PRINTED: 04/16/2019 FORM APPROVED OMB NO. 0938-0391

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G260	B. WING			04/	02/2019
	PROVIDER OR SUPPLIER  LOOP ROAD HOME				RESS, CITY, STATE, ZIP CODE WOOD LOOP ROAD IC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTIO CH CORRECTIVE ACTION SHOULE SS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 189	initial and continuin employee to perfor efficiently, and come This STANDARD is Based on observation interviews, the facil sufficiently trained regait belt. This affect finding is:  Staff were not sufficiently trained regait belt. This affect finding is:  Staff were not sufficiently at 4:30 pm, Significantly at 4:30 pm, Significantly at 4:30 pm, Significant to the first part of the home than the second sufficient to t	ovide each employee with g training that enables the m his or her duties effectively, petently.  Is not met as evidenced by: tions, record reviews and ity failed to ensure staff were regarding the use of client #4's eted 1 of 5 audit clients. The cliently trained regarding the ait belt.  Discriptions in the home on staff B was holding onto client she was walking down the electric staff and the washer. Further led client #4 pulling away from the pulled client #4 pack towards the interview, Staff A revealed to client #4's gait belt because Staff A stated holding onto to prevent her from stealing	W 1	89			
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	1	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.

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			E SURVEY IPLETED		
		34G260	B. WING		04/	02/2019
	PROVIDER OR SUPPLIER  LOOP ROAD HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5910 FARMWOOD LOOP ROAD WILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 189	hallway into the living hallway into the living an interview a habit of mine" to have a habit of a habit of habit of habit of hall and hall a hal	ut of her room, down the ng room.  on 4/2/19, Staff D stated, "It's hold onto client #4's gait belt.  f client #4's IPP stated, "What bulatory." Further review Gross Motor: I ambulate  f client #4's nursing evaluation ed, "Ambulatory Skills: [Client pendently."  on 4/2/19, the qualified es professional (QIDP) vice or training occurred with ing on how to use client #4's  GRAM PLAN (6)(i)  ram plan must describe his to support the individual nce.  s not met as evidenced by: ions, interviews and record failed to ensure 1 of 5 audit al program plan (IPP) included to address the usage of a gait	W 2			
	Client #4's IPP did address the usage	not include guidelines to of a gait belt.				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 -	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		34G260	B. WING		0	4/02/2019
	PROVIDER OR SUPPLIER  LOOP ROAD HOME			STREET ADDRESS, CITY, STATE, 5910 FARMWOOD LOOP ROAD WILSON, NC 27893	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 240	4/1/19 at 4:30pm, S #4's gait belt while s hallway of the home During observations 4/1/19, Staff A was belt while she was her dirty dishes into observations revea Staff A, while Staff A her.  During an immedia she was holding on she will steal food. client #4's gait belt food is part of her "  During observations D was holding onto	pservations in the home on Staff B was holding onto client she was walking down the e.  Is after dinner in the home on holding onto client #4's gait walking into the kitchen to put to the dishwasher. Further led client #4 pulling away from A pulled client #4 back towards to client #4's gait belt because Staff A stated holding onto to prevent her from stealing plan."  Is in the home on 4/2/19, Staff client #4's gait belt as she ut of her room, down the			ICY)	
	a habit of mine" to I so she does not fall Review on 4/2/19 o I Can Do Well: Am revealed, "Mobility/independently"  Review on 4/2/19 o dated 6/5/18 reveal #4] ambulates inde	f client #4's IPP stated, "What bulatory." Further review Gross Motor: I ambulate f client #4's nursing evaluation ed, "Ambulatory Skills: [Client				

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G260	B. WING		04	/02/2019
	PROVIDER OR SUPPLIER  LOOP ROAD HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5910 FARMWOOD LOOP ROAD WILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 240	confirmed there wa client #4's IPP to ac Further interview wi	ge 3 es professional (QIDP) s no specific information in ddress the usage of a gait belt. ith the QIDP revealed client #4 lls in the home while	W 2	40		
W 249	ambulating. PROGRAM IMPLE CFR(s): 483.440(d)	MENTATION	W 2	49		
	formulated a client's each client must re- treatment program interventions and so and frequency to su	rdisciplinary team has so individual program plan, ceive a continuous active consisting of needed ervices in sufficient number apport the achievement of the lin the individual program				
	Based on observat reviews, the facility received a continuous consisting of neede identified in the indi the areas of self he	s not met as evidenced by: ion, interviews and record failed to ensure each client ous active treatment plan id interventions and services vidual program plan (IPP) in Ip skills and medication s affected 1 of 5 audit clients :				
	Client #4 did not us medication adminis	e her adaptive spoon during tration.				
	client #4 was obser plastic spoon. Duri	ion administration ghout the survey on 4/1 - 2/19, ved consuming her pills with a ng meal time observations rey on 4/1/ - 2/19, client #4				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED			
		34G260	B. WING		04/	02/2019
	PROVIDER OR SUPPLIER  LOOP ROAD HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5910 FARMWOOD LOOP ROAD WILSON, NC 27893	, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPROPROFICIENCY)	D BE	(X5) COMPLETION DATE
W 356	curved adaptive sponduring an interview client #4 does not up medication administ Review on 4/1/19 of stated, "I was seen to need the "Good of my right hand, curved Review on 4/2/19 of evaluation dated 6/3 adaptivespoonv [Client #4] was gett properly."  During an interview confirmed client #4 adaptive spoon dur COMPREHENSIVE CFR(s): 483.460(g)  The facility must entreatment services needed for relief of restoration of teeth, health.  This STANDARD is Based on record/dothe facility failed to dental treatment in	uming her meals with an con.  on 4/2/19, Staff E stated se her adaptive spoon during tration.  f client #4's IPP dated 6/4/18 by OT on 3/3/18. I continue Grips" style built up spoonfor ed 30 - 35 degrees"  f client #4's habilitation 5/18 revealed, "an were implemented to ensure ing the food on the utensils  on 4/2/19, the facility's nurse should be using her curved ing medication administration.  E DENTAL TREATMENT  (2)  sure comprehensive dental that include dental care pain and infections, and maintenance of dental  s not met as evidenced by: ocument review and interview, ensure client #5 received a timely manner for relief of This affected 1 out 3 audited	W 2			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		34G260	B. WING		04/	02/2019
	PROVIDER OR SUPPLIER  LOOP ROAD HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5910 FARMWOOD LOOP ROAD WILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC'  (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 356	timely manner.  Review on 4/2/19 or dentist assessment comment "Extract to "Further review, review, form dated 10/18/18 tooth #6, tooth unrerevealed the tooth had/2/19  Interview on 4/2/19 phone revealed clie on timely manner adentist.  Interview on 4/2/19 disabilities profession facility did not follow regarding client #5's DRUG ADMINISTR CFR(s): 483.460(k)  The system for drug that all drugs are ad the physician's order the physician's order interview, the facility of administrating mainplemented. This (#4) The finding is:	f the client's record noted a form dated 4/10/18 with a both #6, tooth unrestorable realed a dental assessment 8 with a comment "Extract estorable," Addition review had not been extracted as of with the facility's nurse via ent #5 tooth was not extracted as recommended by the with the qualified intellectual onal (QIDP) revealed the with dentist recommendation is tooth.  (ATION (1)  g administration must assure deministered in compliance with ers.  Is not met as evidenced by: ion, record review and y failed to ensure the system edications as ordered was affected 1 of 5 audit clients	W 3			
		•				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G260	B. WING			04/	02/2019
	PROVIDER OR SUPPLIER  LOOP ROAD HOME			5	TREET ADDRESS, CITY, STATE, ZIP CODE 910 FARMWOOD LOOP ROAD VILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 368	Continued From pa ordered.	ge 6	W 3	868			
	the home on 4/2/19 administered client with four other pills.	administration observation in at 7:03am, Staff E #4's Omeprazole 20mg along Further observations ad consumed her breakfast at					
	signed 2/1/19 state	f client #4's physician orders d, "Omeprazole 20mg Take outhtake on empty stomach					
W 374	confirmed client #4 Omeprazole 30 mir breakfast. DRUG ADMINISTR		W 3	374			
	that drugs used by	g administration must assure clients while not under the cility are packaged and					
	Based on observate failed to ensure all classified with the narrow the medication, with administer the medication.	s not met as evidenced by: ions and interviews, the facility drugs were packaged and me of the person prescribed in instructions on how to ication and instructions as to ister the medication for 1 of 5 The finding is:					
	Client #3's Iron pill I	bottle was not labeled.					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	34G260	B. WING			04/0	02/2019
			59	10 FARMWOOD LOOP ROAD		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
During afternoon ob 4/1/19 at 4:52pm, Sher Iron pill along wher Iron pill along where Iron pill along where Iron pill along where Iron pill along where Iron pill along an interview intellectual disabilities along an interview confirmed client #3's label on it.  During an interview confirmed client #3's label on it.  DRUG STORAGE ACFR(s): 483.460(I)(CON) authorized perkeys to the drug storm of the storm of	oservations in the home on taff B administered client #3 ith 3 other pills.  on 4/1/19, Staff B revealed ottle should have a label on it.  on 4/1/19, the qualified es professional (QIDP) Iron pill bottle did not have a  on 4/1/19, the facility's nurse s Iron pill bottle should have a  AND RECORDKEEPING 2)  sons may have access to the rage area.  s not met as evidenced by: ions and interviews, the facility authorized persons have be drug storage area. The  s drug storage area were be in the home.  observations in the home on taff A stated the spare by was hanging on the wall, a black magnetic box. s revealed the magnetic box					
	Continued From particular Continued From pill along with Continued	ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  During afternoon observations in the home on 4/1/19 at 4:52pm, Staff B administered client #3 her Iron pill along with 3 other pills.  During an interview on 4/1/19, Staff B revealed client #3's Iron pill bottle should have a label on it.  During an interview on 4/1/19, the qualified intellectual disabilities professional (QIDP) revealed client #3's Iron pill bottle did not have a label on it.  During an interview on 4/1/19, the facility's nurse confirmed client #3's Iron pill bottle should have a label on it.  DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(I)(2)  Only authorized persons may have access to the keys to the drug storage area.  This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure only authorized persons have access to keys to the drug storage area. The	ROVIDER OR SUPPLIER  LOOP ROAD HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  During afternoon observations in the home on 4/1/19 at 4:52pm, Staff B administered client #3 her Iron pill along with 3 other pills.  During an interview on 4/1/19, Staff B revealed client #3's Iron pill bottle should have a label on it.  During an interview on 4/1/19, the qualified intellectual disabilities professional (QIDP) revealed client #3's Iron pill bottle did not have a label on it.  During an interview on 4/1/19, the facility's nurse confirmed client #3's Iron pill bottle should have a label on it.  DURING STORAGE AND RECORDKEEPING CFR(s): 483.460(I)(2)  Only authorized persons may have access to the keys to the drug storage area.  This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure only authorized persons have access to keys to the drug storage area. The finding is:  A key to the facility's drug storage area were accessible to anyone in the home.  During medications observations in the home on 4/1/19 at 5:04pm, Staff A stated the spare medication room key was hanging on the wall, but it is now kept in a black magnetic box. Further observations revealed the magnetic box was unlocked and kept on the side of a metal file	ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  During afternoon observations in the home on 4/1/19 at 4:52pm, Staff B administered client #3 her Iron pill along with 3 other pills.  During an interview on 4/1/19, Staff B revealed client #3's Iron pill bottle should have a label on it.  During an interview on 4/1/19, the qualified intellectual disabilities professional (QIDP) revealed client #3's Iron pill bottle did not have a label on it.  During an interview on 4/1/19, the facility's nurse confirmed client #3's Iron pill bottle should have a label on it.  DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(I)(2)  Only authorized persons may have access to the keys to the drug storage area.  This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure only authorized persons have access to keys to the drug storage area. The finding is:  A key to the facility's drug storage area were accessible to anyone in the home.  During medications observations in the home on 4/1/19 at 5:04pm, Staff A stated the spare medication room key was hanging on the wall, but it is now kept in a black magnetic box. Further observations revealed the magnetic box was unlocked and kept on the side of a metal file	A BUILDING  34G260  34G260  STREET ADDRESS, CITY, STATE, ZIP CODE  \$10 FARMWOOD LOOP ROAD WILSON, NC 27893  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  During afternoon observations in the home on 4/1/19 at 4:52pm, Staff B administered client #3 her Iron pill along with 3 other pills.  During an interview on 4/1/19, Staff B revealed client #3's Iron pill bottle should have a label on it.  During an interview on 4/1/19, the facility's nurse confirmed client #3's Iron pill bottle should have a label on it.  DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(I)(2)  Only authorized persons may have access to the keys to the drug storage area.  This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure only authorized persons have access to keys to the drug storage area. The finding is:  A key to the facility's drug storage area were accessible to anyone in the home on 4/1/19 at 5:04pm, Staff A stated the spare medication room key was hanging on the wall, but it is now kept in a black magnetic box Keurther observations revealed the magnetic box Eurher observations revealed the magnetic box sus unlocked and kept on the side of a metal file	A BUILDING B

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G260	B. WING			04/0	02/2019
	PROVIDER OR SUPPLIER  LOOP ROAD HOME			5	TREET ADDRESS, CITY, STATE, ZIP CODE 910 FARMWOOD LOOP ROAD VILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 383	Continued From pa is located.	ge 8	W 3	83			
		re interview, Staff A confirmed on room key is kept in the					
	intellectual disabiliti revealed the spare the unlocked black file cabinet and it is home.	on 4/1/19, the qualified es professional (QIDP) medication room key is kept in magnetic box, attached to the accessible to anyone in the					
W 455	INFECTION CONT CFR(s): 483.470(l)(		W 4	55			
		ctive program for the and investigation of infection diseases.					
	Based on observat failed to ensure that prevention procedu	s not met as evidenced by: ions and interviews, the facility t the infections control res were carried out. This all clients residing in the home					
		ot taken to promote client possible cross-contamination.					
	1. Client #5 was no silverware.	ot prompted to use clean					
	4/1/19, client #5 wa the table while takin the table for dinner.	ervations in the home on s propelling her wheelchair to ig her dishes and silverware to While propelling her erware dropped to the floor;					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		34G260	B. WING		04	/02/2019
	PROVIDER OR SUPPLIER  LOOP ROAD HOME			STREET ADDRESS, CITY, STATE, ZIP C 5910 FARMWOOD LOOP ROAD WILSON, NC 27893	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 455	another client picket to her. Additional ousing the silverware no time was client silverware.  During an interview client #5 should has silverware.  During an interview intellectual disabilitic client #5 should has silverware.  2. Client #4 was not hands.  During dinner obsectient #4 had finger mouth prior to servic Additional observations reveat spoon to serve hers clients and staff half for the squash. At prompted to sanitiz During an interview client #4 should has her hands prior to hid dinner.  During an interview client #4 should has her hands prior to hid dinner.	d them up and handed it back observations revealed client #5 to consume her dinner. At #5 prompted to get clean on 4/1/19, Staff B revealed we been prompted to get clean on 4/1/19, the qualified es professional (QIDP) stated we been prompted to get clean of prompted to sanitize her revation in the home on 4/1/19, so f both her hands in the ing herself her dinner. In ions revealed the fingers of ad drool on them. Further led client #4 handling the self the squash and then other anding the same serving spoon no time was client #4 hands.  If on 4/1/19, Staff B stated we been prompted to sanitize her serving herself during	W 4	55		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		34G260	B. WING		04/	02/2019
	PROVIDER OR SUPPLIER  LOOP ROAD HOME			STREET ADDRESS, CITY, STATE, ZIP 5910 FARMWOOD LOOP ROAD WILSON, NC 27893	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
W 455	approximately 7:52: gloves when she ob bathrooms and area Client #3 took trash into a large trash ba #1. Client #1 took that and staff #2 helped bathroom trash can dirty disposable glocolient #3 was noted bathroom door and to the kitchen. At no encouraged to wea	ons in the home on 4/2/19 at am, client #3 was not wearing otained the trash from the as throughout the home.  I from each room and poured ag and handed over to client the big trash bag to the kitchen her with hand sanitizer. The as contained items such as eves, used tissues and etc. If to handle the door knob to the cereal box from the table of time was client #3 or gloves or wash her hands.  On 4/2/19, the qualified es professional (QIDP) hould have washed her hand	W 4	55		