| DEPARTI | MENT OF HEALTH AN | ID HUMAN SERVICES | | | | M APPROVED | |
|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------------------------------------------------------------------------------------------------|----------------------------|--------------|--|
| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | OMB N | O. 0938-0391 | |
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | | |
| 34G122 | | B. WING | | R 04/10/2018 | | | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| DODEDT | | IOME | | 1920 WOODHAVEN DR | | | |
| RUBERT | W THOMPSON GROUP H | IOME | | ALBEMARLE, NC 28001 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | (X5) COMPLETION DATE | | |
| W 000 | INITIAL COMMENTS | | W O | 00 | | | |
| {W 189} | W382 and W454 from were corrected. How the 1/22 - 1/23/18 sur compliance. STAFF TRAINING PF CFR(s): 483.430(e)(1 | 87, W240, W288, W324, In the 1/22 - 1/23/18 survey ever, W189 and W249 from evey remain out of ROGRAM | {W 18 | 9} | | | |
| | initial and continuing | ide each employee with training that enables the his or her duties effectively, etently. | | | | | |
| | Based on observatio interviews, the facility sufficiently trained reg | not met as evidenced by: ns, document review and failed to ensure staff were garding client participation in and routines. The finding is: | | | | | |
| | | ately trained to ensure client preparation or family style | | | | | |
| | one staff was working | ome on 4/10/18 at 6:50am, g in the home and all six edrooms with the doors | | | | | |
| | | | | | | | |
| | Immediate interview | with the staff revealed he | | | | | |
| LABORATORY | DIRECTOR'S OR PROVIDER/S | SUPPLIER REPRESENTATIVE'S SIGNATUR | E | TITLE | | (X6) DATE | |

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.

PRINTED: 04/11/2018

| | - | ND HUMAN SERVICES MEDICAID SERVICES | | | | FOI | ED: 04/11/201 RM APPROVE NO. 0938-039 | |
|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------|-----|---------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G122 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | | |
| | | B. WING | | | R 04/10/2018 | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | STR | EET ADDRESS, CITY, STATE, ZIP CODE | P CODE | | |
| ROBERT | W THOMPSON GROUP | HOME | | | 0 WOODHAVEN DR | | | |
| | | | | AL | BEMARLE, NC 28001 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| {W 189} | Continued From pag | e 1 | {W 1 | 89) | | | | |
| | | first shift staff would be | (| , | | | | |
| | arriving at 7:00am. | Additional interview revealed | | | | | | |
| | | eaten breakfast already at | | | | | | |
| | | 6:00am. The staff further indicated he had prepared the breakfast meal, woke up the clients, | | | | | | |
| | fed them and allowed | | | | | | | |
| | The staff added he re | | | | | | | |
| | him to "get them fed' | | | | | | | |
| | tasks before first shift staff arrives. The staff also stated no family style dining was implemented at | | | | | | | |
| | breakfast as several of the clients "will spill | | | | | | | |
| | - | to make it as easy as | | | | | | |
| | • | Additional interview revealed are of nor had he attended | | | | | | |
| | | aining over the last 2 and 1/2 | | | | | | |
| | months. | | | | | | | |
| | | f client #1's IPP dated | | | | | | |
| | 11/20/17 revealed in preparation be requi | the area of meal ires physical assistance to | | | | | | |
| | gather ingredients, c | | | | | | | |
| | | re ingredients, stir/mix items, | | | | | | |
| | | , oven or microwave. The | | | | | | |
| | | lient can serve and pour on ass food items to others. | | | | | | |
| | - | the plan revealed, "Continue | | | | | | |
| | | paration skills through routine | | | | | | |
| | informal participation | i opportunities" and informal assistance and | | | | | | |
| | training throughout th | | | | | | | |
| | | f client #3's IPP dated | | | | | | |
| | | he area of meal preparation, | | | | | | |
| | she requires verbal a gather ingredients, c | and gestural prompts to | | | | | | |
| | | ingredients and to use the | | | | | | |
| | stove, oven and micr | owave. The plan indicated | | | | | | |
| | | re ingredients with physical | | | | | | |
| | assistance. Addition | al review of the IPP noted | | | | | | |

Facility ID: 922483

If continuation sheet Page 2 of 5

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (21) DATE SUPPLY UBINITICATION NUMBER: (22) MUTUPLE CONSTRUCTION A BUILDING (22) MUTUPLE CONSTRUCTION A BUILDING A BUILDING (22) MUTUPLE CONSTRUCTION A BUILDING A BUILDING A BUILDING (EACH CORRECTIVE A COTOR ECTION (EACH CORRECTIVE A COTOR ECTION (CONSTRUCTIVE O TAVID (CONSTRUCTIVE O TAVID (CONSTR | | - | ID HUMAN SERVICES | | | | FORM | D: 04/11/2018 APPROVED | |
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| 346122 B. WNG 04/10/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CTY, STREET, ZP CODE 1920 WOODHAVEN DR (VAL) ID SUMMARY STATEMENT OF DEFICIENCIES BY MY OODHAVEN DR ALBEMARLE, NC 28001 (VAL) ID SUMMARY STATEMENT OF DEFICIENCIES B PROFIDER STATEMENT OF DEFICIENCIES D (VAL) ID SUMMARY STATEMENT OF DEFICIENCIES B PROFIDER STATE ADDRESTON OR ORDERCTION DOEL (VM 189) Continued From page 2 (W 189) EACH CORRECTIVE ACTION SHOULD BET DUE NOT TAG CONSERCE TO THE APPROPRIATE DEFICIENCE OF THE INFORMATION DEFICIENCIA DOEL (W 189) Continued From page 2 (W 189) (W 189) Continued From page 2 (W 189) (W 189) Interview on 4/10/18 with the Qualified Intellectual Dissibilities Professional (QIDP) confirmed clients should have participated with meal preparation and family style inding during their regular morning routine which usually begins at 7.00am on first shift. Additional interview revealed the staff involved head attended all subsequent training required in response to deficiencies cited during the recettrictation survey in January 2018. (W 249) FROGRAM IMPLEMENTATION CFR(s) support the achievement of the objectives is sufficient number and frequency to support the achievement of the objectives additional interviews mea recorrece a continuous active tradment program consisting of need | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | | | | COMPLETED | | | |
| ROBERT W THOMPSON GROUP HOME 1920 WOODHAVEN DR ALBEMARLE, KC 2001 MGI D HYELTK TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S FLANG'C CORRECTION (EACH DERORECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) 000000000000000000000000000000000000 | | | 34G122 | B. WING | | | | | |
| ROBERT W THOMPSON GROUP HOME ALBEMARLE, NC 28001 (W) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY WIST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFX TAG PREFX (EACH OFFICENCY WIST BE REPRECIDED DY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFX TAG PREFX (EACH OFFICENCY WIST BE APPROPRIATE DEFICIENCY) OPERATION STOLENCY (EACH OFFICENCY WIST BE APPROPRIATE DEFICIENCY) OPERATION (CONSERVERTING ACTION STOLENCY (CONSERVERTING ACTION STOLENCY) OPERATION (W 189) (W 189) Continue to provide informal assistance and training throughout the meal routine." (W 189) Interview on 4/10/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients should have participated with meal preparation and family style clining during their regular morning routine which usually begins at 7:00am on first shift. Additional interview revealed the staff involved had attended all subsequent training required in response to deficiencies cited during the recertification survey in January 2018. (W 249) (W 249) (W 249) (W 249) PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) (W 249) This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to resurve a of 2 audit Interviews, the facility failed one surve 2 of 2 audit Interviews, the facility failed one surve 2 of 2 audit | NAME OF PF | ROVIDER OR SUPPLIER | | | | TE, ZIP CODE | | | |
| Preferx TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PRETX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMPLETE DEFICIENCY (W 189) Continued From page 2 the client serves and pours with verbal and gestural prompts and usually passes food items to others. Further review of the IPP indicated, "Continue to provide informal assistance and training throughout the meal routine." (W 189) (W 189) Interview on 4/10/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients should have participated with meal preparation and family style dining their regular morning routine which usually begins at 7.00am on first shift. Additional interview revealed the staff involved had attended all subsequent training required in response to deficiencies cited during the recertification survey in January 2018. (W 249) (W 249) (W 249) CFR(s): 483.440(d)(1) (W 249) As soon as the interdisciplinary team has formulated a client's individual program plan, each olient 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 2 of 2 audit Implete Implete | ROBERT | N THOMPSON GROUP H | IOME | | | | | | |
| the client serves and pours with verbal and gestural prompts and usually passes food items to others. Further review of the IPP indicated, "Continue to provide informal assistance and training throughout the meal routine." Interview on 4/10/18 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients should have participated with meal preparation and family style dining during their regular morning routine which usually begins at 7:00am on first shift. Additional interview revealed the staff involved had attended all subsequent training required in response to deficiencies cited during the recertification survey in January 2018. {W 249} {W 249 PROGRAM INPLEMENTATION CFR(s): 483.440(d)(1) {W 249} 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. (W 249) This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 2 audit Interviews, the facility failed to ensure 2 of 2 audit | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECT CROSS-REFERENC | TIVE ACTION SHOULD BE CED TO THE APPROPRIA | | COMPLETION | |
| clients (#1, #3) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of meal preparation and family style dining. The finding is: | | the client serves and gestural prompts and to others. Further rev "Continue to provide i training throughout th Interview on 4/10/18 v Disabilities Profession should have participa and family style dining morning routine which on first shift. Addition staff involved had atte training required in re during the recertification PROGRAM IMPLEMI CFR(s): 483.440(d)(1 As soon as the interdiformulated a client's in each client must rece treatment program co interventions and serv and frequency to suppobjectives identified in plan. This STANDARD is r Based on observation interviews, the facility clients (#1, #3) receiv treatment plan consis and services as identified in program plan (IPP) in | pours with verbal and usually passes food items view of the IPP indicated, informal assistance and e meal routine." with the Qualified Intellectual hal (QIDP) confirmed clients ted with meal preparation g during their regular h usually begins at 7:00am hal interview revealed the ended all subsequent sponse to deficiencies cited ion survey in January 2018. ENTATION) isciplinary team has ndividual program plan, vive a continuous active onsisting of needed vices in sufficient number port the achievement of the n the individual program | | | | | | |

If continuation sheet Page 3 of 5

| | | | | PLE CONSTRUCTION | | OMB NO. 0938-039 | | |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|--------|---------------------------|--|--|
| IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIP A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | | |
| | | | | | R | | | |
| 34G122 | | B. WING | | 04/10/2018 | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| ROBERT | W THOMPSON GROUP H | IOME | | 1920 WOODHAVEN DR ALBEMARLE, NC 28001 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY) | ILD BE | (X5) COMPLETIO DATE | | |
| {W 249} | Clients were not pron preparation or family Upon arrival to the ho one staff was working | npted to participate in meal | {W 24 | 9} | | | | |
| | | | | | | | | |
| | works third shift and f arriving at 7:00am. A all of the clients had e 6:00am. The staff fur prepared the breakfar fed them and allowed The staff added he ro him to "get them fed" tasks before first shift stated no family style | with the staff revealed he first shift staff would be additional interview revealed eaten breakfast already at ther indicated he had st meal, woke up the clients, it them to go back to bed. butinely does this as it allows and complete his cleaning t staff arrives. The staff also dining was implemented at of the clients "will spill to make it as easy as | | | | | | |
| | 11/20/17 revealed in preparation, he require gather ingredients, concompared in the require cookware, to measure and to use the stove, IPP also noted the clin his own as well as para Additional review of the | res physical assistance to | | | | | | |

Facility ID: 922483

If continuation sheet Page 4 of 5

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | | FORM | D: 04/11/2018 APPROVED D. 0938-0391 |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
| | | 34G122 | B. WING | | | R 04/10/2018 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| ROBERT | W THOMPSON GROUP H | IOME | | | 920 WOODHAVEN DR ILBEMARLE, NC 28001 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREF TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BI | | (X5) COMPLETION DATE |
| {W 249} | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | {vv : | 249} | | | | |

If continuation sheet Page 5 of 5