| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | (| | APPROVED . 0938-0391 |
|---|---|--|-------------------------|-------|--|------------|----------------------|----------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | | ISTRUCTION | | (X3) DATE S COMPL | SURVEY |
| | | 34G138 | B. WING _ | | | 02/09/2021 | | |
| NAME OF PF | ROVIDER OR SUPPLIER | | | STREE | T ADDRESS, CITY, STATE, ZIP CODE | | | |
| COLLEGE PARK | | | | | AKE DRIVE RINBURG, NC 28352 | | | |
| (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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | | (X5) COMPLETION DATE |
| W 242 | INDIVIDUAL PROGR CFR(s): 483.440(c)(6 The individual progra those clients who lack skills essential for priv (including, but not lim personal hygiene, der bathing, dressing, gro of basic needs), until that the client is deve acquiring them. This STANDARD is r Based on observatio review, the facility fail program plan (IPP) in address bathing, dinin needs for 2 of 4 sam The findings include: A. During observation 6:05pm client #5 was table in her wheelcha sectioned plate and h than 1/4 inch pieces. clients were having st cabbage, bread and st for dessert. Tea, wate beverages. Staff B sa verbally cued her to p Staff B helped client # she dropped it back of Client #5 ate less tha | AM PLAN)(iii) m plan must include, for k them, training in personal vacy and independence ited to, toilet training, ntal hygiene, self-feeding, ooming, and communication it has been demonstrated lopmentally incapable of not met as evidenced by: n, interview and record ed to ensure the individual cluded objective training to ng, dressing and grooming pled clients (#2 and #5). as on 2/8/21 of supper at seated at the dining room ir and had a built up er food was cut into less The menu indicated the tuffed bell peppers, strawberry cheesecake cups er and milk were served for at beside client #5 and tick up her spoon and eat. #5 pick up her spoon but in the dining room table. | W 2 | 242 | | | | |
| | 7:32am Staff D sat ne sitting in her wheelch | ext to client #5 who was air. The clients were served d toast. Client #5's toast and | | | | | | |
| | DIRECTOR'S OR PROVIDER/S | SUPPLIER REPRESENTATIVE'S SIGNATU | RE | 1 | TITLE | | (| X6) DATE |

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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.

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ 34G138 B. WING 02/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LAKE DRIVE **COLLEGE PARK** LAURINBURG, NC 28352 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 242 Continued From page 1 W 242 sausage was precut into less than 1/4 inch pieces before her plate was served. Client #5 had great difficulty picking up her spoon and staff D cued her several times to feed herself. Client #5 ate less than 1/4 of her meal. Interview on 2/9/21 with the residential manager (RM) confirmed client #5 did not have a current training program to feed herself. Further interview revealed there may have been a previous objective but it may have been discontinued. Review on 2/8/21 of client #5's individual program plan (IPP) dated 6/16/20 revealed client #5 can feed herself with a fork and spoon and that she can hold a cup to consume her beverages. Further review revealed she requires total assistance with all activities of daily living. Further review of the IPP did not reveal any current training in the area of dining. She has current training objectives to brush her hair and dust end tables in the living area. Review on 2/9/21 of client #5's adaptive behavior inventory (ABI) dated 9/24/20 revealed she can finger feed, eat with a spoon and fork as well as drink from a cup using partial assistance from staff. Review of client #5's nutritional evaluation dated 3/9/20 revealed she requires a 1/4 inch consistency cut diet with thin liquids and that staff are to provide her Ensure plus 4 times daily at 10am, 12 noon, 4pm and 8pm as well as supplement her meals if she eats 1/4 of her meal or less. Her target weight range is listed as 75-95 pounds. Interview on 2/9/21 with the qualified intellectual

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G138 B. WING 02/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LAKE DRIVE **COLLEGE PARK** LAURINBURG, NC 28352 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 242 Continued From page 2 W 242 disabilities professional (QIDP) revealed the team had not considered client #5 for training in the area of dining although the ABI indicates she is not independent in this area. B. Review on 2/9/21 of the client #5's IPP dated 6/16/20 revealed that she requires total assistance in dressing and bathing. Further review of the IPP revealed client #5 can use her left had to wash and dry her right hand. There is no training for client #5 identified in the areas of bathing and dressing. She currently has objectives to brush her hair and dust end tables in the living area. Review on 2/9/21 of the ABI dated 9/24/20 revealed client #5 has no independence in the areas of bathing and dressing. Interview on 2/9/21 with the QIDP revealed the interdisciplinary team had not considered training for client #5 in the areas of bathing and dressing. C. During morning observations on 2/9/21 at 6:15am staff E was observed to brush client #2's hair and to style it while she sat in her wheelchair. Staff E stated client #2 enjoys having her hair brushed and that she likes to look well groomed. Review on 2/8/21 of client #2's IPP dated 7/15/21 revealed she requires assistance in all areas of bathing and grooming. Further review of the IPP revealed she has training programs to wipe her mouth with 80% physical prompts for 3 consecutive months and dust her room with 85% accuracy for 3 consecutive months. There was no training identified in the areas of bathing and grooming.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G138 B. WING 02/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1900 LAKE DRIVE **COLLEGE PARK** LAURINBURG, NC 28352 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 242 Continued From page 3 W 242 Review on 2/9/21 of the ABI dated 2/5/21 revealed she has no independence in the areas of bathing and grooming. Interview on 2/9/21 with the QIDP revealed the interdisciplinary team had not considered training for client #2 in the areas of bathing and grooming. W 249 **PROGRAM IMPLEMENTATION** W 249 CFR(s): 483.440(d)(1) 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. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to consistently implement a system of interventions and services that supported the goals and objectives in the individual program plans (IPP) for 1 of 4 audit clients (#2). The finding is: During observations on 2/8/21 of supper at 6:05pm client #2 had a built up sectioned plate, a left angled spoon and mugs with handles. Her food was ground consistency. The menu indicated the clients were having stuffed bell peppers, cabbage, bread and strawberry cheesecake cups for dessert. Staff B sat on left side and prompted her to scoop. After the meal, direct care staff B wiped her mouth with a napkin.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
| | | 34G138 | B. WING | | | _ | 02/ | 09/2021 | |
| NAME OF F | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | | |
| COLLEG | E PARK | | | 1900 LAKE DRIVE LAURINBURG, NC 28352 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREF TAG | IX | (EACH CORREC CROSS-REFEREN | B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| W 249 | Continued From page | 9 4 | w | 249 | | | | | |
| W 252 | REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 During observations on 2/9/21 of breakfast at 7:32am client #2 had a built up sectioned plate, left angled spoon and mugs with handles. Her food was ground. The menu indicated the clients were having oatmeal, toast and sausage for breakfast with juice, milk and water. Staff C was sitting next to client #2. After the meal, staff C took a napkin and wiped client #2's mouth. Review on 2/9/21 of the adaptive behavior inventory (ABI) dated 2/5/21 revealed client #2 has no independence in the area of dining. Review of client #2's individual program plan (IPP) dated 7/15/20 revealed client #2 can feed herself with hand over hand assistance and that she uses adaptive utensils (left angled spoon) and built up plate. Further review of the IPP revealed a a training objective to wipe her mouth with 80% physical prompts for 3 consecutive months. This objective was revised on 1/25/21 but is listed as current. Interview on 2/9/21 with the residential manager (RM) and the qualified intellectual disabilities professional (QIDP) confirmed client #2's training objective to wipe her mouth is current. PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. | | w | 252 | | | | | |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 02/10/2021 MAPPROVED). 0938-0391 | |
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| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | | SURVEY LETED | |
| | | 34G138 | B. WING | | | _ | 02/09/2021 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | | |
| COLLEGE PARK | | | | | 900 LAKE DRIVE .AURINBURG, NC 2835 | 52 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAC | IX | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| W 252 | This STANDARD is r Based on observatio interviews, the facility relative to the accomp criteria was documen This affected 1 of 4 au findings are: A. Review on 2/8/21 of program plan (IPP) da receives a diet that is pieces and that if she her meal she is to be Further review reveal an Ensure Plus at 10a Review on 2/9/21 of h dated 3/9/20 revealed consistency cut diet w are to provide her Ens 10am, 12 noon, 4pm supplement her meals or less. Her target we pounds. | not met as evidenced by: n, record reviews and failed to ensure all data plishment of objective ted in measurable terms. Judit clients (#5). The of client #5's individual ated 6/16/20 revealed she cut into less than 1/4 inch consumes less than 1/4 of offered an Ensure Plus. ed staff are also to offer her am, 12 noon, 4pm and 8pm. Her nutritional evaluation I she requires a 1/4 inch vith thin liquids and that staff sure plus 4 times daily at and 8pm as well as s if she eats 1/4 of her meal ight range is listed as 75-95 the flow log where client #5's corded from February | W | 252 | | | | | |

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| | | MEDICAID SERVICES | | | | . 0938-039 | |
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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | (X3) DATE COMP | | |
| | | 34G138 | B. WING | | 02/09/2021 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | • | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| COLLEGE PARK | | | | 900 LAKE DRIVE LAURINBURG, NC 28352 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETIO DATE | |
| W 252 | 10 | e 6 | W 252 | | | | |
| | snack: ALL Supper: refused snack: refused | | | | | | |
| | Supplement: 2/3/21: | | | | | | |
| | breakfast: ate 1/3 lunch: refused | | | | | | |
| | snack: all dinner: 1/3 snack" all | | | | | | |
| | supplement: | | | | | | |
| | 2/4/21: breakfast: ate 1/3 | | | | | | |
| | lunch: ate 1/3 snack: refused dinner: 1/2 | | | | | | |
| | supplement: | | | | | | |
| | 2/5/21 breakfast: ate 1/3 | | | | | | |
| | lunch: refused snack: refused | | | | | | |
| | supper: ate 1/2 supplement: | | | | | | |
| | 2/6/21: breakfast: ate 1/3 | | | | | | |
| | lunch: refused snack: refused | | | | | | |
| | supper: ate 1/2 snack: refused supplement: | | | | | | |
| | 2/7/21: breakfast: ate 1/3 | | | | | | |
| | lunch: refused | | | | | | |

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| CENTER | S FOR MEDICARE & | ID HUMAN SERVICES MEDICAID SERVICES | | | | | FORM OMB NC |): 02/10/2021 / APPROVED). 0938-0391 | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | | |
| | | 34G138 | B. WING | | | _ | 02/ | 09/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, ST | TATE, ZIP CODE | | | |
| COLLEGE | PARK | | | | 900 LAKE DRIVE AURINBURG, NC 283 | 52 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAC | IX | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| W 252 | snack: dinner: snack: supplement: 2/8/21: breakfast: ate 1/3 lunch: ate 1/3 snack: refused dinner: ate 1/2 snack: ate all supplement: given Interview on 2/9/21 w and the qualified intel professional (QIDP) r should be consistently and whether supplement as she is under her ta interview confirmed c nutritional supplement adequate calories as B. Review on 2/8/21 of 6/16/20 revealed a for tables in the living are for 2 consecutive revi Review on 2/9/21 of t February 2021 reveal February 2021: No data on the 1st, 30 Interview on 2/89/21 of should be documentind dusting program daily C. During observation | ith the residential manager lectual disabilities evealed direct care staff y documenting meal refusals ients are given to client #5 arget weight range. Further lient #5 is prescribed ts to ensure she receives needed. of client #5's IPP dated rmal program to dust end ea with full physical prompts ew periods. he data for this program in ed the following: rd, 5th or the 8th with the RM confirmed staff | W | 252 | | | | | |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | PRINTED: 02/10/2021 FORM APPROVED OMB NO. 0938-0391 |
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| STATEMENT (| DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING _ | | (X3) DATE SURVEY COMPLETED | |
| | | 34G138 | B. WING | | _ | 02/09/2021 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | TREET ADDRESS, CITY, ST | TATE, ZIP CODE | |
| COLLEGE | PARK | | | 900 LAKE DRIVE AURINBURG, NC 283 | 52 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE) CROSS-REFEREI | S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | |
| W 252 | her elbow extension s Immediate interview w #5 wears the elbow s contractures to her ell tightly to her chest a r Review on 2/8/21 of c revealed client #5 we splint to prevent contr Review of the data for splint revealed the fol February 2021: December 1-9: no da December 10: docum December 11-21: no o December 24-27: no o December 24-27: no o December 28- 31: doo January 2021 : January 2021 : January 20: document January 25: document January 25: document January 29: document January 2021 c Cocumented on Febru Review on 2/8/21 of t 6/16/20 revealed she splints several hours i contractures of her ell | splint on her right arm. with staff F revealed client plints to prevent further bow as she holds her arm najority of the time. dient #5's IPP dated 6/16/21 ars an elbow extension actures of her forearm. r client #5's elbow extension lowing for December 2020- ta ented data cumented ed ted ted ted ted ted ted t | W 252 | | DEFICIENCY) | |
| | contractures of her el | | | | | |

Facility ID: 921672

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM A OMB NO. 0 | PPROVED |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | TIPLE CONSTRUCTION | | (X3) DATE SU COMPLET | RVEY | |
| | | 34G138 | B. WING | | | 02/09/ | /2021 |
| NAME OF F | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY | , STATE, ZIP CODE | | - |
| COLLEGE PARK | | | | 1900 LAKE DRIVE LAURINBURG, NC 2 | 8352 | | |
| (X4) ID PREFIX TAG | | | | X (EACH COR | ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| W 252 | | e 9 ng client #5's splint usage | W | 252 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: MQRA11

Facility ID: 921672

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