JMAN SERVICES					APPROVED		
PROVIDER/SUPPLIER/CLIA	ER/CLIA (X2) MULTIPLE CONSTRUCTION		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED				
34G229	B. WING	3. WING 06//			09/2021		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 554 RIDGE LANE				
T BE PRECEDED BY FULL	ID PREFI TAG	ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE CC			(X5) COMPLETION DATE		
ppropriate client ed as a substitute for m. et as evidenced by: ecord review and to assure techniques ehavior were not used eatment for 6 of 6 and #6) relative to The finding is: 8-9/21 survey revealed om that various clients erved to sit in the living ed observation of the 21 revealed no remote nd to enter the living watching television. evealed staff B to unel and to engage unnel selection. ealed staff B to return e kitchen cabinet after ntifying a preferred 9/21 revealed the the kitchen cabinet clients with breaking,	W	288					
	ICAID SERVICES PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	ICAID SERVICES PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	ICAID SERVICES PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 34G229 B. WING State INT OF DEFICIENCIES TBE PRECEDED BY FULL ENTIFYING INFORMATION) TE CLIENT W 288 ppropriate client red as a substitute for m. et as evidenced by: ecord review and to assure techniques ehavior were not used eatment for 6 of 6 and #6) relative to The finding is: 78-9/21 survey revealed om that various clients erved to sit in the living ed observation of the 21 revealed no remote //21 at 8:10 AM a television remote not to enter the living watching television. evealed staff B to onnel and to engage innel selection. ealed staff B to return e kitchen cabinet after ntifying a preferred 9/21 revealed the the kitchen cabinet clients with breaki	ICAID SERVICES (X2) MULTIPLE CONSTRUCTION A BUILDING 346229 STREET ADDRESS, CITY, STATE, ZIP CODE SS4 RIDGE LANE WILKESBORD, NC 26697 NT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION STREET ADDRESS, CITY, STATE, ZIP CODE S54 RIDGE LANE WILKESBORD, NC 26697 NT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION SHOULD B ENTIFYING INFORMATION) TE CLIENT W 288 Propriate client ed as a substitute for m. et as evidenced by: coord review and to assure techniques ehavior were not used ehavior were not used Provide sith the living add staff B to trevealed no remote ///////////////////////////////////	CAID SERVICES OID NC PROVIDERSUPPLERCLA DENTFICATION NUMBER: (22) MULTIPLE CONSTRUCTION A BUILDING (33) DATE COME 34G229 B. WING 06/ STREET ADDRESS, CITY, STATE, ZIP CODE Ser RIDGE LANE WILKESBORO, NC 28697 06/ NT OF DEFICIENCIES ENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH ONRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TE CLIENT W 288 ppropriate client ed as a substitute for m. W 288 et as evidenced by: ccord review and to assure techniques ehavior were not used eatement for 6 of 6 and #6) relative to The finding is: 8-9/21 survey revealed mot hat various clients proved to sit in the living do observation of the 21 revealed no remote /21 at 8:10 AM a television. verse techniques enmel selection. aated staff B to intel and to engage immel selection. aated staff B to return exitcher cabinet clients with breaking.		

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

TITLE

(X6) DATE

PRINTED: 06/18/2021

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/18/2021 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
34G229		B. WING	_	06/09/2021			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
LAKEWOOD				554 RIDGE LANE WILKESBORO, NC 286	97		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 288	did not have personal and were dependent of to have the ability to w with the facility qualify professional (QIDP) of control to the group he should not be kept in DRUG STORAGE AN CFR(s): 483.460(I)(2) The facility must keep locked except when be administration. This STANDARD is r Based on observation failed to keep a presc 3 sampled clients rest finding is: Observation in the gro AM revealed staff A to #3 and to exit with the was taken to a hallwa observation revealed shower box unattended bathroom door open, room. Observation of shower box revealed prescription label. Su revealed the bathroor client #3's shower box AM until 8:04 AM. Review of records for	verified clients #1, #2 and #4 televisions in their bedroom on the living room television vatch television. Interview ed intellectual disabilities on 6/9/21 verified the remote ome living room television the kitchen cabinet. ID RECORDKEEPING all drugs and biologicals being prepared for not met as evidenced by: ns and interview, the facility ription topical locked for 1 of iding in the facility (#3). The oup home on 6/9/21 at 7:55 o enter the bedroom of client e client's shower box that y bathroom. Continued staff A to leave client #3's ed in the bathroom, with the and to return to client #3's if the contents of client #3's a bottle of shampoo with a ubsequent observation in door to remain open and is to sit unattended from 7:59	W 288				
	Review of records for physician orders date						

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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 34G229 B. WING 06/09/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 554 RIDGE LANE LAKEWOOD WILKESBORO, NC 28697 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 382 Continued From page 2 W 382 review of the current physician orders for client #3 revealed an order for Ketoconazole 2% shampoo with the directive to apply to scalp, leave on 5 minutes before washing; 3 times weekly. Interview with staff A on 6/9/21 verified client #3 has a prescribed shampoo that is kept in the client's shower box. Continued interview with staff A revealed staff are allowed to store medicated shampoo in the client's shower box because it is a shampoo and used during showers. Interview with the facility nurse on 6/9/21 revealed client #3's prescribed shampoo should not be kept in the clients shower box and should not be left unattended. Continued interview with the facility nurse verified a prescription strength shampoo should be kept locked in the medication room and the medication record should be signed when staff administer the shampoo. W 436 SPACE AND EQUIPMENT W 436 CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide teaching relative to eyeglasses for 1 of 3 sampled clients (#5). The finding is:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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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 34G229 B. WING 06/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 554 RIDGE LANE LAKEWOOD WILKESBORO, NC 28697 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 436 Continued From page 3 W 436 Observation in the group home throughout the 6/8-9/21 survey revealed client #5 to participate in various activities to include: leisure activities at the dining table, setting the table for the dinner meal, meal participation, household chores and medication administration. Continued observations throughout the 6/8-9/21 survey revealed client #5 to participate in activities without the use of eyeglasses. Subsequent observation revealed no prompts or direction from staff for client #5 to wear eyeglasses. Review of records for client #5 on 6/9/21 revealed a person centered plan (PCP) dated 12/16/20 with training objectives relative to learning to use a check register, make bed, privacy, brush teeth and wash hands. Continued review of records for client #5 revealed a behavior plan for target behaviors of physical aggression, taking items that belong to others, food snatching, verbal aggression, false accusations, un-cooperation, inappropriate touch, property destruction, hyperactive behavior and depressed behavior. Property destruction was defined as throwing items, breaking items, hitting/kicking items or any other attempt to destroy the environment. Review of a vision consult for client #5 dated 5/7/19 revealed a diagnosis of myopia and astigmatism. Further review of the current vision consult revealed the recommendation to initiate glasses to improve vision. Interview with client #5 on 6/8/21 revealed she had broke her eyeglasses and had new glasses on order. Interview with facility staff verified client #5 had broken her eyeglasses in her sleep and new eyewear had been ordered. Continued interview with facility staff verified client #5 has a

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM): 06/18/2021 1 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED		
		34G229	B. WING		06/09/2021	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKEWO	OD			54 RIDGE LANE /ILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	N BE RIATE	(X5) COMPLETION DATE	
W 436	history of breaking he throw them, sleep in t care. Interview with the fac disabilities profession has a history of break improper care. Conti QIDP verified client # objective to address p Subsequent interview client #5 could benefi proper care of her eye	e 4 r eyeglasses as she will them and is really rough with al (QIDP) verified client #5 sing her eyeglasses due to nued interview with the 5 did not have a training proper care of eyeglasses. With the QIDP revealed t from a program to address ewear and it was unknown ot been implemented.	W 436			

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