

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

PRINTED: 02/11/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G273</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/09/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHSIDE GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3301 BARKSDALE ROAD FAYETTEVILLE, NC 28301</b>		
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E 006	<p>Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] Emergency</p>	E 006	<p><b>E006:</b> By 4/9/2021 the agency will review and update our emergency preparedness plan. The plan will include a community based risk assessment using an all hazards approach. The updated emergency plan will be reviewed with staff during an in-service conducted by the Deputy Director. The emergency plan will be reviewed or updated annually and as needed. The Deputy Director will be responsible for arranging an annual meeting with the Director and other administrative staff to ensure the emergency plan is current and effective.</p> <p><b>DHSR - Mental Health</b></p> <p><b>FEB 22 2021</b></p> <p><b>Lic. &amp; Cert. Section</b></p>		

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

*Tiffany Acunzio* BSOP 2/19/2021

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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E 006	<p>Continued From page 1</p> <p>Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop an Emergency Preparedness (EP) plan including and based upon a community and facility-based risk assessment, utilizing an all-hazards approach. The finding is:</p> <p>The facility's emergency plan did not include a risk assessment.</p> <p>Review on 2/8/21 of the facility's current EP plan dated 2018 revealed the plan did not provide specific information in regards to a facility-based and/or community-based risk assessment using an all-hazards approach including flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing clients or other emergency types.</p> <p>Interview on 2/9/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no risk assessment had been completed during the development of the emergency plan utilizing an all-hazards approach.</p>	E 006			
W 224	INDIVIDUAL PROGRAM PLAN	W 224			



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W 224	<p>Continued From page 2 CFR(s): 483.440(c)(3)(v)</p> <p>The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure the comprehensive functional assessment included meal preparation skills for 3 of 4 audit clients (#2, #3 and #4). The finding is:</p> <p>During morning observations in the home on 2/9/21 from 6:32am - 7:07am, Staff F cooked the breakfast meal without any assistance from clients. Although several clients were sitting nearby in the living room, no clients were prompted or encouraged to participate with any cooking tasks.</p> <p>During an interview on 2/9/21, when asked if the clients assist with cooking in the morning, Staff F indicated she does not usually work in the morning but she thought the clients did participate with cooking. The staff stated, "That's on me."</p> <p>Review on 2/8/21 of client #2's, client #3's and client #4's record did not reveal an assessment of their meal preparation skills.</p> <p>Interview on 2/9/21 revealed the clients should participate with cooking tasks; however, an assessment of their meal preparation skills had not been completed.</p>	W 224	<p><b>W224:</b> By 4/9/2021 All clients will have a comprehensive functional assessment completed to include an assessment of meal preparation skills. The QP will complete this assessment and meet with the interdisciplinary team to make addendums to the habilitation plans if necessary. The interdisciplinary team will review the comprehensive functional assessment annually. By 4/9/2021 the QP will in-service the staff on any changes made to the habilitation plans. All clients will be encouraged to participate in meal preparation and cleanup. The group home manager will observe meal times weekly to ensure all staff are allowing the clients to utilize their meal preparation skills.</p>		
W 227	INDIVIDUAL PROGRAM PLAN	W 227			

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W 227	Continued From page 3 CFR(s): 483.440(c)(4)  The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #4's Individual Program Plan (IPP) included objectives to address his needs. This affected 1 of 4 audit clients. The finding is:  Review on 2/8/21 of client #4's IPP dated 11/6/20 revealed priority needs and formal objectives for Personal Hygiene (shaving), Pre-vocational (packaging) and Behavior management (behavior plan). The plan noted, "All needs deemed as priorities by the team are addressed by formal goals." Additional review of the plan also identified needs for "formal programs" in the areas of communication, self-help and structured activities; however, no other formal objectives were available for review.  Interview on 2/9/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 continues to have needs in the identified areas; however, no formal objectives have been implemented to address those needs.	W 227	<b>W227:</b> By 4/9/2021 the QP will review all comprehensive assessments and habilitation plans and ensure that all formal goals are objective and being documented as written. The QP will ensure that all formal goal information is available at the facility for review. By 4/9/2021 the QP will review all formal program goals with staff and they will address this goals at the facility during the Covid-19 pandemic. The client's day program goals will be completed at the residential facility until they can return to the day program 5 days a week. The group home manager will review the formal program goal data sheets weekly.		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i)  The individual program plan must describe relevant interventions to support the individual	W 240			

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W 240	Continued From page 4 toward independence.  This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #4's Individual Program Plan (IPP) included specific interventions to support his independence towards using his communication device. This affected 1 of 4 audit clients. The finding is:  During observations in the home throughout the survey on 2/8 - 2/9/21, client #4 was non-verbal and communicated his wants and needs through vocalizations and physical movements. The client was no prompted or assisted to utilize any assistive communication devices during interactions with staff.  During an interview on 2/9/21 with Staff E, when asked how client #4 communicates with them, the staff stated, "He don't...We have to figure it out."  Review on 2/9/21 of client #4's IPP dated 11/6/20 revealed, "[Client #4] in non-verbal. He does use a Spelling Ace for basic wants such as eat and drink." Additional review of the plan did not include any specific information regarding the use of client #4's communication device.  Interview on 2/9/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 uses a Spelling Ace communication device. The QIDP acknowledged the client's IPP does not include information regarding the use of his device.	W 240	<b>W240:</b> By 4/9/2021 the interdisciplinary team will meet to discuss the clients that are non-verbal and ways the staff can effectively communicate with them. By 4/9/2021 staff will be trained to assist any resident that has a communication device. The QP will train the staff on when and where to prompt the client to use the communication device. The QP and group home manager will observe the clients weekly to ensure they are using the communication device.		
W 312	DRUG USAGE CFR(s): 483.450(e)(2)	W 312			



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W 312	Continued From page 5  Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a drug used to manage client #4's inappropriate behaviors was used only as an integral part of his Individual Program Plan. This affected 1 of 4 audit clients. The finding is:  Review on 2/8/21 of client #4's behavior plan revealed an objective to demonstrate no more than 1 episode of his target behaviors per month for 6 consecutive months. The plan identified target behaviors of tantrums and property destruction. Additional review of the plan noted the use of Risperdal and Gabitril to address his target behaviors. Further review of client #4's physician's orders dated 2/1 - 2/28/21 also revealed an order for Atarax, take 1 tablet by mouth at bedtime for sleep and anxiety at 8pm. The use of Atarax was not included in client #4's behavior plan.  Interview on 2/9/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 ingests Atarax for behavior control; however, the medication was not included in his behavior plan.	W 312	<b>W312:</b> By 4/9/2021 the QP will review all medications and behavior plans for each resident. The QP will ensure that all medications used to manage inappropriate behaviors will be listed on the behavior plan. The QP will meet with the psychiatrist to update the plans as needed. The QP and group home manager will review the medications monthly for changes and record the changes on the behavior plan.		
W 340	<b>NURSING SERVICES</b> CFR(s): 483.460(c)(5)(i)	W 340			

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W 340	<p>Continued From page 6</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>This STANDARD is not met as evidenced by: Based on observations, staff interviews, records and policies review; the facility failed to adequately train staff on proper glove use, disinfecting shared equipment, not utilizing full COVID-19 screening measures with visitors which had the potential to affect all clients; as well as not following recommendations for clients #3 and #6 for self-medication administration. The findings are:</p> <p>A. During observations in the home on 2/8/2021 at 9:45 am, staff B and staff F were present and allowed the surveyors to enter without asking any COVID-19 screening questions about symptoms or potential exposure and did not attempt to record our body temperatures. Surveyors worked in the home, amongst staff and clients until the qualified intellectual developmental professional (QIDP) arrived at 10:00 am and asked to take our body temperatures. The QIDP did not take further actions to ascertain if the surveyors had been exposed to COVID-19 or had any COVID-19 symptoms.</p> <p>During observations in the home on 2/9/21 at 6:45 am, staff F allowed the surveyor to enter the home and did not ask to take body temperature or ask any screening questions. At 6:50 am, the QIDP approached the surveyor and recorded body temperature but did not ask screening</p>	W 340	<p><b>W340:</b> By 4/9/2021 all staff will be re-trained on proper glove use. The agency's glove policy will also be posted in the facility. The QP and group home manager will conduct the training and will observe the staff weekly to ensure they are following the policy. By 4/9/2021 the agency's nurse will train the staff on Covid-19 screening measures and infection control to include disinfecting equipment.</p> <p>By 4/9/2021 the facility staff will greet all visitors and record body temperatures as they enter the facility. The staff will also ask a series of screening questions to ensure the residents and staff are not being exposed to Covid-19. The information received will be recorded on a data sheet that will be reviewed by the Deputy Director bi-weekly.</p>		



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W 340	<p>Continued From page 7 questions.</p> <p>On 2/8/21, a review of the facility's screening log revealed that 3 staff working first shift and the 2 surveyors had their body temperatures recorded. There were no information on the log, that asked questions about current symptoms or exposure to anyone with COVID-19.</p> <p>An interview with the QIDP on 2/9/21 revealed that she did not know they had an option to ask COVID-19 screening questions; their practice was to only record body temperatures. The QIDP further stated that she "had to get on staff for not screening a repairmen" who did work in the home.</p> <p>An interview with the registered nurse (RN) on 2/9/21 revealed that last year, "midway through the pandemic" she faxed over a form to the facility, at their request, that she took off the center for disease control (CDC) website, that asked COVID-19 screening questions about symptoms like coughing and potential exposure to COVID-19. The RN also stated that she had COVID-19 training at the home as well as the QIDP performs training too.</p> <p>B. During observations in the home on 2/8/21, a blue cloth tablecloth and 6 striped placemats adorned the dining room table. The clients were engaged in leisure activities during the morning, using puzzle pieces, container full of crayons and coloring book. After the activities ended, none of the equipment was wiped down before the clients returned to the table to get ready for lunch at noon. The table setting was not disinfected after lunch and the clients #1, #2, #3, #4 and #6 sat at the clothed dining room table, using electronic</p>	W 340	<p>By 4/9/2021 the facility will increase the infection control procedures to ensure that all leisure activities and the dining table are sanitized throughout the day. The agency will purchase vinyl tablecloths and placemats that can be sprayed with disinfectant and wiped between meals and activities. The group home manager will observe staff weekly to ensure they are following the infection control guidelines.</p> <p>By 4/9/2021 all staff will be re-trained in medication administration. The agency nurse will train the staff on how to involve the clients in the medication administration process. The medication administration process will be observed monthly by the nurse and weekly by the QP to ensure the clients are participating while taking their medications.</p>		



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W 340	<p>Continued From page 8</p> <p>devices, playing cards, building pieces, coloring books and crayons. The game pieces were cleared from the table before dinner began at 5:30 pm, and there was no observation of the table setting being disinfected before the food was brought to the table in bowls.</p> <p>Interview with the QIDP on 2/9/21 revealed that the facility washed the cloth tablecloth at night but she acknowledged that they were not disinfecting contents on the dining room table between activities.</p> <p>Interview with the RN on 2/9/21 revealed that she mainly concentrated on medications and occupational safety and health act (OSHA) and thought it was the responsibility of the home manager to train staff on infection control measures. The RN acknowledged that she was over infection control and commented that it "slipped through the cracks." The RN stated that staff should have developed a cleaning schedule to wash and clean items, after use.</p> <p>C. During observations in the home on 2/8/21 between 12:41-12:47 pm at medication administration, staff F pre-prepared pills in a cup for clients #3 and #6 before they entered the room. Staff F did not involve them in any of the medication administration tasks which included removing pills from blister packs, pouring water into cups, discussing the names and reasons for taking their medications and discarded their trash afterwards.</p> <p>Review on 2/9/21 of the facility's Medication Administration policy, dated 3/1/13 revealed direct care staff and supervisors will be trained annually by a licensed nurse on education/training process</p>	W 340			

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W 340	<p>Continued From page 9 and risk prevention activities. A systematic monitoring and evaluation system was in place to ensure that standards of quality of care were met.</p> <p>Interview with staff F on 2/8/21 revealed that she did not follow policy because she was nervous being observed. Staff F also commented that she did not go over the purpose of the medication, but it was already discussed with the clients during morning medication administration.</p> <p>Interview with the QIDP on 2/9/21 revealed that the nurse has provided ongoing training with the staff on medication administration. She further stated that it was important for the clients to participate in medication administration because it taught independent living skills.</p> <p>Interview with the RN on 2/9/21 revealed that when she has provided training to staff, they were encouraged to allow clients to participate in pouring their liquids and taking their cups to the sink. The RN stated that all hired staff have been trained at hire to administer medications.</p> <p>D. During observations in the home on 2/8/21 from 4:16pm - 5:55pm, Staff C periodically wore latex gloves while interacting with clients during leisure activities, manipulating items in the kitchen and assisting clients during the dinner meal. The staff did not consistently change the gloves between interactions throughout the observations.</p> <p>During observations in the home on 2/9/21 from 6:35am - 8:00am, Staff E periodically wore latex gloves while performing cleaning tasks and assisting clients at the breakfast meal. At 7:25am and 7:35am, Staff E prompted two clients to</p>	W 340			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G273</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/09/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHSIDE GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3301 BARKSDALE ROAD FAYETTEVILLE, NC 28301</b>		
(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 340	Continued From page 10 brush their teeth independently and then brushed their teeth for them. The staff did not wear gloves during this task.  Interview on 2/8/21 with Staff C revealed gloves should be worn "at all times" when interacting with the clients.  Interview on 2/9/21 with Staff E revealed they wear gloves when assisting clients with "really very, very hands-on" activities. The staff identified activities such as bath time, medication administration, meals and cleaning tasks.  Review on 2/9/21 of the facility's policy for latex glove use (revised 7/20/17) revealed, "Wear gloves when touching blood, body fluids, secretions, excretions or mucus membranes...Change gloves between tasks/procedures on the same consumer to prevent cross contamination..."	W 340			
W 369	<b>DRUG ADMINISTRATION</b> CFR(s): 483.460(k)(2)  The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.  This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, staff failed to administer 1 of 4 audit client's (#3) medications without error. The findings is:	W 369	<b>W369:</b> By 4/9/2021 all staff will be re-trained on medication administration that will include the process to document any medication errors. The agency nurse will conduct the training and will monitor the staff monthly. The QP and group home manager will observe weekly to ensure that medications are being given properly. Staff will notify a supervisor immediately if there are medication errors that occur.		

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W 369	Continued From page 11	W 369			
W 382	<p>During medication administration observations on 2/8/21 at 12:46 pm, staff F took a bottle of eye drops and squeezed the bottle, instilling 2 drops into client #3's right and left eyes.</p> <p>Review on 2/8/21 of client #3's physician orders dated 1/31/21, revealed to instill 1 drop of Refresh Optive Advance into each eye.</p> <p>An interview with staff F on 2/8/21 revealed that she thought she gave him one drop in each eye.</p> <p><b>DRUG STORAGE AND RECORDKEEPING</b> CFR(s): 483.460(l)(2)</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure all medications remained locked. This had the potential to affect all clients in the home. The findings is:</p> <p>During medication administration on 2/8/21 at 12:43 pm, staff F had prepared in advance, a cup containing 4 pills of Gabapentin 100 mg, a controlled substance and left it on the table. Staff F then walked out of the office and went to the den, to tell client #4 it was time to take his medications, leaving the surveyor in the room alone. At 12:45 pm, staff F gave client #4 the pills to swallow. At 12:47 pm, after client #3 finished taking his medications, staff F left the bottle of eye drops on the table as she walked toward the doorway to call for the next client, while the</p>	W 382	<p><b>W382:</b> By 4/9/2021 the QP will review the medication policy with all staff. The staff will learn not to leave any medications and/or an unlocked medication cart unattended. This information will also be covered in the medication administration training conducted by the agency nurse. The QP and group home manager will observe staff weekly.</p>		



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W 382	Continued From page 12 surveyor remained near the med cart.  Interview with staff F on 2/8/21 revealed that she was nervous and normally does not walk away from the medications.  Interview with the registered nurse (RN) on 2/9/21 revealed that staff have been trained to stay with medications at all times and to never leave medications unattended.	W 382			
W 383	<b>DRUG STORAGE AND RECORDKEEPING</b> CFR(s): 483.460(l)(2)  Only authorized persons may have access to the keys to the drug storage area.  This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure only authorized persons had access to the drug storage area. The finding is:  During observations in the home throughout the survey on 2/8 - 2/9/21, the keys to the medication cart was periodically noted attached to a lanyard and hanging from a table lamp in the dining/living area of the home. Various staff consistently retrieved the set of keys, used them and returned the keys to the same location. The keys to the medication cart were accessible to anyone in the home.  Review of the facility's Medication and Medical Policies (last updated 12/17/12) revealed, "...only those persons authorized to prescribe or administer medication shall have access to stored medications. The key will be in the	W 383	<b>W383:</b> By 4/9/2021 all staff will review the medication policy that includes who is responsible for the keys to the drug storage area. Only authorized persons (staff, supervisors, nurse, pharmacist) will have access to the drug storage area. The keys will be possessed by staff who is on shift at that time and will be handed to the oncoming staff for the next shift. The QP and group home manager will observe staff weekly to ensure they are holding the drug storage area keys at all times.		

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W 383	Continued From page 13 personal possession of identified staff."  Interview on 2/9/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the keys to the drug storage area should kept on the person administering medications and not accessible to others.	W 383		



Sophia B. Pierce & Associates, Inc.  
1422 Murchison Road  
PO Box 2813  
Fayetteville, NC 28302  
Phone (910) 488-8477 Fax (910) 822-1951

February 19, 2021

Dear Wilma Worsley-Diggs,

Thank you for your recent visit to our facility on February 9, 2021. We have received the list of deficiencies and have already started making adjustments to comply with state regulations and guidelines. Enclosed you will find our plan of correction for those deficiencies. If you have any questions or concerns please contact our office at (910) 488-8477.

Sincerely,

  
Tiffany Harrington  
Qualified Professional

DHSR - Mental Health

FEB 22 2021

Lic. & Cert. Section

