DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 093							
STATEMENT OF DEFICIENCIES (X1) F		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G274	B. WING _	G			04/06/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
LOCKLE	Y ROAD				17 LOCKLEY RD OLLY 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	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 130	PROTECTION OF CFR(s): 483.420(a)		W 13	30			
	The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.						
	Based on observation observation interview, the facilit	s not met as evidenced by: tions, record review and y failed to ensure privacy was personal care. This affected 1 2). The finding is:					
	3:56pm, client #2 w the dining room tab She entered the ba and sat down on th was open. During located in the office the kitchen and din At 3:59pm, client #2 At no time during th	s in the home on 4/5/21 at vas observed to get up from ble and walk down the hall. throom, pulled her pants down e toilet. The bathroom door the observation, staff were e next to the bathroom and in ing area right down the hall. 2 walked out of the bathroom. he observation was client #2 the door nor did staff close the					
	Community/Home 11/12/20. Review of Assessment reveal observing privacy v	f client #2's record revealed a Life Assessment dated of the Community/Home Life ed that in the area of while toileting, client #2 mpts to close the bathroom					
	Disabilities Profess staff must prompt of but sometimes she	with the Qualified Intellectual ional (QIDP) revealed that client #2 to go to the bathroom, will go on her own. The QIDP happens, staff are to follow					

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

TITLE

(X6) DATE

PRINTED: 04/07/2021

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.

		AND HUMAN SERVICES				FORM	04/07/2021 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	34G274		B. WING	;		04/06/2021		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
LOCKLEY ROAD			4617 LOCKLEY RD 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 130	the door for privacy should have followe and prompted her to have closed the door DRUG ADMINISTR CFR(s): 483.460(k) The system for drug that all drugs are act the physician's order Based on observation interview, the facility medication was adr physician's orders. clients. The finding During observations in the home on 4/6/ client #3 were obse Multi-Vit/Tab Minera several other pills. package stated "Ta (Administer with ap the pill with a glass Review on 4/6/21 o dated 1/21/21 revea Mineral, "Take one Administer with app Interview on 4/6/21	aroom to ensure she closes The QIDP confirmed staff ed client #2 to the bathroom o close the door or should or for her. CATION (1) g administration must assure dministered in compliance with ers. s not met as evidenced by: tions, record review and y failed to ensure client #3's ministered in accordance with This affected 1 of 6 audit is: s of medication administration 21 at 6:15am, Staff A and erved to punch one al tablet into a pill cup with Directions on the medication ke one tablet daily by mouth plesauce)." Client #3 ingested of water. f client #3's physician's orders aled an order for Multi-Vit/Tab tablet by mouth daily. olesauce." with Staff A revealed she did cation with applesauce as	W S)			
		vealed she does not typically medications but when she						

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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 AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G274 B. WING 04/06/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4617 LOCKLEY RD LOCKLEY ROAD HOLLY SPRINGS, NC 27540 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 368 Continued From page 2 W 368 does, she does not give the medication with applesauce. Interview on 4/6/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that client #3 should have received the pill with applesauce as the physician's orders indicates. INFECTION CONTROL W 454 W 454 CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the potential for cross-contamination was prevented. This potentially affected all clients residing in the home (#1, #2, #3, #4, #5 and #6). The findings are: A. During observations in the home on 4/5/21 from 4:13pm to 4:53pm, Staff B and client #3 were observed preparing the dinner meal. At 4:17pm, Staff B and client #3 were observed to put on clear, plastic gloves. Throughout the observation, Staff B and client #3 were observed to touch multiple surfaces and objects in the kitchen, washed dishes, opened packages of foods and touched them. Staff B and client #3 were observed to wear the same pair of gloves throughout the observation. In addition, client #3 was observed to stick his hands in the front and back of his pants, while wearing the gloves. Staff B was observed to tell client #3 not to do that, but did not prompt him to change his gloves or wash his hands. At 4:39pm, client #3 removed his gloves. Client #3 was observed to sneeze into

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 955751

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PRINTED: 04/07/2021

		AND HUMAN SERVICES				FORM	04/07/2021 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
	34G274		B. WING	;		04/06/2021				
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•				
LOCKLEY ROAD			4617 LOCKLEY RD HOLLY SPRINGS, NC 27540							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
W 454	his hand, then use his nose. Client #3 sneezing into it or v assisted Staff B wit Interview on 4/6/21 Disabilities Profess gloves are worn by preparation while si- confirmed that staff gloves and wash the various surfaces, a washed his hands a his pants and after B. During observation 12:11pm, Staff A are preparing lunch. C spoon to stir a pot of into the sink of wate A told client #4 he r stirring the pasta are was observed to ge water, and stir the p Interview on 4/6/21 Staff A should have clean spoon to stir C. During observation 4:57pm, all clients w Client #2 was observed and a spoon to clie to dip out two spoon and back of the spoon back into the bowl. and used by client a	the back of his hand to wipe did not wash his hand after viping his nose. He then h cutting up tomatoes. with the Qualified Intellectual ional (QIDP) revealed that some staff during meal ome staff do not. The QIDP f and clients should change heir hands after touching nd that client #3 should have after sticking his hands down sneezing into his hand. tons in the home on 4/5/21 at nd client #4 were observed lient #4 was observed to use a of pasta, and put the spoon er with other dirty dishes. Staff heeded the spoon to finish nd Italian dressing. Client #4 et the spoon out of the sink of pasta again. with the QIDP confirmed that prompted client #4 to use a	W 2	454						

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		AND HUMAN SERVICES				FORM	04/07/2021 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
34G274			B. WING	i		04/06/2021			
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
LOCKLEY ROAD			4617 LOCKLEY RD HOLLY SPRINGS, NC 27540						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
W 454		d the spoon, it should not have the bowl and a clean spoon		454					

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Facility ID: 955751