DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/18/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G278	A. BUILDING _____ B. WING _____	C 09/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENT FERRY HOME	904 AVENT FERRY ROAD 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 complaint survey was completed on 9/15/20 for intakes NC00161881, NC00166866 and NC00166334. One defeciency was cited as a result of the complaint survey.	W 000		
W 214	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(iii) The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure all adaptive behavior inventories (ABI) which serve as the comprehensive functional assessments (CFA) were updated to contain an accurate assessment of the individual's abilities. This affected 1 of 3 audit clients (#4). The finding is: The CFA for client #4 was not updated per the recommendations of an internal investigation. All clients were observed in the home on 9/15/20 briefly at 9:45am and again from approximately 12:30p - 1:45p. Client #4 was seen completing all tasks independently (i.e. unloading the dishwasher and putting away dishes). Review on 9/15/20 of an internal investigation conducted by the facility regarding the loss of personal hygiene skills, laundry skills, etc. by client #4 revealed a recommendation to update the client's CFA. Interview with the Qualified Intellectual Disabilities	W 214		

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

QIDP | 10/16/2020

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.

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W 214	Continued From page 1 Professional (QIDP) on 9/15/20 confirmed client #4's CFA had not been updated as of the date of this survey.	W 214	QIDP will ensure that CFA is Complete and Current (yearly).	10/9/2020

COMMUNITY INNOVATIONS, INC.
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FACSIMILE TRANSMITTAL SHEET

Wilma Worsley-Diggs — **TO:**
Tonya Beckwith — **FROM:**

NC Dept of Health and Human Servics — **COMPANY:**
10/16/2020 — **DATE:**

(919) 715-8078 — **FAX NUMBER:**
3 — **TOTAL NO. OF PAGES INCLUDING COVER**

(919) 855-3795 — **PHONE NUMBER:**

Please accept our Plan of Correction for Aunt Fern Home. Thank you. — **NOTES/COMMENTS:**

THANK YOU.