the group home on 12/11/24 at 7:36 AM revealed client #3 at the dining room table eating her breakfast meal. The breakfast meal for client #3 consisted of the following: toast, sausage (ground), and milk. Continued observations revealed that client #3 was provided with the following adaptive equipment: a maroon spoon. At no point during the observation period did staff provide her high sided divided dish for the breakfast meal or offer her prescribed shirt protector at any meals. Review of records on 12/11/24 for client #3 revealed a P.O. dated 9/30/24. Continued review of the P.O. revealed that the client is prescribed the following adaptive equipment: shirt protector, high sided divided dish, and maroon spoon. Inteview on 12/11/24 with the facility nurse verified that client #3's P.O.'s was current. Continued interview confirmed that staff should have provided the client with prescribed adaptive equipment.	W 249	W249: Staff will be in serviced trained on adaptive equipment needs and implementation of adaptive equipment during mealtimes. Any new program implementation staff will be ins erviced and trained by the QP. The QP will meet with the IDT to discuss any recommendaton made by OT.	12/20/24

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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 assure all drugs were administered without error for 1 of 6 clients (#5) observed during medication administration. The finding is: Observations in the group home on 12/11/24 at 7:26 AM revealed client #5 to enter the medication room and wash her hands. Continued observation revealed the staff to educate client #5 on medications while the client punched medications into a medicine cup. Subsequent observations revealed client # 5 to take all medications administered by staff D whole with water containing PEG3350 Powder 510G. Review of records for client #5 on 12/11/24 revealed physician orders dated 9/30/24. Review of the 9/30/24 physician orders revealed medications to administer at 8:00 AM to be Benztropine Tab 0.5MG, Clonazepam Tab 0.05MG, IBRANCE Tab 75MG, Lamotrigine Tab 25MG, Lithium Carb Tab 300 MG, Magnesium Glycinate 100 MG, PEG3350 Powder 510G, Senna-Plus Tab 8.6-50MG, Tamoxifen Tab 20MG, Vitamin B-12 Tab 1000MCG, Vitamin C tab 500MG, Vitamin D3 2000 IU (50MCG), and Clozapine Tab 25MG. Staff D did not administer the 8:00 AM Clozapine Tab 25MG to client #5 which is prescribed by mouth twice daily for behaviors. Interview with the facility nurse on 12/11/24	W 369	W369 Nursing department will in service and retrain staff on proper medication administration.	01/01/25

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W 369	Continued From page 4 confirmed the 9/30/24 physician orders for client #5 to be current. Continued interview with the facility nurse revealed that staff should administer all medications as prescribed.	W 369		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure food was served in a form consistent with the developmental level for 4 of 6 clients (#1, #2, #3, and #6). The findings are: A. The facility failed to ensure prescribed diet consistency for client #1. For example: Morning observations in the group home on 12/11/24 at 7:30 AM revealed client #1 at the dining room table eating her breakfast meal. The breakfast meal for client #1 consisted of the following: toast, sausage, and orange juice. Continued observations revealed the staff to provide client #1's toast in a bite size consistency. Further observations revealed client #1 consumed her breakfast meal with no further assistance from staff to ensure toast was ground. Review of records for client #1 on 12/11/24 revealed a nutritional assessment dated 2/24/24. Review of the nutritional assessment for client #1 indicates that the client is prescribed a heart healthy ground diet, no caffeine, no grapefruit, offer seconds. All meds in pudding. Ensure Plus 1 can three times a day in metered cup, ½ prune mixture 2 x a day.	W 474	W 474 Staff will be in-services and re trained on proper diet consistencies and diets for the residents in the home.	12/20/24

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W 474	Continued From page 5 Interview with the facility nurse on 12/11/24 confirmed client #1's diet as current. Continued interview with the facility nurse confirmed that staff should have provided client #1 with prescribed diets. B. The facility failed to ensure prescribed diet consistency for client #2. For example: Evening observation in the group home on 12/10/24 at 5:15 PM revealed client #2 to participate in the dinner meal which included chicken tenders, green beans, onion rings, and juice. Continued observations revealed the staff to provide client #2's meat ground. Further observations revealed client #2 consumed her dinner meal with no further assistance from staff to ensure food items with the exception of meat to be 1" consistency. Morning observations in the group home on 12/11/24 at 7:36 AM revealed client #3 at the dining room table eating her breakfast meal. The breakfast meal for client #3 consisted of the following: toast, sausage, and milk. Continued observations revealed the staff to provide client #2's sausage in ground consistency. Further observations revealed client #2 consumed her breakfast meal with no further assistance from staff to ensure toast was 1" consistency. Review of records for client #2 on 12/11/24 revealed a nutritional assessment dated 11/26/24. Review of the nutritional assessment for client #2 indicates that the client is prescribed a heart healthy diet, no grapefruit, 1" consistency. Thin liquids. Double portions as requested.	W 474	W 474 Staff will be in-services and re trained on proper diet consistencies and diets for the residents in the home.	12/20/24

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W 474	Continued From page 6 Interview with the facility nurse on 12/11/24 confirmed client #2's diet as current. Continued interview with the facility nurse confirmed that staff should have provided client #2 with prescribed diets. C. The facility failed to ensure prescribed diet consistency for client #3. For example: Evening observation in the group home on 12/10/24 at 5:15 PM revealed client #3 to participate in the dinner meal which included chicken tenders, green beans, onion rings with ranch, water, and juice. Continued observations revealed staff to provide client #3's meat ground. Further observations revealed client #3 consumed her dinner meal with no further assistance from staff to ensure food items with the exception of the meat was to be ½ inch. Review of records for client #3 on 12/11/24 revealed a nutritional assessment dated 1/22/22. Review of the nutritional assessment for client #3 indicates that the client is prescribed an 1800 calorie diet, ground meats, thin liquids, all other food cut into ½" pieces. No seconds. Interview with the facility nurse on 12/11/24 confirmed client #3's diet as current. Continued interview with the facility nurse confirmed that staff should have provided client #3 with prescribed diets. D. The facility failed to ensure prescribed diet consistency for client #6. For example: Morning observations in the group home on 12/11/24 at 8:04 AM revealed client #6 at the dining room table eating his breakfast meal. The	W 474	W 474 Staff will be in-services and re trained on proper diet consistencies and diets for the residents in the home.	12/20/24

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W 474	Continued From page 7 breakfast meal for client #6 consisted of the following: toast, sausage, and strawberries. Continued observations revealed client #6 consumed his breakfast meal with no further assistance from staff to ensure 1" consistency. Review of records for client #6 on 12/11/24 revealed a nutritional assessment dated 7/21/24. Review of the nutritional assessment for client #6 indicates that the client is prescribed a regular 1" diet, thin liquids. Interview with the facility nurse on 12/11/24 confirmed client #6's diet as current. Continued interview with the facility nurse confirmed that staff should have provided client #6 with his prescribed diet.	W 474	W 474 Staff will be in-services and re trained on proper diet consistencies and diets for the residents in the home.	12/20/24