STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G274	A. BUILDING _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOCKLEY ROAD	4617 LOCKLEY RD HOLLY SPRINGS, NC 27540

(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 351	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(1) Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain in a timely manner a dental examination for 1 newly admitted client (#3). The finding is: The facility failed to obtain a dental examination for client #3 within 30 days of admission. Review on 9/18/19 of client #3's individual program plan (IPP) dated 2/11/19 revealed he was admitted to the facility on 1/23/19. Further review of client #3's record revealed he had a dental examination on 4/18/19. During an interview on 9/19/19, the qualified intellectual disabilities professional (QIDP) confirmed client #3's dental examination did not occurr within 30 days of admission.	W 351	This deficiency will be corrected by the following actions: A. The Home Manager and the Clinical Supervisor will review CANC Policy C2.8 Admission to ensure that they are within guidelines for the completion of medical assessments for new consumers. B. This training will be documented on form F9.8 Inservice/Training Signature Sheet which will be filed in the training binder at the group home. C. The Home Manager and/or the Clinical Supervisor will contact client #3's dentist for a copy of the dental exam conducted prior to admission to the home. Once obtained, that assessment will be reviewed by the RN and filed in client #3's medical chart.	10/15/2019
W 418	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(ii) The facility must provide each client with a clean, comfortable mattress.	W 418	Please see Page 2.	

DHSR-Mental Health
SEP 2 6 2019
Lic. & Cert. Section

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

DAVP | Program Manager | 9/24/19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G274	A. BUILDING _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOCKLEY ROAD	4617 LOCKLEY RD HOLLY SPRINGS, NC 27540

(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 418	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure client #5 had a comfortable mattress. This affected 1 of 3 audit clients. The finding is: Client #5 was in need of a new mattress. During observations in the group home on 9/19/19, client #5's mattress was noted to have an indentation or dip in the middle. During an interview on 9/19/19, the home manager acknowledged the mattress had a noticeably dip or sink in the middle. She further added client #5 had a new behavior of jumping on his bed, which will be addressed during the next review period. During an interview on 9/19/19 with the qualified intellectual disabilities professional (QIDP) confirmed the mattress had a dip in the middle.	W 418	This deficiency will be corrected by the following actions: A. The Home Manager and/or the Clinical Supervisor will contact maintenance to request that the mattress for client #5 is replaced in a timely manner. B. The Home Manager will complete a monthly assessment, form F2.32B Home Checklist, of the home and the items within it to ensure that any items that need replacement or repair are addressed. C. The Home Manager will ensure that any items that do need replacement or repair are addressed by the appropriate individuals. D. The Program Manager will monitor this monthly assessment checklist through documentation review which will occur at a minimum of 1x/month.	10/15/2019

September 24, 2019

Wambui Karanu, BSN, RN
NurseConsultant I
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Plan of Correction for Recertification Survey
Lockley Road, 4617 Lockley Road Apex, NC 27539
Provider Number: 34G274
MHL Number: MHL-092-119

Dear Ms. Karanu,

Thank you for your time and the feedback given during the survey you completed on September 19, 2019. We appreciate your diligence in assisting us in providing the best care possible to the consumers we serve. We look forward to making the recommended changes that will improve the services we provide.

Enclosed you will the Plan of Correction. If you have any questions, please call me at (919) 387-1011 ext. 217. Again, thank you for your time and patience.

Sincerely,

Gary J. Ricci II, BA/QP
Program Manager, CANC

Enclosures