STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G224	A. BUILDING _____ B. WING _____	R 12/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LANE	**534 COUNTRY LANE 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 000	INITIAL COMMENTS A follow-up survey survey was completed on 12/2/2020 for recertification survey completed 10/13/2020. All deficiencies cited were corrected. New deficiency was cited and the facility is not in compliance.	W 000		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure sufficient staff were provided to supervise clients and provide services in accordance with their governing body. This potentially affected all the clients residing in the facility. The finding is: Upon arrival at the group home on 12/2/2020 at 11:27am-12:30pm, Staff A was working in the home alone with six clients. The staff stood at the door as the home was on 14 days quarantine since the clients had returned from home visit. The staff was only able to carry a conversation at the door as she kept going back to the client and to the door since she was the only staff working that shift. Interview on 12/2/20 with Staff A, who is the Home Manager (HM), revealed she had worked	W 186		

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
	34G224	A. BUILDING _____ B. WING _____	R 12/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LANE	**534 COUNTRY LANE HOLLY SPRINGS, NC 27540**

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W 186	Continued From page 1 alone since 7:00am because the staff scheduled to work was not coming since she had a doctors appointment. Additional interview indicated first shift starts at 7:00am -300pm and minimum of two staff should be scheduled to work but the second staff was not expected until 2:00pm. Interview via phone on 12/2/20 with the acting Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility's staff to client ratio continues to be 2 to 6 and at least two staff should be working on each shift. The QIDP acknowledged adequate coverage must be maintained on each shift.	W 186		