STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G038	A. BUILDING _____ B. WING _____	C 02/17/2025

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W 000	INITIAL COMMENTS A complaint survey was completed on 2/17/25 for intake #NC00226197 and intake #NC00226641. Intake #NC00226197 was unsubstantiated and no deficiencies were cited. Intake #NC00226641 was substantiated and deficiencies were cited.	W 000		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on record review and interviews the facility failed to ensure the qualified intellectual disabilities professional (QIDP) coordinated, integrated, and monitored the changing health status for client #1. The finding is: Review of the record for client #1 on 2/17/25 revealed q-notes, wound care consults, medical consults, nurse's notes, and hospital discharge summaries indicating the client has had multiple hospitalizations dated from 4/1/24-current due to concerns with pressure sores (stage 3 and 4), positive for E-Coli, MRSA, facial bruising and scratches (long jagged nails), suprapubic catheter severely kinked, exposure to the flu, and abrasions to knuckles for repeatedly striking himself in the forehead. Review of an infectious disease consult dated 9/11/24 indicated the need to further discuss frequent hospitalizations due to pressure wounds. Subsequent review of the record for client #1 on 2/17/25 revealed two q-notes dated 12/17/24 (shopped for Christmas gift) and 1/15/25(reviewed behavioral data). There was no	W 159		

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

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W 159	Continued From page 1 documentation relative to core team meetings and no update on coordinating care for client #1's medical changes and needs. Review of the record for client #1 did not reveal evidence of staff in-service training post discharge instruction, no repositioning logs completed, no nail care logs completed, no catheter checked/changed logs completed, and no staff T-Log notes relative to client #1's behaviors or medical needs. Interview with the director of nursing (DON) and facility administrator on 2/17/25 verified that staff have not received in-service training to address client #1's changing medical needs. Further interview verified that staff did not document on any T-Log notes, repositioning, nail care, and catheter logs. The DON revealed that it is the responsibility of both the QIDP and the Nurse to coordinate team meetings. Interview with the QIDP on 2/17/25 revealed there have not been any interdisciplinary meetings or in-service training with staff to address the client's changing medical condition. Continued interview with the QIDP revealed that she doesn't coordinate meetings and it's the responsibility of the Nurse. Further interview verified staff did not document on any T-Log notes, repositioning, nail care, and catheter logs. The QIDP stated that she only takes the word of the staff that the clients' needs are being met and that she can't check behind every person.	W 159		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.	W 192		

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W 192	Continued From page 2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were sufficiently trained relative to the client's (#1) changing medical needs. The finding is: Review of the record for client #1 on 2/17/25 revealed wound care consults, medical consults, nurse's notes, and hospital discharge summaries indicating the client has had multiple hospitalizations since 4/1/24 due to concerns with pressure sores. Continued review of hospital discharge summary dated 4/1/24 indicated the client had the following diagnoses: pressure sores to the left heel (stage 3), left ischium, and right foot. Review of the hospital discharge summary dated 4/1/24 also provided the following recommendations: repositioning schedule every two hours and wound care weekly. Review of wound care consult dated 8/9/24 indicated recommendations for edema control guidelines/instructions. Subsequent review of the record for client #1 on 2/17/25 revealed an infectious disease consult dated 9/11/24 indicated the need to further discuss frequent hospitalizations due to pressure wounds. Review of the record for client #1 did not reveal evidence of staff in-service training to address the client's changing medical needs. Interview with the director of nursing (DON) and facility administrator on 2/17/25 verified that staff have not received in-service training to address client #1's changing medical needs. Continued interview with the DON could not verify if staff have been trained to complete edema control guidelines.	W 192		

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W 192	Continued From page 3 Interview with the qualified intellectual disabilities professional (QIDP) on 2/17/25 revealed staff are completing the repositioning for client #1 every two hours and changing the dressing three times a week. Continued interview with the QIDP could not verify if staff have been trained to complete edema control guidelines to elevate the legs to the level of the heart for 30 minutes, 3 times a day. Further interview with the QIDP revealed there have not been any interdisciplinary meetings or in-service training with staff to address the client's changing medical condition.	W 192		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that tracking logs were documented for 1 of 3 sampled clients (#1). The finding is: Review of the record for client #1 during the complaint investigation survey on 2/17/25 revealed the client has had multiple hospitalizations since 4/1/24 due to the following diagnoses: pressure sores to the left heel (stage 3), left ischium, and right foot. Review of hospital and wound care consults from 4/1/24-1/23/25 recommended the following interventions: repositioning every two hours,	W 252		

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W 252	Continued From page 4 wound care weekly, and edema control guidelines. Review of the record for client #1 did not reveal evidence of repositioning logs and edema control interventions as prescribed. Interview with the director of nursing (DON) on 2/17/25 verified that the client has been receiving repositioning according to the facility repositioning schedule but is not being tracked. Continued interview with the DON revealed that staff are to reposition the client and change dressings three times a week. Further interview with the DON verified dressing changes should be logged electronically. Interview with the qualified intellectual disabilities professional (QIDP) on 2/17/25 revealed staff are repositioning the client every two hours, however it is not being tracked. Continued interview with the QIDP verified there is no formal documentation for repositioning, edema control, and dressing changes.	W 252		
W 253	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to document significant events relative to body checks and tracking the rates of target behaviors, affecting 1 sampled client (#1). The finding is: A. Review of the record for client #1 during the complaint investigation survey on 2/17/25 revealed a behavior support plan (BSP) dated	W 253		

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W 253	Continued From page 5	W 253		

12/30/23 which revealed self injurious behavior (SIBs) as a target behavior. Continued review of the record for client #1 indicated a physician consult dated 12/14/24 revealing pictures with scratches under the client's neck. Review of the hospital discharge summary dated 1/17/25 also indicated the client had abrasions to knuckles from repeatedly striking himself in the forehead and head trauma. Review of a nurses' note dated 1/23/25 indicated the client is in the hospital and being treated for redness and bruising to forehead and nose, presence of dried blood on bilateral mittens, and client was repeatedly hitting himself in the face.

Subsequent review of the record for client #1 revealed behavior data on 11/7/24, 11/8/24, and 11/10/24. Continued review of 11/2024 behavior data indicated the client kept "knocking his face all night" and "spinning turtle should be used to deter SIB behaviors, but item is no longer available". Review of the record for client #1 did not reveal an updated BSP since 12/30/23 and no behavior data available from 9/2024, 10/2024, 12/2024, and 1/2025.

Interview with the qualified intellectual disabilities professional (QIDP) on 2/17/25 revealed the client has been known to scratch his face and hit himself in the face. Continued interview with the QIDP revealed when client scratches his skin staff should place bilateral mittens on his hands. Interview with the QIDP also revealed the client should be receiving nail care weekly on Thursdays. Further interview with the QIDP revealed there is no documentation to verify client is receiving nail care weekly. Interview with the QIDP also revealed it could not be determined what happened to the spinning turtle to be used

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W 253	Continued From page 6 to deter SIB behaviors. Additional interview with the QIDP revealed it could not be determined if the client's BSP has been updated since 12/30/23. B. Review of the record for client #1 on 2/17/25 revealed wound care consults, medical consults, nurse's notes, and hospital discharge summaries indicating the client has had multiple hospitalizations dated from 4/1/24-current due to concerns with pressure sores (stage 3 and 4) facial bruising and scratches (long jagged nails), suprapubic catheter severely kinked, and abrasions to knuckles from repeatedly striking himself in the forehead. Subsequent review of the record for client #1 on 2/17/25 revealed one body check sheet dated 12/2/24. No others body checks were provided prior to exit. Interview with the director of nursing (DON) on 2/17/25 verified that body checks are not completed daily and that they are to be completed after each hospital visit. Continued interview with the DON stated that the facility could benefit from documenting the body checks weekly or daily.	W 253		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Behavior Support Plan (BSP)	W 255		

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W 255	Continued From page 7 for client #1 was reviewed and revised as needed after completion of an objective. The findings is: Review on 2/17/25 of client #1's record revealed a BSP dated 12/30/23 with a target date of 12/30/24. Continued review revealed target behaviors to include disruptive behavior, leaving assigned area, skin/sore picking, aggression, disrobing, oppositional behavior, and taking other's items. Further review revealed no current or updated BSP addressing SIBs. Interview on 2/17/25 with the facility administrator confirmed no current BSP and no core team meetings addressing SIBs for client #1.	W 255		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #1 receive the necessary ongoing nursing services to decrease or prevent pressure sores. Finding are: Review of the record for client #1 on 2/17/25 revealed wound care consults, medical consults, nurse's notes, and hospital discharge summaries indicating the client has had multiple hospitalizations since 4/1/24 due to concerns with pressure sores (stage 3 and stage 4). Review of nursing note dated 1/17/25 revealed client #1 was transported from wound care appointment due to high fever and urinary catheter was kinked; treated for candidal UTI. Review of the hospital discharge summary dated	W 331		

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W 331	Continued From page 8 4/1/24 also provided the following recommendations: repositioning schedule every two hours and wound care weekly. Review of wound care consult dated 8/9/24 indicated recommendations for edema control guidelines/instructions. Subsequent review of the record for client #1 on 2/17/25 revealed an infectious disease consult dated 9/11/24 indicating the need to further discuss frequent hospitalizations due to pressure wounds. Review of the record also revealed one body check sheet dated 12/2/24. There was no documentation relative to core team meetings and no update on coordinating care for client #1's medical changes and needs. There was no evidence of staff in-service training post discharge instructions, no repositioning logs completed, and no catheter checked/changed logs completed. Interview with the director of nursing (DON) on 2/17/25 verified that staff have not received in-service training to address client #1's changing medical needs. Continued interview with the DON could not verify if staff have been trained to complete edema control guidelines. Further interview with the DON verified that staff did not document on any repositioning and catheter logs or that body checks are done after hospital visits.	W 331		