STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G277	A. BUILDING _____ B. WING _____	C 09/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASON STREET	306 N MASON STREET APEX, NC 27502

(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 000	INITIAL COMMENTS A complaint investigation was completed on 9/2/2020. Intake # NC00166361. The complaint was unsubstantiated.	W 000		
W 418	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(ii) The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure client #3 had a comfortable mattress. This affected 1 of 2 audit clients. The finding is: Client #3 was in need of a new mattress. During observations in the group home on 9/2/2020, client #3's mattress was noted to have a large indentation or dip in the middle of it. The head and foot of the mattress were noticeably higher than the middle of the mattress. During an interview on 9/2/2020, staff acknowledged the mattress had a noticeably large dip or sink in the middle. Interview on 9/2/2020 with the qualified intellectual disabilities professional (QIDP) confirmed the mattress had a large dip in the middle and was also slanted to one side. Additional interview revealed the client's matress needs to be replaced.	W 418	W418 This deficiency will be corrected by the following actions: A. The facility replace all mattresses B. The facility will monitor the need to repair/ replace all mattresses monthly C. Site Supervisor will monitor monthly D. Clinical manager will monitor monthly.	09.02.2020

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

Marika Whuck BJK | Executive Director | 9/11/2020

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.