| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G241 | A. BUILDING _____ B. WING _____ | 10/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ARCHES-HORIZONS RESIDENTIAL CARE CENTER | 5900 BETHABARA PARK BOULEVARD WINSTON SALEM, NC 27106 |

| (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 130 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(7)<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure privacy of 3 of 3 sampled clients #2, #5, #8 and 2 nonsampled clients #4 and #7 during medication administration. The finding is:<br><br>Morning observations conducted on 10/7/20 at 7:30AM to 9:30 AM in the home revealed clients #2, #5, and #8 were in a day program and sensory room along with other clients to include clients #4, #7 awaiting to eat and consuming breakfast. Continued observations revealed client #2 to receive his medications at 7:30 AM in the middle of the hallway directly in front of the facilty entry door without the use of a privacy screen or another mode of privacy, while other clients and staff walked by. Further observations at 7:50 AM revealed client #7 to receive her medications via G tube in the middle of the hallway directly in front of the facilty entry door without the use of a privacy screen or another mode of privacy where staff walked by. Subsequent observations at 8:20 AM revealed client #8 to receive her medications outside the day program entry door without the use of a privacy screen or another mode of privacy where staff entered and exited the room. Observations at 8:58 AM revealed client #5 to receive his medications in the middle of the hallway directly in front of the facilty entry door without the use of a privacy screen or another mode of privacy where staff walked by. Continued observations at 9:30 AM revealed client #4 to | W 130 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G241 | A. BUILDING _____ B. WING _____ | 10/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ARCHES-HORIZONS RESIDENTIAL CARE CENTER | 5900 BETHABARA PARK BOULEVARD WINSTON SALEM, NC 27106 |

| (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 130 | Continued From page 1<br>receive her medications in the middle of the hallway directly in front of the facilty entry door without the use of a privacy screen or another mode of privacy.<br><br>Interviews on 10/7/20 with the facility nurse confirmed clients who are not in their bedrooms at the time of mediation administration are removed out of the area, away from other clients to receive the medications. Further interview with the facility nurse verified that clients are moved out of the dayroom into the hallway to be as discreet as possible during medication administration. Interview with the director of nursing (DON) verified that some clients are provided medication administration in their rooms. Further interview with the DON verified the facility previously administered medications in the corner directly in front of the exit door leading to the back yard. The DON also confirmed privacy should be provided for all clients during the administering of individuals' medications. | W 130 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, review of records and | W 249 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G241 | A. BUILDING _____ B. WING _____ | 10/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ARCHES-HORIZONS RESIDENTIAL CARE CENTER | 5900 BETHABARA PARK BOULEVARD WINSTON SALEM, NC 27106 |

| (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 249 | Continued From page 2 | W 249 | | |

interviews, the facility failed to ensure objectives listed in the individual program plan (IPP) were implemented as prescribed for 1 sampled client (#7) and 1 non-sampled client (#1) relative to a communication device. The findings are:

A. The facility failed to ensure a communication objective for client #7 was implemented as prescribed. For example:

Afternoon observations in the facility on 10/6/20 from 4:30 PM to 6:30 PM revealed client #7 to participate in various activities including an outdoor activity, a sensory activity in the dayroom, participation in the dinner meal and 2-person transfer from wheel chair to a recliner chair. Further observations on 10/6/20 from 5:00 PM to 6:30 PM revealed client #7 to wash her hands with staff hand over hand assistance and to participate in the dinner meal. At no point during the afternoon observation period was client #7 observed to be offered a mack switch communication device.

Morning observations in the facility on 10/7/20 from 7:00 AM to 9:15 AM revealed client #7 to participate in various activities including getting dressed with staff assistance, a game activity, and to participate in the breakfast meal. At no point was client #7 observed to be offered a mack switch communication device during the observation period.

Review of the record for client #7 revealed an IPP dated 5/6/20 which indicates that client #7 has the following programming goals: identify rights via voice output box, express my feelings, talk about a story, and choose my clothing. Further review of the record revealed that client #7 has the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G241 | A. BUILDING _____ B. WING _____ | 10/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ARCHES-HORIZONS RESIDENTIAL CARE CENTER | 5900 BETHABARA PARK BOULEVARD WINSTON SALEM, NC 27106 |

| (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 249 | Continued From page 3 | W 249 | | |

following adaptive equipment: big mack switch, grasp switch, and little mack step by step.

Interview with staff A on 10/7/20 verified client #7 should have had access to her mack switch device while in the day room. Interview with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that client #7's goals are current. Further interview with Director of Nursing (DON) confirmed that client #7 should have been offered a big mack switch to communicate with staff.

B. The facility failed to ensure that client #1's mealtime guidelines and a communication objective were implemented as prescribed. For example:

Afternoon observations in the facility on 10/6/20 from 4:30 PM to 6:30 PM revealed client #1 to participate in various activities including games in the day room, taking a walk with staff, an outdoor activity, and participating in the dinner meal. Further observations on 10/6/20 from 5:00 PM to 6:30 PM revealed client #1 to wash her hands with staff assistance and to participate in the dinner meal. At no point during the afternoon observation period was client #1 observed to be offered a mack switch communication device.

Morning observations in the facility on 10/7/20 from 7:00 AM to 9:15 AM revealed client #1 to participate in various activities including a bead activity and participating in the breakfast meal. Further observation at 7:30 AM revealed client #1 to have a mack switch communication device in her hands. Continued observation at 7:45 AM revealed staff B to test the mack switch device

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G241 | A. BUILDING _____ B. WING _____ | 10/07/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ARCHES-HORIZONS RESIDENTIAL CARE CENTER | 5900 BETHABARA PARK BOULEVARD WINSTON SALEM, NC 27106 |

| (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 249 | Continued From page 4<br>and it was not in working order. Staff B was later observed to put in new batteries and to provide client #1 with the mack switch communication device.<br><br>Review of the record on 10/7/20 for client #1 revealed an IPP dated 3/9/20 which indicates client #1 has the following adaptive equipmrent: wheel chair, chest harness, lap belt, big mack switch, and eye gaze board.. Further review of the record revealed mealtime guidelines dated 5/27/20 which indicates that staff should ask client #1 if she is ready to set her placemat and should be offered a communication device programmed to say "yes".<br><br>Interview with staff A verified client #1 should have had her mack switch communication device during mealtimes. Interview with the Qualified Intellectual Disabilities Professional (QIDP) verified that client #1 goals and guidelines are current. Further interview with the Director of Nursing (DON) confirmed that client #1 should have access to her communication device according to mealtime guidelines. | W 249 | | |