PRINTED: 08/09/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G089	B. WING _			l	C <b>/27/2021</b>
	ROVIDER OR SUPPLIER	ANNANOA RESIDENTIAL		91	REET ADDRESS, CITY, STATE, ZIP CODE POPLAR CIRCLE WANNANOA, NC 28778	1 017	2172021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 000	INITIAL COMMENTS		W	000			
W 104	GOVERNING BODY CFR(s): 483.410(a)(1 The governing body r	C00179341, NC00179668 ) nust exercise general policy, g direction over the facility.	W	104			
	Based on observation governing body failed and operating direction	to exercise general policy on over the facility by failing ture was in good repair in					
	7/27/21 revealed a re left side. Continued or rest of the chair to prochair and staff I to atte Upon staff I's attempt wooden leg came out the foot rest was obsethen placed the chair position. Further obset AM to 9:30 AM for clie with the recliner leaning	lay room of Beaucatcher on cliner to slightly lean to the observation revealed the foot outward from the empt to recline the chair. to recline the chair, the from under the chair and erved to be broken. Staff I, back into an unreclined ervation revealed from 9:10 ent #11 to sit in the recliner ng to the left side.					
	sitting in the recliner a while as the recliner w broke for a while. Fur client #6 also enjoys s Interview with staff I o	19 revealed she enjoys and had not done so for a was broken and had been of the interview confirmed sitting in the recliner.  In 7/27/21 revealed she had repairs for the recliner and					

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.

PRINTED: 08/09/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G089	B. WING _		_	1	27/2021
	ROVIDER OR SUPPLIER	ANNANOA RESIDENTIAL	•	STREET ADDRESS, CITY, S 91 POPLAR CIRCLE SWANNANOA, NC 287		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 104	interview with staff J v prefer to sit in the rec Additional interview w order should be comp for furniture repairs.  Interview with the clin revealed all furniture without safety concer Continued interview v revealed furniture sho removed after an obsprovide safety to the maintenance can con CLIENT PROTECTIC CFR(s): 483.420  The facility must ensurprotections requirement of the facility failed to: and procedures that preglect and abuse of	irs were completed. Further verified client #6 and #19 liner while in the dayroom. with staff J revealed a work pleted to address the need lical director on 7/27/21 should be in good repair and the stockients in the home. With the clinical director pull also be arranged or ervation of a safety issue to clients in the facility until duct necessary repairs. Which is the facility and the safety is the safe met.  In ot met as evidenced by: implement written policies prohibit mistreatment, clients (W149) and failed to all alleged violations were	W				
W 149	The cumulative effect resulted in the facility statutorily mandated for it's clients. STAFF TREATMENT CFR(s): 483.420(d)(1	of these systemic practices s failure to provide services of Client Protection  OF CLIENTS	W	49			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		34G089	B. WING			C 07/27/2021
	ROVIDER OR SUPPLIER	ANNANOA RESIDENTIAL	STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE SWANNANOA, NC 28778		•	3172172321
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 149	policies and procedure mistreatment, neglect.  This STANDARD is a Based on observation and interview, the fact policies and procedure neglect were implementabuse for 1 of 6 samplis:  Review of internal fact revealed an incident. Review of the 7/14/2 staff A had observed the bedroom door of females that resided client #16 had inform bed (10:20 PM). Cordocumentation from the staff A to indicate about the incident.	res that prohibit to rabuse of the client.  not met as evidenced by: In, record/document review cility failed to assure it's res that prohibit abuse and ented to prevent peer to peer clied clients (#4). The finding cility documents on 7/26/21 report dated 7/14/21.  1 incident report revealed client #16 to exit and close clients #4 and #23, two in the group home, after ed staff A he was going to	W 1-			
	7/14/21 incident and not observed any direction the site of client #4 after the incident to the site of client #4 after the incident brief to be opened up interview with the clirunursing evaluation was and #23 on 7/15/21 to	had confirmed staff A had ect physical contact between #4 or #23 during the 7/14/21 nterview with the clinical incident was immediately upervisor and an observation ncident revealed the client's and pulled down. Further incal director revealed a as conducted on client #4 or assess for sexual abuse.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G089	B. WING _			1	27/ <b>2021</b>
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 077	21/2021
DI LIEWE	T ODDODTI NUTICO 014/	ANNANOA DEGIDENTIAL		91	POPLAR CIRCLE		
BLUEWES	ST OPPORTUNITIES-SW	ANNANOA RESIDENTIAL		SV	VANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 149	W 149 Continued From page 3 7/26/21 revealed an in-service training was		W	149			
	conducted with all sta on 7/16/21 relative to client. Interview with no additional protective implemented with the a nursing evaluation of in-service regarding of alarm and considerate the appropriateness of in the same home as with the clinical direct not initiated a formal of 7/14/21 incident althous interviewed staff A and in the group home frod director further confirmal had started 7/25/21 designs.	aff that work with client #16 In the bedroom alarm for the Inthe clinical director verified In the clinical team as to of the clinical					
	revealed a person ce 5/9/21. Continued re #16 revealed a behave 9/24/20. Review of the client #16 revealed ta non-compliance, intruinappropriate contact physical aggression, verbally threatening sinjury, making untrue sexual self stimulation other persons bedroof foods. Additional recrevealed a diagnosis	sive attention seeking, , verbal aggression, PICA, property destruction, AWOL, eelf injurious behavior, self statements, inappropriate n, invading the privacy of ems and taking inappropriate ord review for client #16 history of mild intellectual levelopmental disorder,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G089	B. WING _			C 07/27/2021
	ROVIDER OR SUPPLIER	VANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE SWANNANOA, NC 28778		0112112021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
W 149	the initial interview, history of involveme sexual behavior tow allegation of sexual substantiated. The confirmed clients #4 the current day, to a facility site, outside to Observation in the goverified client #4 and another residence of Observation of clien relocated residence clients to be non-verin a wheelchair with	al director on 7/26/21, after verified client #16 has had a nt in allegations regarding ards other clients although no abuse had ever been clinical director further and #23 would be moved, on nother residence on the the residence of client #16.  Iroup home on 7/26/21 d #23 had been moved to n the facility site. It #4 and #23, at their in Sunset, revealed both real and client #4 to ambulate	W 1.	49		
	Continued interview did not observe dire #16 with client #4 or what did happen. F verified he immediat the site supervisor.  Interview with the si 7/26/21 revealed he the incident on 7/14. Continued interview conducted an immediand #23 with the reposerved the blanke back, the brief of cliebrief to be folded do	with staff A revealed while he ct physical contact of client #23 he was concerned with urther interview with staff A rely reported the incident to the supervisor, staff B, on was informed by staff A of #21 involving client #16. with staff B revealed he diate observation of clients #4 for client #4 to be pulled ent #4 to be undone and the with staff B revealed he				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		34G089	B. WING _			C <b>07/27/202</b>	1	
	ROVIDER OR SUPPLIER	WANNANOA RESIDENTIAL	•	STREET ADDRESS, CITY, STATE, ZIP ( 91 POPLAR CIRCLE SWANNANOA, NC 28778	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	D 47	ETION	
W 149	Additional interview observation of clier consistent with the back her own bed I down.  Interview with the cadministrator on 7/2 of camera footage client #16 had ente and #23 for approx and it could not be while client #16 wa interview revealed facility director to verify discovered, with vice sexually abused cliinterview with admi #16 had sexually alteroing for the group in Subsequent interview confirmed the staff clients as (1) staff verify and the other staff clients as (1) staff verify and the other staff conduct medication residence on the singular resi	vation to the clinical director.  visit staff B revealed the at #4 after the incident was not client's physical abilities to pull inens, undue her brief or fold it  dinical director and facility 27/21 revealed, after a review during the survey process, that red the bedroom of client #4 imately 8 minutes on 7/20/21 determined what occurred is in the bedroom. Continued the clinical director and the erify it had also been deo review, that client #16 had ent #4 on 7/23/21. Further nistration staff verified client bused client #4 in the common nome with (2) staff on shift. ew with administration on shift were not supervising was in the medication room had left the group home to a administration in another te.  of the facility's abuse and "Abuse, Neglect and 7/1/2019 revealed all by the organization are to be se, neglect, exploitation and tinued review of the facility's policy revealed allegations of exploitation are to be	W 1	49				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	34G089	B. WING _			C <b>07/27/2021</b>	
	ANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE SWANNANOA, NC 28778	<b>_</b>	07/27/2021	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	( (EACH CORRECTIVE ACTION	SHOULD BE	DATE	
had neglected to prot peer abuse and failed safeguards after rece a possible incident of have prevented a sub on 7/23/21. Subseque administration staff ve supervision guideline as of the current surv training for any staff piclient.  STAFF TREATMENT CFR(s): 483.420(d)(3)  The facility must have violations are thorough the facility failed to prof abuse was thorough sampled clients (#4).  Review of internal factor revealed an incident of the 7/14/21 staff A had observed bedroom door of clienthat resided in the growth of the 7/14/21 incident of the 7/14/2	ect client #4 from peer to It to implement sufficient iving information regarding abuse on 7/14/21 that could obstantiated finding of abuse ent interview with erified client #16's is would be increased to 1:1 ey date with additional providing supervision to the OF CLIENTS (a) is evidence that all alleged phly investigated.  The finding is:  Selicity records and interview, ovide evidence an allegation phly investigated for 1 of 6. The finding is:  Selicity documents on 7/26/21 report dated 7/14/21. It incident report revealed client #16 to close the ints #4 and #23, two females out phome, after client #16 in ewas going to bed (10:20 ew of documentation from evealed staff A to indicate It during the incident.  Sicilal director on 7/26/21 viewed staff A after the					
77 147∠ FINCIDENT and I	nau cominneu stali A nau					
	ROVIDER OR SUPPLIER ST OPPORTUNITIES-SW.  SUMMARY ST. (EACH DEFICIENC REGULATORY OR I  Continued From page had neglected to prot peer abuse and failed safeguards after rece a possible incident of have prevented a sub on 7/23/21. Subseque administration staff ve supervision guideline as of the current surv training for any staff pacient.  STAFF TREATMENT CFR(s): 483.420(d)(3)  The facility must have violations are thorough the facility failed to prof abuse was thorough sampled clients (#4).  Review of internal factor revealed an incident in Review of the 7/14/21 staff A had observed bedroom door of client that resided in the group that informed staff A had informed staff A	ROVIDER OR SUPPLIER  ST OPPORTUNITIES-SWANNANOA RESIDENTIAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6 had neglected to protect client #4 from peer to peer abuse and failed to implement sufficient safeguards after receiving information regarding a possible incident of abuse on 7/14/21 that could have prevented a substantiated finding of abuse on 7/23/21. Subsequent interview with administration staff verified client #16's supervision guidelines would be increased to 1:1 as of the current survey date with additional training for any staff providing supervision to the	TOPPORTUNITIES-SWANNANOA RESIDENTIAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6 had neglected to protect client #4 from peer to peer abuse and failed to implement sufficient safeguards after receiving information regarding a possible incident of abuse on 7/14/21 that could have prevented a substantiated finding of abuse on 7/23/21. Subsequent interview with administration staff verified client #16's supervision guidelines would be increased to 1:1 as of the current survey date with additional training for any staff providing supervision to the client.  STAFF TREATMENT OF CLIENTS  CFR(s): 483.420(d)(3)  The facility must have evidence that all alleged violations are thoroughly investigated.  W 1  This STANDARD is not met as evidenced by: Based on review of facility records and interview, the facility failed to provide evidence an allegation of abuse was thoroughly investigated for 1 of 6 sampled clients (#4). The finding is:  Review of internal facility documents on 7/26/21 revealed an incident report dated 7/14/21.  Review of the 7/14/21 incident report revealed staff A had observed client #16 to close the bedroom door of clients #4 and #23, two females that resided in the group home, after client #16 had informed staff A he was going to bed (10:20 PM). Continued review of documentation from the 7/14/21 incident revealed staff A to indicate abuse was suspected during the incident.  Interview with the clinical director on 7/26/21 revealed he had interviewed staff A after the	ROUIDER OR SUPPLIER  34G089  STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE SWANNANOA, NC 28778  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  had neglected to protect client #4 from peer to peer abuse and failed to implement sufficient safeguards after receiving information regarding a possible incident of abuse on 7/14/21 that could have prevented a substantiated finding of abuse on 7/23/21. Subsequent interview with administration staff verified client #16's supervision guidelines would be increased to 1:1 as of the current survey date with additional training for any staff providing supervision to the client.  STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3)  The facility must have evidence that all alleged violations are thoroughly investigated for 1 of 6 sampled clients (#4). The finding is:  Review of internal facility documents on 7/26/21 revealed an incident report dated 7/14/21. Review of the 7/14/21 incident report revealed staff A had observed client #16 to close the bedroom door of clients #4 and #23, two females that resided in the group home, after client #16 had informed staff A he was going to bed (10:20 PM). Continued review of documentation from the 7/14/21 incident revealed staff A for indicate abuse was suspected during the incident.  Interview with the clinical director on 7/26/21 revealed he had interviewed staff A after the	ROVIDER OR SUPPLIER  346089  346089  STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE SWANNANOA, NC 28778  SUMMARY STATEMENT OF DEPICIENCIES (EACH COPRICTORY MUST BE PRECEDED DY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)  Continued From page 6  had neglected to protect client #4 from peer to peer abuse and fallied to implement sufficient safeguards after receiving information regarding a possible incident of abuse on 7/14/21 that could have prevented a substantiated finding of abuse on 7/23/21. Subsequent interview with administration staff verified client #16's supervision guidelines would be increased to 1:1 as of the current survey date with additional training for any staff providing supervision to the client.  This STANDARD is not met as evidenced by: Based on review of facility records and interview, the facility failed to provide evidence an allegation of abuse was thoroughly investigated for 1 of 6 sampled clients (#4). The finding is:  Review of internal facility documents on 7/26/21 revealed an incident report dated 7/14/21. Review of the 7/14/21 incident report revealed staff A had observed client #16 to close the bedroom door of clients #4 and #23, two females that resided in the group home, after client #16 had informed staff A he was going to bed (10:20 PMM, Continued review of documentation from the 7/14/21 incident revealed staff A to indicate abuse was suspected during the incident.  Interview with the clinical director on 7/26/21 revealed he had interviewed staff A after the	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G089	B. WING			1	C (27/2024	
NAME OF P	ROVIDER OR SUPPLIER	0.4000		STR	EET ADDRESS, CITY, STATE, ZIP CODE	07/	27/2021	
10 10 1	TO VIDER OR GOLF ELER				POPLAR CIRCLE			
BLUEWES	ST OPPORTUNITIES-SW	ANNANOA RESIDENTIAL			ANNANOA, NC 28778			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
W 154	Continued From pag	e 7	w	154				
	not observed any direction #16 and client incident. Continued director revealed the reported to the site s of client #4 after the brief to be opened up interview with the clir nursing evaluation w and #23 on 7/15/21 t Subsequent interview revealed an in-service revealed an in-service relative to the bedrood Interview with the clir verified no additional been implemented sinursing evaluation for in-service regarding Interview with the clir the clinical team was appropriateness of k the same home as # interview, all clients r interview with the clir facility had not initiate regarding the 7/14/2 had interviewed staff footage in the group clinical director further inquiry had started 7 information that was	ect physical contact between #4 or #23 during the 7/14/21 interview with the clinical incident was immediately upervisor and an observation incident revealed the client's o and pulled down. Further nical director revealed a as conducted on client #4 o assess for sexual abuse. w with the clinical director the training was conducted on that work with client #16 om alarm for the client.  Inical director on 7/26/21 protective measures had ince 7/14/21 other than a or client #4 and #23, and client #16's bedroom alarm. Inical director also revealed or reviewing the eeping client #4 and #23 in 16, while at the time of resided together. Additional inical director verified the ed a formal investigation 1 incident although the facility of A and reviewed camera home from 7/14/21. The er confirmed a current facility 1/25/21 due to a report of different from the information						
	Review of records for revealed a person centre 5/9/21. Continued records	21 incident by staff A.  r client #16 on 7/26/21 entered plan (PCP) dated eview of the PCP for client vior support plan dated						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED		
		34G089	B. WING _			C <b>07/27/2021</b>		
	ROVIDER OR SUPPLIER	WANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP COD 91 POPLAR CIRCLE SWANNANOA, NC 28778		· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
W 154	client #16 revealed non-compliance, in inappropriate contar physical aggression verbally threatening injury, making untrusexual self stimulated other persons bedrefoods. Additional revealed a diagnost disability, pervasive bi-polar disorder and disorder.  Interview with clinicate the initial interview, history of involvements exual behavior towallegation of sexual substantiated. The confirmed clients # the current day to a facility site, outside  Observation in the verified client #4 are another residence of Observation of clients to be non-verified client with the bedroom door of 7/14/21. Continued while he did not observed while he did not observed.	it the current behavior plan for target behaviors of trusive attention seeking, ct, verbal aggression, PICA, n, property destruction, AWOL, g self injurious behavior, self us statements, inappropriate ion, invading the privacy of coms and taking inappropriate ecord review for client #16 is history of mild intellectual edevelopmental disorder, id oppositional defiant  all director on 7/26/21, after verified client #16 has had a cent in allegations regarding vards other clients although no labuse had ever been clinical director further 4 and #23 would be moved on another residence on the the residence of client #16.  group home on 7/26/21 and #23 had been moved to on the facility site. In the facility site. In the facility site in Sunset, revealed both erbal and client #4 to ambulate	W 1	54				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G089	B. WING			C <b>07/27/2021</b>		
	ROVIDER OR SUPPLIER	VANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, 91 POPLAR CIRCLE SWANNANOA, NC 28778	ZIP CODE	07/21/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
W 154	Continued From page 9		W	154				
		n. Further interview with staff ately reported the incident to						
	7/26/21 revealed he the incident on 7/14/Continued interview conducted an immed and #23 with the repobserved the blanke back, the brief of cliebrief to be folded dor Subsequent interview reported the observationical director. Addrevealed the observationical abilities to pundue her brief or for Interview with the clieb administrator on 7/2 of camera footage diclient #16 had entered and #23 for approximal remainism on 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #23 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #14/2 for approximal remainism of 7/14/2 of camera footage diclient #16 had entered and #14/2 for approximal r	e supervisor, staff B, on was informed by staff A of 21 involving client #16. with staff B revealed he diate observation of clients #4 ort received by staff A and at for client #4 to be pulled ent #4 to be undone and the wn between the client's legs. w with staff B revealed he ditional interview with staff B ation of client #4 after the sistent with the client's hull back her own bed linens, and it down.  Inical director and facility 7/21 revealed, after a review uring the survey process, that end the bedroom of client #4 anately 8 minutes on 7/20/21 etermined what occurred						
	while client #16 was interview revealed the facility administrator discovered, with vide process, that client #4 client #4 on 7/23/21. administration staff was exually abused clies the group home with Subsequent interview confirmed the staff of	in the bedroom. Continued the clinical director and the to verify it had also been to review during the survey the survey that a sexually abused a Further interview with the rerified client #16 had the survey of the survey that the survey with the survey of the survey						

PRINTED: 08/09/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G089	B. WING				27/2021
	ROVIDER OR SUPPLIER	ANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE SWANNANOA, NC 28778			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRING DEFICIENCY)			(X5) COMPLETION DATE
W 154	conduct medication a residence on the site.  Interview with adminishad failed to protect of failed to implement sureceiving information incident of abuse on prevented a substant 7/23/21. Additional ir investigation had bee 7/14/21 incident, findifurther incidents that and client #4.  DIRECT CARE STAFCFR(s): 483.430(d)(1)  The facility must provistaff to manage and saccordance with their Direct care staff are conduty staff calculated period for each defined.  This STANDARD is reasonable and superiod for each defined.  This STANDARD is reasonable and superiod for each defined.  This STANDARD is reasonable and superiod for each defined.  Interview on 7/27/21 reasonable and superiod for each defined to manage and superio	d left the group home to dministration in another stration staff verified they client #4 from abuse and afficient safeguards after regarding a possible 7/14/21 that could have inted finding of abuse on atterview verified if a thorough in conducted relative to the ings could have prevented occurred between client #16		154			

. ,	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	34G089	B. WING _			07/	27/ <b>2021</b>	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		1 077.	21/2021	
			91 POPLAR CIRCLE				
BLUEWEST OPPORTUNITIES-SWANN	ANOA RESIDENTIAL		SWANNANOA, NC 28778				
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE	
W 186 Continued From page 11 #4 and #23 for approximal Continued interview with a it could not be determined 7/20/21 while client #16 we client #4 and #23. Further clinical director and the far had also been discovered client #16 had sexually ab 7/23/21. Subsequent interest administration staff verifies sexually abused client #4 the group home with (2) swith administration addition on shift were not supervist was in the medication room had left the group home to administration in another of the revealed a person centeres 5/9/21. Continued review #16 revealed a behavior so 9/24/20. Review of the cuclient #16 revealed target non-compliance, intrusive inappropriate contact, very physical aggression, proping verbally threatening self in injury, making untrue states sexual self stimulation, involver persons bedrooms a foods. Additional record revealed a diagnosis historical disability, pervasive develobi-polar disorder and oppositional interview with other 7/26-27/2021 survey with 7/26-	administration revealed a what occurred on was in the bedroom of a interview revealed the cility director to verify it all, with video review, that bused client #4 on erview with a client #16 had in the common room of staff on shift. Interview onally verified the staff ing clients as (1) staff in and the other staff of conduct medication residence on the site.  Int #16 on 7/26/21 and plan (PCP) dated for the PCP for client support plan dated current behaviors of attention seeking, bal aggression, PICA, erty destruction, AWOL, njurious behavior, self ements, inappropriate vading the privacy of and taking inappropriate eview for client #16 ory of mild intellectual opmental disorder, ositional defiant	W 1	86				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		34G089	B. WING			C <b>7/27/2021</b>
	ROVIDER OR SUPPLIER	NANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE SWANNANOA, NC 28778	1 5	772772021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 186	inappropriate sexual clients although no a had ever been substand facility administ interview on 7/27/21 provide appropriate a time period that a sexual abuse had of and client #4.  PROGRAM IMPLEM CFR(s): 483.440(d):  As soon as the interformulated a client's each client must reconstructed that is the content of the con	Int in allegations regarding I behavior towards other allegation of sexual abuse tantiated. The clinical director rator further verified, with , the facility had failed to supervision on 7/23/21 during substantiated incident of occurred between client #16	W 18			
	Based on observati staff interviews, the objectives and guide centered plans (PCI prescribed for 1 of 6 of 7 clients in Pisgal of 8 clients in Beauc The findings are:  A. The facility failed	a not met as evidenced by: cons, review of records and facility failed to ensure elines listed in the person P's) were implemented as a clients in Hawksbill (#16), 4 an (#2, #7, #10 and #17) and 4 catcher( #1,#5, #6 and #21).  If to ensure a behavior support lemented as prescribed for imple:				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		34G089	B. WING _				27/2021
	ROVIDER OR SUPPLIER	ANNANOA RESIDENTIAL		91 F	REET ADDRESS, CITY, STATE, ZIP CODE POPLAR CIRCLE VANNANOA, NC 28778	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
W 249	1. The facility failed to as prescribed for client Observation in the facility and the facility on 7/27/21 at the facility on 7/27/21 at the bedroom door. Contificatility on 7/27/21 at the bedroom dobservation revealed bedroom and walk the Subsequent observation period reto client #16's door all common area, unattee observations ended at Review of records for revealed a PCP dated diagnosis history to in Disability, Pervasive I Bi-polar Disorder. Rerevealed a BSP dated current BSP for client behaviors of noncomposeking behavior, inat touching people in pribody; possibly escala pulling or inappropriate aggression, pica, phy destruction, AWOL, vietlening, making uninappropriate sexual sinvading the privacy of into the the bedroom permission or approversions.	o implement a silent alarm of #16.  cility on 7/26/21 during as revealed an alarm to be om door of client #16 and observation in the 3:50 AM revealed client #16 with the door closed. Further client #16 to exit his a hallway of the facility. ion throughout the morning vealed the alarm control box arm to sit on a table in the anded by staff until at 9:15 AM.  cilient #16 on 7/27/21 and 5/9/21 that reflected a anclude Mild Intellectual Developmental Disorder and eview of client #16's PCP at 7/14/20. Review of the affler evealed target poliance, intrusive attention ppropriate contact (spitting, invate-sexual areas of the atting to aggressive grabbing, the "horse play"), verbal sical aggression, property erbally threatening taking items inappropriately true statements, self stimulation, and of other persons room (going of another client without	W 2	249			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G089	B. WING			C 07/27/2021
	ROVIDER OR SUPPLIER	WANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE SWANNANOA, NC 28778		0112112021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC 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	on the exits from his designated times du room at night on seinto the bedroom of guidelines relative to #16 revealed when activated they will o to ensure he does rhome resident.  Review on 7/27/21 in-service training we client #16's room altraining revealed in room, staff must have their person at all tirthis means that staff #16 and see what he charger for the buzz office, put it in there with staff A revealed staff use the alarm of #16 by keeping the monitoring the box indicate the client halt should be noted to off the alarm to ensicontrol box. Further evealed the alarm area when not in us accessing the alarm controls.	es that include: a silent alarm is bedroom during team use to client #16 leaving his cond and third shift and going others. Further review of the silent alarm for client staff are aware the alarm is beserve and monitor the client not enter the room of another of internal training revealed an with staff on 7/16/21 specific to arm. Review of the 7/16/21 the event client #16 is in his eve his "buzzer" (alarm) on mes; when the buzzer vibrates of must go and check on client is doing immediately. The zer is in the Hawksbill front	W 24	49		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		34G089	B. WING				27/2024
NAME OF D	ROVIDER OR SUPPLIER	04000		9-	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	27/2021
NAME OF T	NOVIDER OR SOLT LIER						
BLUEWES	ST OPPORTUNITIES-SW	ANNANOA RESIDENTIAL			1 POPLAR CIRCLE WANNANOA, NC 28778		
(X4) ID PREFIX TAG			ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 249	Continued From page	e 15	W	249			
w 249	revealed the alarm or been sitting on a table area of the group hor observations of surve interview with facility guidelines regarding should be more specteam designated time.  2. The facility failed to prescribed for client #  Interview on 7/27/21 facility director reveal home camera video of administration staff, it that client #16 had er #4 and #23 for approach Continued interview with the client #4 and #23. Further that also been discovered that also been discovered in the group home with with administration staff we sexually abused client the group home with with administration are on shift were not sup was in the medication had left the group home with ad left the group home home with the group home with the gr	entrol box should not have e unattended in the common me during morning ey of 7/27/21. Continued clinical director verified the silent alarm for client #16 iffic than to be used "during es".  To implement supervision as #16. For example:  With the clinical director and led, after a review of group for 7/26/21 and 7/27/21 by the was discovered on 7/20/21 intered the bedroom of client eximately 8 minutes.  With administration revealed in hined what occurred on 16 was in the bedroom of curther interview revealed the fire facility director to verify it for ered, with video review, that the supervision with a supervision of the facility director to verify it for ered, with video review, that the supervision with a supervision of the facility director to verify it for ered, with video review, that the supervision with		249			
	revealed a person ce 5/9/21. Continued re	r client #16 on 7/26/21 ntered plan (PCP) dated view of the PCP for client vior support plan dated					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		34G089	B. WING _			C 07/27/2021	
	ROVIDER OR SUPPLIER	WANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP COD 91 POPLAR CIRCLE SWANNANOA, NC 28778			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
W 249	client #16 revealed non-compliance, int inappropriate conta physical aggression verbally threatening injury, making untru sexual self stimulati other persons bedre foods. Additional revealed a diagnosi disability, pervasive bi-polar disorder and disorder.  Additional interview the 7/26-27/2021 substantiated. The administrator furthe 7/27/21, client #16 and the facility had supervision which hincident of sexual a client #4.  3. The facility failed behaviors as prescribe behaviors as prescribes on 7/2 dressed in a pair of Continued observations reveal wearing the same of	the current behavior plan for target behaviors of rusive attention seeking, ct, verbal aggression, PICA, property destruction, AWOL, self injurious behavior, self e statements, inappropriate on, invading the privacy of boms and taking inappropriate ecord review for client #16 s history of mild intellectual developmental disorder, d oppositional defiant  with clinical director during arvey verified client #16 had a ent in allegations regarding all behavior towards other close supervision although no abuse had ever been clinical director and facility r verified, with interview on needs eyesight supervision failed to provide appropriate ad resulted in a substantiated buse between client #16 and  It to address non-compliance fibed for client #16.  It was a diving survey 6/21 revealed client #16 to be	W 2	49			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G089	B. WING _			07/3	27/2021
	ROVIDER OR SUPPLIER	ANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CO 91 POPLAR CIRCLE SWANNANOA, NC 28778	ODE	0172	27/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
W 249	set of clothes ,folded bedroom door.  Review of records for revealed a person ce 5/9/21. Continued re revealed a diagnosis disability, pervasive obi-polar disorder and disorder. Review of trevealed a behavior se 9/24/20. Review of the client #16 revealed to non-compliance, intrustinappropriate contact physical aggression, verbally threatening sinjury, making untrue sexual self stimulation other persons bedroof foods.  Subsequent review of revealed non-compliance of the persons bedroof foods.  Subsequent review of revealed non-compliance of the persons bedroof foods.  Subsequent review of revealed non-compliance of the persons bedroof foods.  Subsequent review of revealed non-compliance of the persons bedroof foods.  Subsequent review of revealed (3) days of the food of the survey of data relations to the survey of th	vealed client #16 to have a on the floor, outside his  conclient #16 on 7/26/21 Intered plan (PCP) dated cord review for client #16 Inistory of mild intellectual developmental disorder, oppositional defiant the PCP for client #16 Isupport plan (BSP) dated the current behavior plan for arget behaviors of usive attention seeking, verbal aggression, PICA, property destruction, AWOL, self injurious behavior, self statements, inappropriate in, invading the privacy of orms and taking inappropriate with activities necessary for respectively. The behaviors to include with activities necessary for respectively. In the self data for 4/2021 with no data of data for 5/2021 with no (13) days of data collection ection for 6/2021 was not yor.  The BSP for client #16	W 2	249			
	non-compliance to in	clude: A) Ask once, if client ay and go reinforce someone					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G089	B. WING _			C 07/27/2021
	ROVIDER OR SUPPLIER	WANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE SWANNANOA, NC 28778		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 249	B) If necessary, ask and help him remer for getting his jobs of outings for being coprompts he still doe about 5-10 minutes another staff to try a if after 1 hour client complete any necestare activities such programs, etc).  Interview with staff of #16 has non-compliment have taken a shower fused. Continued revealed client #16 outside his bedroom client to either put a linterview with the client even additional train client #16 with hygie b. The team failed to objectives for 4 of 7 in Pisgah. For exam 1. The team failed to client #2.  Surveyor arrived at 6:50 AM. Observation AM revealed client style breakfast mea	with the same or similar task. a again after a few minutes a mber what reinforcers he gets done; remind him he earns operative. C) If after two s not cooperate then wait then try again or have again. D) Notify the supervisor #16 cannot be encouraged to sary habilitation activities (self as bathing, chores, goal  C on 7/27/21 revealed client ance behaviors and should er the evening of 7/26 and I interview with staff C is clothing in the hallway in was in the hallway for the away or use when he showers. Inical director on 7/27/21 takes showers regularly and bort the client with prescribed clients BSP. Continued inical director verified staff aning relative to supporting ene tasks. o implement handwashing clients (#2, #7, #10, and #17)	W 2	49		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		34G089	B. WING _			C 7/ <b>27/2021</b>	
	ROVIDER OR SUPPLIER	ANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP COL 91 POPLAR CIRCLE SWANNANOA, NC 28778		7772772021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 249	a prompt from staff to Review of client #2's dated 6/14/21. Contir PCP revealed a hand implementation date revealed client #2 wil independently 80% or review periods.  2. The team failed to client #7.  Observation in the grevealed client #7 to breakfast meal. At no observation of client a client wash her hand staff to wash her hand staff to wash her hand Review of client #7's dated 8/11/20. Contir PCP revealed a hand implementation date revealed client #7 wil verbal prompt 70% or review periods.  3. The team failed to client #10.  Observation in the gr revealed client #10 to breakfast meal. At no observation of client;	nt wash his hands or receive o wash his hands.  record revealed a PCP nued review of client #2's lwashing objective with an of 8/20/20. Further review I wash his hands if the time for 3 consecutive implement handwashing for roup home at 7:50 AM participate in a family style of time during the surveyor's #7 prior to breakfast did the sor receive a prompt from ds.  record revealed a PCP nued review of client #7's lwashing objective with an of 5/19/20. Further review I wash her right hand with a fight the time for 3 consecutive implement handwashing for oup home at 7:50 AM of participate in a family style of time during the surveyor's #10 prior to breakfast did the sor receive a prompt from	W 2	249			

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	DATE SURVEY COMPLETED
	34G089	B. WING _			C <b>07/27/2021</b>
ROVIDER OR SUPPLIER	/ANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE SWANNANOA, NC 28778		01/21/2021
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
Review of client #10' dated 11/16/20. Con revealed a handwasl implementation date revealed the client w gestural prompt 70% review periods.  4. The team failed to client #17.  Observation in the grevealed client #17 to breakfast meal. At no observation of client she wash her hands staff to wash her hands staff to wash her hands implementation date revealed a handwasl implementation date revealed the client w partial physical promonsecutive review purposecutive review purposecutive review purposecutive with the client wit	s record revealed a PCP tinued review of her PCP ning objective with an of 5/26/21. Further review ill wash her hands with a of the time for 3 consecutive implement handwashing for roup home at 7:50 AM or participate in a family style of time during the surveyor's #17 prior to breakfast did or receive a prompt from ads.  s record revealed a PCP tinued review of her PCP ning objective with an of 8/18/20. Further review ill wash her hands with a pt 80% of the time for 3 periods.  Inical director on 7/27/21 should be prompted to wash neal participation. Continued nical director verified all should be trained at every the emented as prescribed. In implement handwashing clients (#1, #5, #6, and #22) the example:	W 2	49		
	ROVIDER OR SUPPLIER  ST OPPORTUNITIES-SW  SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From pag Review of client #10' dated 11/16/20. Contrevealed a handwasl implementation date revealed the client w gestural prompt 70% review periods.  4. The team failed to client #17.  Observation in the grevealed client #17 to breakfast meal. At no observation of client she wash her hands staff to wash her hands staff to wash her hands staff to wash her hands implementation date revealed a handwasl implementation date revealed the client w partial physical promoconsecutive review publication for the confirmed all client's their hands prior to not interview with the client on the confirmed all client's their hands prior to not interview with the client objectives for 4 of 8 confirmed all client's the program objectives so poportunity and implementation in the great of the confirmed all client's their hands prior to not interview with the client objectives for 4 of 8 confirmed all client's the program objectives so poportunity and implementation in the great of the confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 confirmed all client's the program objectives for 4 of 8 conf	ROVIDER OR SUPPLIER  ST OPPORTUNITIES-SWANNANOA RESIDENTIAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 20  Review of client #10's record revealed a PCP dated 11/16/20. Continued review of her PCP revealed a handwashing objective with an implementation date of 5/26/21. Further review revealed the client will wash her hands with a gestural prompt 70% of the time for 3 consecutive review periods.  4. The team failed to implement handwashing for	ROVIDER OR SUPPLIER  STOPPORTUNITIES-SWANNANOA RESIDENTIAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 20  Review of client #10's record revealed a PCP dated 11/16/20. Continued review of her PCP revealed a handwashing objective with an implementation date of 5/26/21. Further review revealed the client will wash her hands with a gestural prompt 70% of the time for 3 consecutive review periods.  4. The team failed to implement handwashing for client #17.  Observation in the group home at 7:50 AM revealed client #17 to participate in a family style breakfast meal. At no time during the surveyor's observation of client #17 prior to breakfast did she wash her hands or receive a prompt from staff to wash her hands.  Review of client #17's record revealed a PCP dated 11/16/20. Continued review of her PCP revealed a handwashing objective with an implementation date of 8/18/20. Further review revealed the client will wash her hands with a partial physical prompt 80% of the time for 3 consecutive review periods.  Interview with the clinical director on 7/27/21 confirmed all client's should be prompted to wash their hands prior to meal participation. Continued interview with the clinical director verified all program objectives should be trained at every opportunity and implemented as prescribed.  C. The team failed to implement handwashing objectives for 4 of 8 clients (#1, #5, #6, and #22) in Beaucatcher. For example:  Observation in the group home on 7/26/21 from 4:15 PM - 6:30 PM revealed all clients to	ROUNDER OR SUPPLIER 34G089  ROUNDER OR SUPPLIER 35 OPPORTUNITIES-SWANNANOA RESIDENTIAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 20  Review of client #10's record revealed a PCP dated 11/16/20. Continued review of her PCP revealed a handwashing objective with an implementation date of 5/26/21, Further review revealed the client will wash her hands with a gestural prompt 70% of the time for 3 consecutive review periods.  4. The team failed to implement handwashing for client #17 to participate in a family style breakfast meal. At no time during the surveyor's observation of client #17 prior to breakfast did she wash her hands.  Review of client #17's record revealed a PCP dated 11/16/20. Continued review of her PCP revealed a handwashing objective with an implementation date of 8/18/20. Further review revealed the client will wash her hands with a gestural prompt 80% of the time for 3 consecutive review periods.  Review of client #17's record revealed a PCP dated 11/16/20. Continued review of her PCP revealed a handwashing objective with an implementation date of 8/18/20. Further review revealed the client will wash her hands with a partial physical prompt 80% of the time for 3 consecutive review periods.  Interview with the clinical director on 7/27/21 confirmed all client's should be prompted to wash their hands prior to meal participation. Continued interview with the clinical director verified all program objectives should be trained at every opportunity and implemented as prescribed.  C. The team failed to implement handwashing objectives for 4 of 8 clients (#1, #5, #6, and #22) in Beaucatcher. For example:  Observation in the group home on 7/26/21 from 4.15 PM - 6.30 PM revealed all clients to	A BUILDING  34089  34089  34089  34089  31REET ADDRESS, CITY, STATE, ZIP CODE  91 POPAR CIRCLE  SWANNANOA, NC 28778  SUMMARY STATEMENT OF DEFDIENCIES  (PECAL OFFICIENCY WIST PER PERCEDER DE NY PILL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 20  Review of client #10's record revealed a PCP dated 11/16/20. Continued review of her PCP revealed a handwashing objective with an implementation date of 5/26/21. Further review revealed the client will wash her hands with a gestural prompt 70% of the time for 3 consecutive review periods.  4. The team failed to implement handwashing for client #17 prior to breakfast did she wash her hands or receive a prompt from staff to wash her hands.  Review of client #17 prior to breakfast did she wash her hands or receive a prompt from staff to wash her hands.  Review of client #17's record revealed a PCP dated 11/16/20. Continued review of her PCP revealed a handwashing objective with an implementation date of 8/18/20. Further review revealed the client will wash her hands with a partial physical prompt 80% of the time for 3 consecutive review periods.  Interview with the clinical director on 7/27/21 confirmed all clients should be trained at every opportunity and implemented as prescribed.  C. The team failed to implement handwashing objectives should be trained at every opportunity and implement handwashing objectives for 4 of 8 clients (#1, #5, #6, and #22) in Beaucatcher. For example:  Observation in the group home on 7/26/21 from 4.15 PM. 6.30 PM revealed all clients to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		TE SURVEY MPLETED
		34G089	B. WING _			C <b>7/27/2021</b>
	ROVIDER OR SUPPLIER	/ANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP COD 91 POPLAR CIRCLE SWANNANOA, NC 28778	•	772772521
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
W 249	Continued From pag	e 21	W 2	49		
	the kitchen after the	o tasks, and to take dishes to meal. At no time during ients prompted to wash their				
	6:50 AM - 9:30 AM re dressed, to participal take dishes to the kit medication administr home for thier vocation	roup home on 7/27/21 from evealed all clients to get te in the breakfast meal, to chen, to participate in ation and to leave the group onal setting. At no time were clients prompted to				
	of client #1's PCP re- objective. Further re- wash her hands thore	1's record on 7/27/21 d 4/29/21. Continued review vealed a handwashing view revealed client #1 will oughly with gestural prompts consecutive review periods.				
	of client #5's PCP re- objective. Further re- wash his hands thore	5's record on 7/27/21 d 8/17/20. Continued review vealed a handwashing view revealed client #5 will bughly with gestural prompts consecutive review periods.				
	of client #6's PCP revolution	d 9/23/20. Continued review vealed a handwashing view revealed client #6 will gestural prompts 80% of the				
	revealed a PCP date of client #22's PCP re	22's record on 7/27/21 d 7/22/20. Continued review evealed a handwashing view revealed client #22 will				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G089	B. WING				27/ <b>2021</b>
	ROVIDER OR SUPPLIER	ANNANOA RESIDENTIAL		9	TREET ADDRESS, CITY, STATE, ZIP CODE  1 POPLAR CIRCLE  WANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	Interview with the climerevealed all handwas implemented as present be encouraged to water activity transitions. Collinical director confirmerompted to wash the SPACE AND EQUIPM CFR(s): 483.470(g)(2). The facility must furnified and teach clients to use the collinear and other collinical director and other devices identified in the second collinical director and other devices identified in the second collinear and second collinear and second collinear and second collinear and collinear a	verbal prompts 80% of the e review periods.  nical director on 7/27/21  thing objectives should be cribed and all clients should sh their hands throughout continued interview with the med all clients should be eir hands before meals.  MENT  2)  ish, maintain in good repair, ise and to make informed e of dentures, eyeglasses, mmunications aids, braces,		436			
	Based on observation staff interviews, the factor adaptive devices were in Hawksbill (#3, #9, in Beaucatcher(#6 and A. The facility failed the equipment was clean Hawksbill. For example, 1. The facility failed the equipment relative to client #3.	e kept clean for 3 of 6 clients and #15) and 2 of 8 clients nd #14 ). The findings are: to ensure adaptive for 4 of 6 clients in ple:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		34G089	B. WING _			C 07/27/2021
	ROVIDER OR SUPPLIER	WANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE SWANNANOA, NC 28778	•	0772772021
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 436	ambulate with a hel #3's helmet revealed that covered the clic Continued observat survey revealed the appear dirty with accinside of the shield.  Review of records for revealed a person-continued review of the adaptive equipment Continued review of #3 revealed a physist the client's helmet in prevent facial injury.  Interview with the controver revealed all adaptive clean for all clients. Clinical director revealed all staff should device to ensure control.  The facility failed	se revealed client #3 to met. Observation of client d a face shield to be attached ents full facial area. Sion throughout the 7/26-27/21 of face shield of client #3 to occumulated debris on the correction of client #3 on 7/26-27/21 of the PCP for client #3 revealed to include a helmet. If adaptive equipment for client cal therapy note to indicate includes a face shield to continued interview with the ealed staff on third shift are ning adaptive equipment d be monitoring adaptive leanliness.	W 4	,		
	survey observations ambulate in a whee the clients waist. O wheelchair lap belt to be accumulated observation through revealed the gait be	facility during the 7/26-27 so revealed client #9 to elchair with a gait belt around elbservation of client #9's revealed dried food and debris across the belt. Continued the 7/26-27/21 survey elt that client #9 was observed red to have dried debris and				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED	` ′	
	34G089	B. WING		C 07/27/2024		
			STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE		021	
EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE COMPLET E APPROPRIATE DATE	TION	
ains along the of records for daperson-color Review of e equipment added gait be of the work with the clind all adaptive or all clients. Director reveasible for clear list staff should at the entirelative to the color of the electric facility failed ent relative to the electric facility failed entirelative entir	e front of the belt.  or client #9 on 7/27/21 entered plan (PCP) dated the PCP for client #9 revealed to include a wheelchair and elt.  nical director on 7/27/21 e equipment should be kept Continued interview with the aled staff on third shift are ning adaptive equipment be monitoring adaptive eanliness.  to ensure adaptive or a wheelchair was clean for  acility during the 7/26-27 revealed client #15 to chair. Observation of client belt revealed dried food and lated across the belt.  or client #15 on 7/27/21 entered plan (PCP) dated the PCP for client #15 quipment to include a  nical director on 7/27/21 and a new wheelchair on order and tear concerns with the elchair. Continued interview	W 4	36			
The Company of the co	SUMMARY S (EACH DEFICIENT REGULATORY OR  ued From pagains along the vof records for de a person-co D. Review of ve equipment added gait be ew with the cli de all adaptive or all clients. director reversible for clear all staff should s to ensure cla de facility failed nent relative to extensive to the facility failed nent relative to the facility failed the facility failed nent relative to the facility failed the facility f	TION  34G089  DR SUPPLIER  RTUNITIES-SWANNANOA RESIDENTIAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ued From page 24  ains along the front of the belt.  of records for client #9 on 7/27/21  ed a person-centered plan (PCP) dated on the equipment to include a wheelchair and readded gait belt.  ew with the clinical director on 7/27/21  ed all adaptive equipment should be kept for all clients. Continued interview with the director revealed staff on third shift are sible for cleaning adaptive equipment should be kept for cleaning adaptive equipment adaptive in the staff should be monitoring adaptive in the staff should be monitoring adaptive in the relative to a wheelchair was clean for each of the staff of the staff should be in the staff should be staff should be in the staff should be in the staff should be in the staff should be staff should be in the staff should be in the staff should be staf	TION    A BUILDIN   B. WING	TION    AG089   B. WING	A BUILDING  34G089  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE SWANNANOA, NC 28778  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D. PROVIDERS HAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAN OF CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAN OF CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAN OF CROSS-REFERENCED TO THE APPROPRIATE  OF RECORD HAN OF CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAN OF CROSS-REFERENCED TO THE APPROPRIATE  OF RECORD HAN OF CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAN OF CROSS-REFERENCED TO THE APPROPRIATE  OF RECORD HAN OF CROSS-REFERENCED TO THE APPROPRIATE  OF RECORD HAN OF CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAN OF CROSS-REFERENCED TO THE APPROPRIATE  OF RECORD HAN OF CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAN OF CROSS-REFERENCED TO THE APPROPRIATE  OF RECORD HAN OF CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAN OF CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAN OF CROSS-REFERENCED TO THE APPROPRIATE  OF RECORD HAND OF CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAN OF CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAND OF CROSS-REFERENCED TO THE APPROPRIATE  D. PROVIDERS HAND OF CROSS-REFERENCED TO THE APPROPRIATE  TAGE  TAGE  TAGE  TO THE APPROPRIATE  STATE THE APPROPRIATE  TAGE  TAGE  TA	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		34G089	B. WING			C 07/27/2021
	IAME OF PROVIDER OR SUPPLIER  BLUEWEST OPPORTUNITIES-SWANNANOA RESIDENTIAL  STREET ADDRESS, CITY, STATE, ZIP CODE  91 POPLAR CIRCLE  SWANNANOA, NC 28778		P CODE	07/27/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
W 436	revealed staff on third	d shift are responsible for uipment while all staff should	W 4	36		
	B. The facility failed equipment was clear Beaucatcher: For ex	for 2 of 8 clients in ample:				
		o ensure adaptive equipment air was clean for client #6.				
	7/27/21 survey obser ambulate in a wheeld #6's wheelchair revea be accumulated bene	cility during the 7/26/21 and vations revealed client #6 to chair. Observation of client aled dried food and debris to eath the seat cushion and on the wheelchair frame and				
	9/23/20. Review of t	r client #6 on 7/27/21 entered plan (PCP) dated he PCP for client #6 revealed o include a wheelchair.				
	revealed all adaptive clean for all clients. I clinical director revea responsible for clean	nical director on 7/27/21 equipment should be kept Further interview with the sled staff on third shift are ing adaptive equipment be monitoring adaptive uipment is clean.				
		o ensure adaptive equipment trap was clean for client #14.				
	Observation in the fa	cility during the 7/26/21 and				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G089	B. WING		C 07/27/2021	
	ROVIDER OR SUPPLIER	NANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 91 POPLAR CIRCLE SWANNANOA, NC 28778	1 07/27/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
W 436	to ambulate through helmet. Observation revealed dried food across the strap.  Review of records for revealed a person-of 12/11/20. Review of revealed adaptive endeath adaptive endeath adaptive death for all clients. Clinical director reverses on sible for clear while all staff should devices to ensure endeath adaptive endeath adaptive devices to ensure endeath adaptive endeath ad	ervations revealed client #14 cout the home wearing a in of client #6's helmet strap and debris to be accumulated  or client #6 on 7/27/21 centered plan (PCP) dated if the PCP for client #14 quipment to include a helmet.  inical director on 7/27/21 ce equipment should be kept Further interview with the aled staff on third shift are ning adaptive equipment I be monitoring adaptive quipment is clean.  (2)(ii)  d at appropriate temperature.  s not met as evidenced by: on and interview, the facility d was served at the ature for 8 of 8 clients (#1, #5, in 9, and #22) in Beaucatcher.  group home on 7/27/21 at 7:10 to place breakfast items on waffles, juice and milk. ions at 7:30 AM revealed if 11, #14, #18, #19 and #22) to	W 43			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		34G089	B. WING_			C	
	ROVIDER OR SUPPLIER	ANNANOA RESIDENTIAL		STREET ADDRESS, CITY, STATE, ZIP CO 91 POPLAR CIRCLE SWANNANOA, NC 28778		07/27/2021	
(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 C ( (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
W 473	Further observation a assist client #11, #14, plates and to pour mil for each client. Obser the milk to sit out of the minutes. Subsequen revealed all clients to drinking breakfast iter at 8:15 AM revealed sitems to the kitchen, i placed back into the run Interview with the fact 8:15 AM revealed that of refrigeration for more Continued interview reshould be checked with appropriate serving to been on the table and Interview with the clin confirmed milk should remain outside of refriminutes. The clinical the milk remaining in	at 7:45 AM revealed staff I to a #19 and #22 to fix their lk from the pitcher into a cup evation at 7:45 AM revealed the refrigerator for over 30 to observation at 7:50 AM engage in eating and ms. Additional observation staff I to return the drink including the milk which was refrigerator.  Which is a state of the first state of the f	W 4	173			