CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		34G027	B. WING			02/	26/2020
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SCOTTHU	RST I & II				74 HOOTS DRIVE		
				N	/INSTON-SALEM, NC 27107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
W 130	CFR(s): 483.420(a)(7 The facility must ensu) ure the rights of all clients.	Ŵ	130			
	Therefore, the facility must ensure privacy during treatment and care of personal needs.						
	Based on observatio interview, the facility f	not met as evidenced by: ns, record review and failed to ensure privacy al needs for 1 of 6 sampled ng is:					
	6:45 AM revealed clie with the door open. F AM revealed client #2 his room, completing with the door slightly at 7:40 AM revealed s the same bathroom. bathroom leaving the another client attempt redirected the other c	lient to wait until client #2					
	revealed client #2 to e towards the laundry re with his bathrobe ope redirected client #2 to walked towards staff observed entering his the door open. Client prompted by staff to o privacy.	E. Client #2 was then room to get dressed with #2 was not observed to be close the door to ensure					
	a person centered pla indicating client #2 lik	cord on 2/26/2020 revealed an (PCP) dated 7/31/2019 es private time in his SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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: 03/06/2020 FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/06/2020 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		(X3) DATE	
		34G027	B. WING				02/2	26/2020
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
SCOTTHU	RST I & II				174 HOOTS DRIVE WINSTON-SALEM, NC 27107			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
W 130 W 227	listed are but not limit washing machine, ide operate clothes dryer, and behavior support. Interview with the qua professional (QIDP) of facility staff should as client should be in a b order to ensure client personal needs. QIDF should have prompted or staff should have c privacy during care of INDIVIDUAL PROGR CFR(s): 483.440(c)(4 The individual program objectives necessary as identified by the co	active treatment goals red to: bathing, operate entify community safety, state equivalency of coins, alified intellectual disabilities on 2/26/2020 confirmed that esure no more than one bathroom at one time in privacy during the care of P further confirmed staff d client #2 to close the door closed the door to ensure f personal needs. CAM PLAN		227				
	Based on observation interview, the facility f centered plan (PCP) i client needs relative to sampled clients (#12) Observations on 2/25 revealed client #12 to with a gait belt wrapp seat and fastened over	i/20 at the day program be sitting in a wheelchair ed around the back of the er her lap. Continued out the survey from 2/25/20						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/06/2020 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		34G027	B. WING			02/	26/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SCOTTHU	IRST I & II				174 HOOTS DRIVE WINSTON-SALEM, NC 27107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
W 227	wheelchair at all times chair during lunch and van for transport. Dur staff I were pushing c to room at the day pro group home. Client # herself while in the wh ambulate with staff as Record review on 2/2 dated 7/24/19 instruct use the wheelchair fo review included the for maintain daily walking to maintain client #12 and decrease edema a physical therapy (P' indicating use of a wh and community outing Interview at the group J revealed she did no programs for client #1 interview with staff L r when client #12 shoul Interview on 2/26/20 v disabilities (QIDP) ver PCP directions to use distances and commu revealing there is not staff to follow for client DRUG ADMINISTRAT CFR(s): 483.460(k)(4	s except for transferring to a d transferring to a seat in the ring that time, staff H and lient #12 around from room ogram as well as at the effective of the staff the second provide the staff the second sistence. 6/20 of client #12's PCP ted that client #12's PCP ted that client #12 should r long distances. Further ollowing recommendations: g opportunities plus 1 assist 's strength, dynamic balance . Continued review revealed T) consult dated 6/21/19, teelchair for long distances gs. home on 2/25/19 with staff t know of any guidelines or 2's wheelchair. Further revealed she was not sure to use the wheelchair. with the qualified intellectual rified the PT consult and the wheelchair for long unity outings were current, a program or guidelines for t #12's wheelchair use. TION) administration must assure to administer their own		371			

Facility ID: 922547

If continuation sheet Page 3 of 11

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/06/2020 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE	
		34G027	B. WING			_	02/:	26/2020
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, ST	FATE, ZIP CODE		
SCOTTHU	RST I & II				174 HOOTS DRIVE WINSTON-SALEM, NC	27107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 371		ective, and if the physician	w	371				
	Based on observation interviews, the system failed to assure 2 of 2 observed during the r provided teaching rela	· /						
	assure client #1 was	ug administration failed to provided teaching related to possible side effects of For example:						
	during medication adr #1 to receive medicat Probiotic Blend 1 cap 0.1%. Continued obs pour a mixture of grap sippy cup. Further ob prompt and provide h with client #1 to punch medication cup. Clien all medications mixed over hand assistance not observed to be pr	nt #1 was observed to take I with applesauce with hand from staff. Client #1 was rovided with teaching related or possible side effects of						
	a person centered pla Further review of the administration strengt	ecord on 2/26/2020 revealed an (PCP) dated 3/27/2019. PCP revealed a medication th section to include client dications, pour his water,						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/06/2020 APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMPL	SURVEY
		34G027	B. WING		_	02/2	26/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
SCOTTHU	RST I & II			174 HOOTS DRIVE WINSTON-SALEM, NC	27107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 371	review revealed client purpose of his medication identify his medication chooses to. Interview with the faci- verified client #1 shou- education during his r- identification of medica- effects. B. The system for dru assure client #6 was p the name, purpose or medications received. Observations conduct AM during medication client #6 to receive m cap 24 mcg, Carbama 10mg, Clonidine 0.1m C CHW 250mg, Chlor Benzoyl Peroxide Top observations during the administration revealed of grape juice and wa observation revealed punch medications int #6 was observed to ta with applesauce spoor was not observed to ta related to the name, p effects of medical re a person centered pla Further review of the	when finished. Continued #1 understands the ations and can name and as on occasions if he lity nurse on 2/26/2020 Id have been provided nedication pass with ation, purpose and side ug administration failed to provided teaching related to possible side effects of For example: ted on 2/26/2020 at 7:10 administration revealed edications including Amitiza azepine 200mg, Cetirizine ug, Multivitamin tab, Vitamin hexidine Gluc 0.12%, ical 10%. Continued his medication ed staff D to pour a mixture ter in a cup. Further staff D to prompt client #6 to to a medications mixed n fed by staff. Client #6 pe provided with teaching purpose or possible side	W 37	1			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 03/06/2020 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	
		34G027	B. WING		02/	26/2020
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
SCOTTHU	RST I & II			74 HOOTS DRIVE VINSTON-SALEM, NC 27107		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
W 371	Continued From page		W 371			
		dications, pour his water, when finished. Continued t #6 understands the				
		ations and can name and				
	verified client #6 shou education during his r	ility nurse on 2/26/2020 uld have been provided medication pass with cation, purpose and side				
W 460	FOOD AND NUTRITI CFR(s): 483.480(a)(1		W 460			
	Each client must rece well-balanced diet inc specially-prescribed d	cluding modified and				
	Based on observation interviews, the facility specifically prescribed	not met as evidenced by: ns, record review, and failed to ensure a d diet was followed for 3 #5, #6). The findings are:				
	A. Client #2's specific followed.	ally prescribed diet was not				
	2/26/2020 at 8:45 AM the dining table to ind water into his cups. C revealed staff D to cur rocker knife and staff cream cheese to clien revealed client #2 to p	t client #2's boiled eggs with F to offer whole bagels with nt. Further observations participate in the breakfast t boiled eggs, whole bagel				

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If continuation sheet Page 6 of 11

	-	ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 03/06/2020 ORM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) E	DATE SURVEY OMPLETED
		34G027	B. WING				02/26/2020
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SCOTTHU	IRST I & II				174 HOOTS DRIVE WINSTON-SALEM, NC 27107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 460	Continued From page	∂ 6	w	460			
	revealed a person cer 7/31/2019. Review of to have a regular 1/4 double portions at me mustard/collard green spicy foods were lister records for client #2 m physician's order for t diet with 1/4 consisten Interview with the qua professional (QIDP) of client #2 has a regula QIDP further confirme should be followed at should have been cut B. Client #5's specific followed. Observation in the gra 2/26/2020 at 8:45 AM the dining table to ind water into his cups. C revealed client #5 to of knife. Further observ participate in the breat boiled eggs, whole bat juice and water. Review of records for revealed a PCP dated PCP revealed client # consistency diet, with of records for client #2 physician's order for t	the client to have a regular ncy. alified intellectual disabilities on 2/26/2020 confirmed ir 1/4 consistency diet. The ed client #2's prescribed diet all meals and his bagel it into 1/4 pieces. ally prescribed diet was not oup home on the morning of I revealed client #5 to sit at lependently pour juice and continued observation cut boiled eggs with a rocker ations revealed client #5 to akfast meal consisting of cut agel with cream cheese, it client #5 on 2/26/2020 d 4/24/2019. Review of the t5 to have a regular 1/2 inch no seconds. Further review					

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	-	ID HUMAN SERVICES				FORM): 03/06/2020 MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		34G027	B. WING		_	02/2	26/2020
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
SCOTTUU			1	74 HOOTS DRIVE			
SCOTTHU	KƏLIQII		v	VINSTON-SALEM, NC	27107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG W 460	Continued From page record revealed a cho 8/28/2019 which indic rapid pace and diet m consistency. Interview with the QIE client #5 has a regula QIDP further confirme assessment is curren should have been cut C. Client #6's specific followed. Observation in the gro 2/26/2020 at 8:45 AM the dining table and h fix the client's place a Continued observation cut the client's boiled Further observations cup of coffee to the cl whole bagel with creat observations revealed the breakfast meal co whole bagel with creat Review of records for revealed a PCP dated PCP revealed client to inch consistency diet, 4pm. Further review revealed a current ph	e 7 oking risk assessment dated cated the client eats at a nodifications made to 1/2 DP on 2/26/2020 confirmed r 1/2 consistency diet. The ed client #5's choking risk t and the client's bagel based on prescribed diet. cally prescribed diet was not oup home on the morning of revealed client #6 to sit at rand over hand assistance to nd pour juice into his cup. n revealed staff D to then eggs with a rocker knife. revealed staff F to bring a ient at the table and offer a um cheese. Subsequent d the client to participate in onsisting of boiled eggs, um cheese, juice and water. client #6 on 2/26/2020 d 2/12/2020. Review of the o have a weight gain, 1/4 and ensure 4 oz. daily at of records for client #6 ysician's order for the client	TAG W 460				
	Continued review of r risk assessment date choking risk assessm poor control of food/lid	, 1/4 inch consistency diet. ecord revealed a choking d 2/12/2020. Review of the ent revealed the client has quid in mouth, difficulty ns, talks with food in mouth,					

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-					FORM	: 03/06/2020 APPROVED . 0938-0391
DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE S COMPL	SURVEY
	34G027	B. WING			02/2	26/2020
ROVIDER OR SUPPLIER				TATE, ZIP CODE		
RST I & II				27107		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BI		(X5) COMPLETION DATE
holds food between cl in mouth, GERD and Interview with the QIE client #6 to have a we consistency diet. The client #6's choking risi client's bagels should prescribed diet. MEAL SERVICES CFR(s): 483.480(b)(2 Food must be served This STANDARD is m Based on observation failed to assure 3 of 6 #6) and 1 non sample with appropriate utens independently as pose their highest functionin A. The facility failed to provided with appropriate their highest functionin A. The facility failed to provided with appropriate their highest functioning Dinner observations co home at 5:45 PM revel his meal consisting of vegetables, and apple observations revealed spoon and rocker knif another client during to staff offer or provide co	heeks and gums, stuffs food 1/4 inch consistency. DP on 2/26/2020 confirmed eight gain, 1/4 inch e QIDP further confirmed k assessment is current and have been cut based on his 2)(iv) with appropriate utensils. not met as evidenced by: n and interview, the facility is sampled clients (#2, #5, ed client (#3) were provided sils to enable them to eat as sible in accordance with ng level. The findings are: to assure client #2 was riate utensils during the on 2/25/2020 in the group ealed client #2 consuming f salmon stir fry, rice, e cinnamon bread. Further d client #2 had a regular fe which was shared with this meal. At no time did client #2 with a fork.	W 460				
	-					
	S FOR MEDICARE & I F DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER RST I & II Continued From page holds food between c in mouth, GERD and Interview with the QIE client #6 to have a we consistency diet. The client #6's choking ris client's bagels should prescribed diet. MEAL SERVICES CFR(s): 483.480(b)(2 Food must be served This STANDARD is r Based on observation failed to assure 3 of 6 #6) and 1 non sample with appropriate utens independently as pos- their highest functioni A. The facility failed to provided with appropriate utens independently as pos- their highest functioni A. The facility failed to provided with appropriate utens independently as pos- their highest functioni Dinner observations c home at 5:45 PM reve his meal consisting of vegetables, and apple observations revealed spoon and rocker knif another client during to staff offer or provide c	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 34G027 ROVIDER OR SUPPLIER RST I & II SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 holds food between cheeks and gums, stuffs food in mouth, GERD and 1/4 inch consistency. Interview with the QIDP on 2/26/2020 confirmed client #6 to have a weight gain, 1/4 inch consistency diet. The QIDP further confirmed client #6's choking risk assessment is current and client's bagels should have been cut based on his prescribed diet. MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure 3 of 6 sampled clients (#2, #5, #6) and 1 non sampled client (#3) were provided with appropriate utensils to enable them to eat as independently as possible in accordance with their highest functioning level. The findings are: A. The facility failed to assure client #2 was provided with appropriate utensils during the	S FOR MEDICARE & MEDICAID SERVICES IP DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING_ 34G027 B. WING	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDERSUPPLER/CLIA UDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 34G027 b. WING SOUDER OR SUPPLIER STREET ADDRESS, CITY. S. TAT HOOTS DRIVE (REAT DEFICIENCY WILL BE PRECEDED BUT PULL RESULATORY OR LSC IDENTIFYING INFORMATION) D. PREPTX RESULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 holds food between cheeks and gums, stuffs food in mouth, GERD and 1/4 inch consistency. W 460 Continued From page 8 holds food between cheeks and gums, stuffs food in mouth, GERD and 1/4 inch consistency. W 460 Continued From page 8 holds food between cheeks and gums, stuffs food in mouth, GERD and 1/4 inch consistency. W 460 Continued From page 8 holds food between cheeks and gums, stuffs food in mouth, GERD and 1/4 inch consistency. W 460 Consistency Uiet. The QIDP further confirmed client #6's choking risk assessment is current and clients bages should have been cut based on his prescribed diet. W 475 MEAL SERVICES CFR(s): 483.480(b)(2)(iv) W 475 W 475 Food must be served with appropriate utensils. W 475 Kit appropriate utensils to enable them to eat as independently as possible in accordance with their highest functioning level. The findings are: A. The facility failed to assure client #2 was provided with appropriate utensils during the dinner meal. Dinner observations on 2/25/2020 in the group home at 5:45 PM revealed client #2 consuming	MENT OF HEALTH AND HUMAN SERVICES SPOR MEDICARE & MEDICAD SERVICES PERICIENCIES OWNECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BULDING RST1 & II XHORE OR SUPPLIER RST1 & II SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERCIENCY MUST BE PRECEDED BY FULL RECULATORY OR LIC DEPTICIENCIES (EACH OPERCIENCY MUST BE PRECEDED BY FULL RECULATORY OR LIC DEPTICIENCIES (EACH OPERCIENCY MUST BE PRECEDED BY FULL RECULATORY OR LIC DEPTICIENCIES (EACH OPERCIENCY MUST BE PRECEDED BY FULL RECULATORY OR LIC DEPTICIENCIES (EACH OPERCIENCY MUST BE PRECEDED BY FULL RECULATORY OR LIC DEPTICIENCIES (EACH OPERCIENCY MUST BE PRECEDED BY FULL RECULATORY OR LIC DEPTICIENCIES (EACH OPERCIENCY MUST BE PRECEDED BY FULL RECULATORY OR LIC DEPTICIENCIES (EACH OPERCIENCY ACTION BIOLDED (EACH OPERCIENCE ACTION SHOULD BY RECULATORY OR LIC DEPTICIENCIES) D PREVIDENCY Continued From page 8 holds food between cheeks and gums, stuffs food in mouth, GERD and 1/4 inch consistency. W 460 Interview with the QIDP On 2/26/2020 confirmed client's bagies should have been cut based on his prescribed diet. W 475 CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. W 475 This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to assure 3 of 6 sampled client (#2, #5, #0) and 1 non sampled client (#2, #5, #0) and 1 non sampled client #2 was provided with appropriate utensils during the dinner meal. Interview and provide action Bay Must provide and happropriate utensis further observations revealed client #2 had a regular	MENT OF HEALTH AND HUMAN SERVICES FORM S FOR MEDICARE & MEDICALD SERVICES OMB NO overdenseise (x1) PROVERSIMPLERCUA IDENTIFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A BULDING (x2) DUT overdenseise (x1) PROVERSIMPLERCUA IDENTIFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A BULDING (x2) DUT overdenseise (x3) PROVERSIMPLERCUA IDENTIFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A BULDING (x2) DUT overdenseise (x3) PROVERSIMPLERCUA IDENTIFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A BULDING (x2) DUT overdenseise (x3) PROVERSIMPLERCUA IDENTIFICATION NUMBER (x2) PROVERSIMPLERCUA IT HOORS DRIVE WINSTON-SALEM, NC 27107 (x3) PROVERSIMPLERCUA IDENTIFICATION NUMBER (x3) PROVERSIMPLERCUA IDENTIFICATION NUMBER (x4) PROVERSIMPLERCUA IDENTIFICATION NUMBER (x4

Facility ID: 922547

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/06/2020 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	-	(X3) DATE S COMPL	SURVEY
		34G027	B. WING			02/2	26/2020
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
SCOTTHU	JRST I & II			174 HOOTS DRIVE WINSTON-SALEM, NC	27107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 475	confirmed client #2 re his meals. Further interview confirmed client #2 re his meals. Further interview confirmed client with a place setting co fork and spoon during B. The facility failed to provided with appropri- dinner meal. Dinner observations of home at 5:30 PM revel- his meal consisting of vegetables and apple observations revealed spoon during this mea- with another client. A provide client #5 with Interview on 2/26/202 client #5 can appropri- Further interview with should be provided w of a rocker knife, fork C. The facility failed to provided with appropri- dinner meal. Dinner observations co home at 5:30 PM revel- his meal consisting of vegetables, and apple observations revealed spoon during this mea- or provide client #6 w	equires a rocker knife to eat erview confirmed client #2 e all utensils. Continued lient #2 should be provided onsisting of a rocker knife, g all meals. b assure client #5 was riate utensils during the on 2/25/2020 in the group ealed client #5 consuming f salmon stir fry, rice, e cinnamon bread. Further d client #5 had a regular al and shared a rocker knife at no time did staff offer or a fork. 20 with the QIDP confirmed iately use all utensils. 9 QIDP confirmed client #5 ith a place setting consisting and spoon during all meals. to assure client #6 was riate utensils during the on 2/25/2020 in the group ealed client #6 consuming f salmon stir fry, rice, e cinnamon bread. Further d client #6 had a regular al. At no time did staff offer	W 475				

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: FORM A OMB NO. (PPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G027	B. WING		_	02/26	6/2020
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
SCOTTHU	IRST I & II			74 HOOTS DRIVE VINSTON-SALEM, NC	27107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 475	should be provided w of a knife, fork and sp D. The facility failed to provided with appropri- dinner meal. Dinner observations of home at 5:30 PM reve his meal consisting of vegetables and apple observations revealed spoon during this mea- or provide client #3 w Interview on 2/26/202 client #3 can appropri- Further interview with	iately use all utensils. a QIDP confirmed client #6 ith a place setting consisting boon during all meals. o assure client #3 was riate utensils during the on 2/25/2020 in the group ealed client #3 consuming f salmon stir fry, rice, e cinnamon bread. Further d client #3 had a regular al. At no time did staff offer ith a fork and knife. 20 with the QIDP confirmed iately use all utensils. a QIDP confirmed client #3 ith a place setting consisting	W 475				

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