PRINTED: 07/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` /				` '	E SURVEY IPLETED
		34G239	B. WING			R 06/30/2021	
	PROVIDER OR SUPPLIER			75	REET ADDRESS, CITY, STATE, ZIP CODE 59 DECATUR DRIVE YETTEVILLE, NC 28303	1 007	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 000	INITIAL COMMEN	TS	w c	000			
{W 130}	A revisit was condiprevious deficiencies have in noncompliance was compliance with all PROTECTION OF CFR(s): 483.420(a) The facility must ender the facility must endered the facility during medication actions (#1 and #3) A. During afternoof the home on 2/1/2 medications while for the home on 2/1/2 medications while for the facility must endered the fac	ucted on 6/30/2021 for all es cited on 2/2/2021. All not been corrected and new s found. The facility is not in regulations surveyed. CLIENTS RIGHTS)(7) Insure the rights of all clients. lity must ensure privacy during e of personal needs. Its not met as evidenced by: tions, record review and ty failed to ensure privacy administration for 2 of 5 audit	{W 1:	30}			
	Review on 2/2/21,	of client #1's client rights (no					
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		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.

ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		34G239	B. WING		06	R / 30/2021
	PROVIDER OR SUPPLIER S S DECATUR HOME			STREET ADDRESS, CITY, STATE, ZIP COD 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303		700/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 130}	date) revealed, "r B. During morning the home on 2/2/21 put on his back by revealed client #3's vertical window whit covering. During an interview client #3 had alway back in the medicar has no covering. F client #3 could have the bathroom. Review on 2/2/21, odate) revealed, "r During an interview stated all the clients privacy during their A follow-up survey which revealed the privacy issue during 5 of 5 audit clients example: A. During morning the home on 6/30/2 close the door closed. B. During morning the home on 6/30/2 close the door closed.	ight to privacy." medication administration in , client #3 was having a cream Staff A. Further observations back was facing a long ch does not have any on 2/2/21, Staff A revealed s received the cream for his tion room where the window urther interview Staff A stated e got his cream for his back in of client #3's client rights (no	{W 13			

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		34G239	B. WING	B. WING		⋜ 30/2021
	PROVIDER OR SUPPLIER S DECATUR HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{W 130}	#2 was receiving his the door closed. C. During morning the home on 6/30/2 close the door leadir #5 was receiving he was the door closed. D. During morning the home on 6/30/2 close the door leadir #6 was receiving he was the door closed. E. During morning the home on 6/30/2 close the door leadir #6 was receiving his the door closed. During an interview was "told not to close revealed she was to hired. When asked.	medications. At no time was medication Adminstration in 1 at 8:31am, Staff A did not ing into the kitchen while client er medications. At no time d. medication Adminstration in 1 at 8:36am, Staff A did not ing into the kitchen while client er medications. At no time d. medication Adminstration in 1 at 8:41am, Staff A did not ing into the kitchen while client is medications. At no time was on 6/30/21, Staff A stated she se the door". Further interview old that when she was first twice who told her that, Staff	{W 1:	30}		
{W 189}	revealed the door to have been closed. staff have been trai room is closed durin STAFF TRAINING CFR(s): 483.430(e) The facility must proinitial and continuing	on 6/30/21, the facility's nurse the medication room should Further interview revealed ned to ensure the medicationing medication administration. PROGRAM	{W 18	39}		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		34G239	B. WING			R		
	PROVIDER OR SUPPLIER S S DECATUR HOME	340239	B. WING	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303	06/3	30/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE	(X5) COMPLETION DATE	
{W 189}	Continued From pa efficiently, and com	-	(W 18	39}				
	Based on observat interviews, the facili sufficiently trained to	s not met as evidenced by: ions, record review and ity failed to ensure staff were o document in the medication rd (MAR). The finding is:						
	observations in the 8:21am and ending	dication administration home on 2/2/21, beginning at at 8:58am Staff B signed the client consuming their						
	has always signed t	on 2/2/21, Staff A stated she the MAR prior to the clients ving their topical medications.						
	medication adminis "Enter initials on the	f the facilty's employee tration guide (no date) stated, e MARin prescribed space (not after preparing it for						
	confirmed staff have	on 2/2/21, the facility's nurse e been trained not to sign the ents consuming their						
	interviews, the facili sufficiently trained to administration reco- clients (#2) and exp	ons, record review and ity failed to ensure staff were o document in the medication rd (MAR) for 1 of 5 audit plaining the medications for 5 s (#1, #2, #4, #5 and #6). The						

			NG		(X3) DATE SURVEY COMPLETED	
	34G239	B. WING			R 06/30/2021	
PROVIDER OR SUPPLIER S DECATUR HOME	040200		STREET ADDRESS, CITY, STATE, ZIP CODE 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303	06/	30/2021	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	JLD BE	(X5) COMPLETION DATE	
A. During morning observations in the Staff A signed the M consuming their me During an interview signed the MAR do "was on my back". Review on 6/30/21 of	medication administration home on 6/30/21, at 8:25am IAR prior to client #2 edications. on 6/30/21, Staff A stated she to the fact that the surveyor of the facilty's employee	{W 18	9}			
"Enter initials on the after administration administration)." During an interview confirmed staff have MAR prior to the cliemedications. B. During medication home on 6/30/21, S#1, #2, #4, #5 and #	e MARin prescribed space (not after preparing it for on 6/30/21, the facility's nurse been trained not to sign the ents consuming their on administrations in the staff A did not explain to clients to the reasoning why they					
Review on 6/30/21 of adminstration preparation preparation preparation preparation in the residual properties of the pro	of the facility's medication aration steps (no date) stated, lent what you are going to do". on 6/30/21, the facility;s nurse suppose to explain to the medications they are taking. MENTATION (1) rdisciplinary team has a individual program plan,	{W 24	9}			
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From part A. During morning observations in the Staff A signed the Moreon consuming their medication administration administration administration administration administration." During an interview signed the MAR do "was on my back". Review on 6/30/21 of medication administration administration administration administration." During an interview confirmed staff have MAR prior to the cliemedications. B. During medication home on 6/30/21, Septimed staff have were taking their medication prepared to the residual properties of the clients what type of PROGRAM IMPLEICFR(s): 483.440(d) As soon as the interformulated a client's	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 A. During morning medication administration observations in the home on 6/30/21, at 8:25am Staff A signed the MAR prior to client #2 consuming their medications. During an interview on 6/30/21, Staff A stated she signed the MAR do to the fact that the surveyor "was on my back". Review on 6/30/21 of the facilty's employee medication administration guide (no date) stated, "Enter initials on the MARin prescribed space after administration (not after preparing it for administration)." During an interview on 6/30/21, the facility's nurse confirmed staff have been trained not to sign the MAR prior to the clients consuming their	S DECATUR HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 A. During morning medication administration observations in the home on 6/30/21, at 8:25am Staff A signed the MAR prior to client #2 consuming their medications. During an interview on 6/30/21, Staff A stated she signed the MAR do to the fact that the surveyor "was on my back". Review on 6/30/21 of the facility's employee medication administration guide (no date) stated, "Enter initials on the MARin prescribed space after administration (not after preparing it for administration)." During an interview on 6/30/21, the facility's nurse confirmed staff have been trained not to sign the MAR prior to the clients consuming their medications. B. During medication administrations in the home on 6/30/21, Staff A did not explain to clients #1, #2, #4, #5 and #6 the reasoning why they were taking their medications. Review on 6/30/21 of the facility's medication adminstration preparation steps (no date) stated, "Explain to the resident what you are going to do". During an interview on 6/30/21, the facility;s nurse confirmed staff are suppose to explain to the clients what type of medications they are taking. PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan,	S DECATUR HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 A. During morning medication administration observations in the home on 6/30/21, at 8:25am Staff A signed the MAR prior to client #2 consuming their medications. During an interview on 6/30/21, Staff A stated she signed the MAR AR do to the fact that the surveyor "was on my back". Review on 6/30/21 of the facility's employee medication administration (not after preparing it for administration)." During an interview on 6/30/21, the facility's nurse confirmed staff have been trained not to sign the MAR prior to the clients consuming their medications. B. During medication administrations in the home on 6/30/21, Staff A did not explain to clients #1, #2, #4, #5 and #6 the reasoning why they were taking their medications. Review on 6/30/21 of the facility's medication administration preparation steps (no date) stated, "Explain to the resident what you are going to do". During an interview on 6/30/21, the facility's nurse confirmed staff are suppose to explain to the clients what type of medications they are taking. PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan,	S DECATUR HOME SUMMARY STATEMENT OF DEFICIENCIES (LEAN DEFICIENCIES TAGE PROFICE) AND THE PREVIOUS MUST BE PRECEDED BY FULL (READ DEFICIENCY MUST BE PRECEDED BY FULL (READ DEFICIENCY MUST BE PRECEDED BY FULL (READ DEFICIENCY MUST BE PRECEDED BY FULL (READ DEFICIENCY) Continued From page 4 A. During morning medication administration observations in the home on 6/30/21, at 8:25am Staff A signed the MAR prior to client #2 consuming their medications. During an interview on 6/30/21, Staff A stated she signed the MAR do to the fact that the surveyor "was on my back". Review on 6/30/21 of the facility's employee medication administration (not after preparing it for administration)." During an interview on 6/30/21, the facility's nurse confirmed staff have been trained not to sign the MAR prior to the clients consuming their medications. B. During medication administrations in the home on 6/30/21, Staff A did not explain to clients #1, #2, #4, #5 and #6 the reasoning why they were taking their medications. Review on 6/30/21 of the facility's medication administration preparation steps (no date) stated, "Explain to the resident what you are going to do". During an interview on 6/30/21, the facility's nurse confirmed staff ras expose to explain to the clients what type of medications they are taking. PROGRAM IMPLEMENTATION (FR(s): #83.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan,	

· , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		34G239	B. WING				⋜ 30/2021		
	PROVIDER OR SUPPLIER S S DECATUR HOME			7	TREET ADDRESS, CITY, STATE, ZIP CODE 559 DECATUR DRIVE AYETTEVILLE, NC 28303	1 00.	00/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
{W 249}	interventions and so and frequency to su	ge 5 consisting of needed ervices in sufficient number upport the achievement of the I in the individual program	{W 24	49}					
	Based on observatinterviews, the facilication clients (#1, #3 and active treatment prointerventions and solution of the control of the contro	s not met as evidenced by: ions, record reviews and ity failed to ensure 3 of 5 audit #6) received a continuous ogram consisting of needed ervices as identified in the Plans (IPP) in the areas of ive equipment. The findings							
	the home on 2/1/21 #1 his medication. prompted to feed hi administration on 2.	n medication administration in at 4:04pm, Staff B fed client At no time was client #1 imself. Additional medication /2/21 at 8:58am, Staff A feed ation. At no time was client #1 imself.							
	administration asse client #1 can indepe from the medication	f client #1's medication self essment dated 7/1/20 revealed endently scoop his medication in cup and then place the once the medication is on the							
		on 2/1/21, Staff B revealed he nt #1 his medications because s.							
		on 2/2/21, Staff A revealed client #1 his medications							

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		COMPLETED		
		34G239	34G239 B. WING				R 30/2021
	PROVIDER OR SUPPLIER S S DECATUR HOME			75	TREET ADDRESS, CITY, STATE, ZIP CODE 559 DECATUR DRIVE AYETTEVILLE, NC 28303	1 00/	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{W 249}	because he will "was During an interview revealed client #1 sopportunity to feed B. During medication 2/2/21 clients #1 prompted to wash to medication administrevealed there were the table where the time where they prosanitizer. Review on 2/2/21 of scale (ABS) dated where they prosanitizer. Review on 2/2/21 of scale (ABS) dated where they prosanitizer. Review on 2/2/21 of scale (ABS) dated where they prosanitizer. Review on 2/2/21 of revealed to assistance. Review on 2/2/21 of dated 12/4/20 revealed to they discussed when they discussed buring an interview confirmed all clients prior to their medical confirmed to the confirme	on 2/2/21, management staff hould have been given the himself his medication. on administration in the home , #3 and #6 were not heir hands prior to the tration. Further observations a 2 bottles of hand sanitizer on clients were sitting. At no empted to use the hand f client #1's adaptive behavior 4/23/20 revealed he needs he washing his hands. f client #3's ABS (no date) total assistance with washing f client #6's ABS dated the can wash her hands with f a inservice/training form aled Staff B was in attendance		49}			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED R	
		34G239	B. WING		06	/30/2021	
	PROVIDER OR SUPPLIER S DECATUR HOME		•	STREET ADDRESS, CITY, STATE, ZIP COE 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{W 249}	she was pouring the #6 because she was During an interview staff confirmed clie been given the oppliquids. D. During morning 2/2/21 from 6:39am observed not weariears. At no time was her hearing aids in. Review on 2/2/21 of assessment dated Aids." During an interview stated client #6 sho once she has show morning. Further in been trained to ensaids in. Additional hearing aids are kenightstand. Based on observation interviews, the facilic clients (#1, #2, #5, active treatment prointerventions and solidividual Program	on 2/2/21, Staff A revealed e liquids for clients #1, #3 and is "helping them." on 2/2/21, the management ints #1, #3 and #6 should have ortunity to pour their own observations in the home on a until 8:21am, client #6 was ing her hearing aids in both her as client #6 prompted to put	{W 24	9}			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		34G239	B. WING _			R 30/2021
	PROVIDER OR SUPPLIER S S DECATUR HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303	1 00/	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE	(X5) COMPLETION DATE
{W 249}	Continued From pa	ge 8	{W 24	9}		
W 340	the home on 6/30/2 Staff A punched out #1, #2, #5 and #6. none of the clients of participate in their r During an interview reason why she did #6 participate in the was because they r During an interview intellectual disability revealed clients #1 hand assistance with administration. The need verbal or gest their medication ad revealed client #6 of her own medication NURSING SERVIC CFR(s): 483.460(c) Nursing services mother members of the appropriate protection measures that inclustraining clients and health and hygiene This STANDARD is Based on observation interview, the nursing that staff were sufficients and the staff were sufficients and the staff were sufficients.	e QIDP stated client #5 would ure prompts to help them with ministration. Further interview an independently punch out is. ES (5)(i) ust include implementing with the interdisciplinary team, ive and preventive health ide, but are not limited to staff as needed in appropriate	W 34	40		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		34G239	B. WING _		06	R 3 /30/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 7559 DECATUR DRIVE FAYETTEVILLE, NC 28303		70012021
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 340	home (#1, #2, #3, #During morning ob: 6/30/21, the survey home, but when St thermometer, it was The surveyor went their personal thermometer. Furth A entering the hom temperature. Addit Staff C was working 8:30am, Staff D lock thermometer, put the took her temperature observations reveal.	ected all clients residing in the #4, #5 and #6). The finding is: servations in the home on or attempted to enter the aff B tried to use the homes' is discovered not to be working out to their car and obtained mometer and took their own her observations revealed Staff in an and not taking her tional observations revealed gotherd shift in the home. At eated the batteries for the hem in the thermometer and are at 8:35am. Additional eled Staff A, Staff B and Staff D emperatures when the batteries		40		
	did not take his ten home. Staff C reportemperature before During an interview he did not take his the home. Staff B his temperature be Review on 6/30/21 (COVID-19) symptowas documentation and then the next of at 4pm. Further rethe check-in sheet	on 6/30/21, Staff C stated he operature when he entered the present he should have taken his entered he should have taken his entered he began working. If on 6/30/21, Staff B confirmed temperature when he entered revealed he should have taken fore he began working. If the homes, Coronavirus om check-in revealed there in on 6/13/21 at 12 midnight documentation was on 6/29/21 view revealed Staff D signing on 6/30/21 at 8:35am. If on 6/30/21, the facility's nurse even trained to take their				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G239	B. WING			R		
NAME OF F	PROVIDER OR SUPPLIER	340239	D. WING		FREET ADDRESS, CITY, STATE, ZIP CODE	06/3	30/2021	
	S DECATUR HOME			75	559 DECATUR DRIVE AYETTEVILLE, NC 28303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 340 W 382	sheet before they b	document on the check-in egin working. AND RECORDKEEPING	W 3					
	The facility must ke	ep all drugs and biologicals n being prepared for						
	Based on observat	s not met as evidenced by: tions and interviews, the facility medications remained locked.						
	the home on 6/30/2 the medication room. For the medication for the medications for the	administration observations in at 8:20am, Staff A exited to escort a client into the Further observations revealed tet door remained and the clients was visible. Additional led the surveyor was left alone from.						
		on 6/30/21, Staff A confirmed et door was open, which left attended.						
		on 6/30/21. the facility's nurse been trained to ensure all t left unattended.						