STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G110	A. BUILDING _____ B. WING _____	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSS II GROUP HOME	1615-B MOSS SPRINGS ROAD ALBEMARLE, NC 28001

(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 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained in hygiene methods specific to ensuring paper supplies were accessible in bathrooms for 4 of 6 clients (#1, #3, #5, and #6). The finding is: Observation in the group home on 3/16/21 - 3/17/21 revealed two bathrooms utilized by clients #1, #3, #5 and #6. Continued observations of both bathrooms revealed no paper products to be located in either bathroom throughout observations on 3/16/21 or 3/17/21. Observations on 3/16/21 and 3/17/21 revealed clients #1, #3, #5 and #6 at various times to enter into the bathrooms with no paper products, close the door and to exit the bathroom. Subsequent observation in the group home on 3/17/21 revealed both bathrooms to remain with no paper supplies throughout the observation period. Interview with the Home Manager (HM) on 3/17/21 verified that there were no paper supplies in both bathrooms and then retrieved paper products from the closets. Continued interview with the HM confirmed that all bathrooms should have an ample supply of paper products. Interview with the qualified intellectual disabilities professional (QIDP) on 3/17/21 verified all bathrooms should have an ample supply of paper products available to clients when occupying the	W 189		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G110	A. BUILDING _____ B. WING _____	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOSS II GROUP HOME	**1615-B MOSS SPRINGS ROAD ALBEMARLE, NC 28001**

(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 189	Continued From page 1 bathrooms in the group home.	W 189		