		AND HUMAN SERVICES			0		APPROVED 0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT	(X3) DATE SURVEY COMPLETED		
		34G033	B. WING _			03/	04/2020		
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE	•			
SOUTHRIDGE ROAD			301 SOUTHRIDGE RD JAMESTOWN, NC 27282						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
W 371	CFR(s): 483.460(k) The system for drug that clients are taug medications if the in determines that sel is an appropriate of does not specify oth This STANDARD is Based on observat interviews, the syste failed to assure 3 o observed during the provided teaching r side effects of med findings are: A. The system for assure client #3 wa the name, purpose medications receive Observations condu- during medication a #3 to receive medic 5000 IU, Benztropir and Restasis EMO	(4) g administration must assure ght to administer their own nterdisciplinary team f-administration of medications ojective, and if the physician herwise. s not met as evidenced by: tions, record review and em for drug administration f 3 clients (#2, #3 and #4) e medication pass were elated to name, purpose and ications administered. The drug administration failed to is provided teaching related to or possible side effects of ed. For example: ucted on 3/4/2020 at 7:10 AM administration revealed client cations including Vitamin D ne 0.05mg, Fluoromethol 0.1% 0.05%. Continued	W 3	71	DEFICIENCY)				
	#3 to punch medica Client #3 was obse Client #3 was not o teaching related to side effects of med Review of medical	led with staff E direction, client ations into a medication cup. rved to take all medications. bserved to be provided with the name, purpose or possible ications administered. record on 3/4/2020 revealed a							
	Further review of th	an (PCP) dated 9/1/2019. he PCP revealed client #3							
LABURATUR	T DIRECTOR S OR PROVIL	DER/SUPPLIER REPRESENTATIVE'S SIGI	VALUKE		TITLE		(X6) DATE		

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(X6) DATE

PRINTED: 03/06/2020

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.

		AND HUMAN SERVICES				FORM	03/06/2020 APPROVED 0938-0391			
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED				
		34G033	B. WING	i		03/	04/2020			
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE					
SOUTHRIDGE ROAD			301 SOUTHRIDGE RD JAMESTOWN, NC 27282							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE			
W 371	knows what he's tal Continued review o independent daily a Client #3 requires n physical assistance and stating medicat Interview with the q professional (QIDP should have been p medication pass wi one medication, pu B. The system for assure client #2 wa the name, purpose medications receive Observations condu during medication a #2 to receive medic Carbamezepine CH Sertraline 50mg, Re Spray. Continued of medication adminis prompt client #2 to assistance into a m observations revea medications. Clien provided with teach purpose or possible administered. Review of medical PCP dated 3/1/2019 revealed a living sk 2/10/2020. Review	hedication administration and king and why he is taking it. f record revealed an issessment dated 8/27/2019. moderate/gestural or partial e with describing, dispensing, tion and purpose. ualified intellectual disability) on 3/4/2020 verified client #3 provided education during his th the identification of at least rpose and side effect. drug administration failed to is provided teaching related to or possible side effects of ed. For example: ucted on 3/4/2020 at 7:20 AM administration revealed client	W 3	371						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/06/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
34G033		B. WING			03/04/2020		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHR	IDGE ROAD				01 SOUTHRIDGE RD AMESTOWN, NC 27282		
(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 371	accuracy and safety Interview with the G #2 should have been his medication pass least one medication C. The system for assure client #4 wat the name, purpose medications receive Observations condu- during medication a #4 to receive medic 20mg, Vitamin D 10 600/400 IU, Docusa tab/Antioxid, Polyet observations reveal to punch medication Further observations medications. Client provided with teach purpose or possible administered. Review of medical PCP dated 10/1/20 PCP revealed an in assessment dated 9 the independent da client #4 requires fu medication adminis state medication an why he is taking the Interview with the G	tration but relies on others for y. NDP on 3/4/2020 verified client en provided education during s with the identification of at on, purpose and side effect. drug administration failed to s provided teaching related to or possible side effects of ed. For example: ucted on 3/4/2020 at 7:30 AM administration revealed client cations including Omeprazole 000 Unit, Calcium + Vit D ate Sodium 100mg, Certavite hyene Glycol Powd. Continued led staff E to prompt client #4 ns into a medication cup. Its revealed client #4 to take all t #4 was not observed to be ing related to the name, e side effects of medications record on 3/4/2020 revealed a 19. Continued review of the dependent daily living 9/9/2019. Further review of ily living assessment revealed ull assistance during tration to describe, dispense, ad purpose, and understand em.	W 3	571			
	clients should have	been provided education					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM A CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO.									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
34G033			B. WING _		03/04/2020				
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE					
SOUTHR	RIDGE ROAD		301 SOUTHRIDGE RD JAMESTOWN, NC 27282						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
W 371	during the medicati	age 3 ion pass with the identification lication, purpose and side	W 37						

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Facility ID: 922667

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