DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE							
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OI	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · ·	E SURVEY PLETED
		34G146	B. WING _			08/ <sup>,</sup>	10/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
EXTRA S	SPECIAL CARE				214 KILMORY DRIVE AYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 130	PROTECTION OF CFR(s): 483.420(a)		W 13	30			
		nsure the rights of all clients. ity must ensure privacy during of personal needs.					
	Based on observat interviews, the facili	s not met as evidenced by: tion, record review and ity failed to ensure client #6 cy while toileting. This affected The finding is:					
	8/10/21 at 8:05am, the bathroom for to toilet, Staff A left the and watched the cli The staff continued door open for six m	servations in the home on Staff A prompted client #6 to ileting. As the client sat on the bathroom door wide open ient from several feet away. I to watch client #6 with the ninutes while providing verbal te tasks (i.e. flushing the toilet,					
	toileting, they alway watch client #6 bec	1 with Staff A revealed during /s leave the door opened and ause he smears feces. The ave to keep a visual on him."					
	Behavior Inventory	of client #6's Adaptive (ABI) dated 3/1/18 revealed al independence with closing for privacy.					
W 150	Manager (HM) indic feces at times; how	on 8/10/21 with the Home cated client #6 does smear vever, staff should not be m door wide open to monitor	10/ 1/	50			
W 159	QIDP		W 15	59			

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

TITLE

(X6) DATE

PRINTED: 08/11/2021

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/11/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		34G146	B. WING			08/	10/2021
NAME OF F	ROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
EXTRA S	PECIAL CARE				214 KILMORY DRIVE AYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 159	integrated, coordina qualified intellectual This STANDARD is Based on record re facility failed to ensu Disabilities Professi revised the Individu needed to determin	-	. W 1	59			
	annually and monitor identified programs clients (#2, #4 and a A. Review on 8/10/ revealed objectives with 75% independer reviews (implement wearing his eyeglas eyeglasses for 30 m consecutive months toilet himself with 90 consecutive months to identify money w review periods (imp review of progress revealed the last no 10/30/19. Further m books indicated no objectives. Interview on 8/10/27 was in the process objectives and no a been written on the	<ul> <li>bred data collection for all</li> <li>This affected 3 of 5 audit</li> <li>#5). The findings are:</li> <li>21 of client #2's record</li> <li>to brush his teeth thoroughly</li> <li>ence for 2 consecutive</li> <li>de 4/26/18), to improve</li> </ul>					

Facility ID: 944892

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		AND HUMAN SERVICES				FORM	: 08/11/2021 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY IPLETED
		34G146	B. WING	;		08/	10/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
EXTRA S	SPECIAL CARE			_	5214 KILMORY DRIVE FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
TAG W 159	Continued From particle month of Augusting B. Review on 8/10/ revealed objectives with 75% independent reviews (implemented attention span by refor 30 minutes 50% months (implemented 3/1/1 verbal prompts for 3 (implemented 3/1/1 verbal prompts for 3 (implemented 3/1/1 open/close buttons independence for 3 (implemented 3/1/1 progress notes for clast notes had beer review of objective data collection for a Interview on 8/10/2	age 2	W -		DEFICIENCY)	RIATE	DATE
	objectives and no a been written on the identified. The QID collections sheets h the month of Augus C. Review on 8/10/ revealed objectives with 100% indepen- reviews (implement eating routine by lay bite with 95% accur (3/1/20), to prepare independence for 2 (implemented 3/1/2	additional progress notes had objectives since the date OP also acknowledged no data nad been provided to staff for					

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		AND HUMAN SERVICES				FORM	08/11/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G146	B. WING			08/ <sup>,</sup>	10/2021
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
EXTRA S	SPECIAL CARE				214 KILMORY DRIVE AYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 159	3/1/20). Additonal is each objective rever- written on 4/30/20. training books indici- identified objectives Interview on 8/10/2 was in the process objectives and no a been written on the identified. The QID collections sheets h the month of Augus D. Review on 8/9/2 revealed no IPP in Interview on 8/10/2 Intellectual Disabilit revealed client #2 of the date of the surv E. Initial review on revealed no IPP in current IPP was reo plan dated 6/26/20 was provided. Interview on 8/10/2 indicated 6/26/20 w available for client # PROGRAM DOCU CFR(s): 483.440(e) Data relative to acc specified in client in	review of progress notes for ealed the last notes had been Further review of objective sated no data collection for all s. 1 with the QIDP revealed she of reviewing client #5's additional progress notes had objectives since the date OP also acknowledged no data had been provided to staff for st '21. 21 of client #2's record the record. 1 via phone with the Qualified ties Professional (QIDP) did not have a current IPP as of rey. 8/10/21 of client #6's record the record. After the most quested by the surveyor, a was provided. No current IPP 1 via phone with the QIDP ras the most current IPP 46. MENTATION	W 1				

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IEDICAID SERVICES				APPROVED . 0938-0391
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DA	TE SURVEY MPLETED
34G146	B. WING _		08	/10/2021
			ODE	
		6214 KILMORY DRIVE FAYETTEVILLE, NC 28304		
INT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
	W 2	52		
a met as evidenced by: vs and interviews, the data relative to the rria specified in objectives m Plan (IPP) was able terms. This affected #4 and #5). The findings of client #2's record rush his teeth thoroughly for 2 consecutive aring his eyeglasses by for 30 minutes 90% of the nonths, to toilet himself e for 2 consecutive months ith 50% verbal prompts additional review of indicated no data ed objectives. In the Home Manager ect data using data sheets ever, no data collection ed. phone with the Qualified Professional (QIDP) ective data sheets were completed data sheets v. of client #4's record rush her teeth thoroughly e for 2 consecutive				
	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 34G146 NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION) met as evidenced by: vs and interviews, the lata relative to the ria specified in objectives n Plan (IPP) was able terms. This affected #4 and #5). The findings f client #2's record rush his teeth thoroughly for 2 consecutive uring his eyeglasses by for 30 minutes 90% of the nonths, to toilet himself for 2 consecutive months th 50% verbal prompts Iditional review of indicated no data d objectives. In the Home Manager ext data using data sheets ever, no data collection ed. phone with the Qualified professional (QIDP) ctive data sheets were completed data sheets v. f client #4's record	PROVIDER/SUPPLIER/CLIA       (X2) MULT         DENTIFICATION NUMBER:       (X2) MULT         34G146       B. WING         Image: Superstand Strength Strengt Strengt Strength Strength Strength Strength Strength	PROVIDER/SUPPLIER/CLIA       (x2) MULTIPLE CONSTRUCTION         34G146       B. WING         34G146       B. WING         STREET ADDRESS, CITY, STATE, ZIP C         6214 KILMORY DRIVE         FAYETTEVILLE, NC 28304         NT OF DEFICIENCIES         To F DEFICIENCIES         To F DEFICIENCIES         Tag         PROVIDER'S PLAN OF COF         PAYETTEVILLE, NC 28304         NT OF DEFICIENCIES         Tag         PROVIDER'S PLAN OF COF         CROSS-REFERENCED TO THE.         DEFICIENCY         W 252         W 252         Interviews, the         lata relative to the         ira specified in objectives         n Plan (IPP) was         ble terms. This affected         #4 and #5). The findings         f client #2's record         rush his teeth thoroughly         for 2 consecutive         ring his eyeglasses by         for 3 0 minutes 90% of the         to 72 consecutive         nh the Home Manager         ctd data using data sheets         wer, no data collection         ad.         phone with the Qualified         rofessional (QIDP)	PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DATA         DENTIFICATION NUMBER:       A BUILDING       (X3) DATA         34G146       B. WING       08         STREET ADDRESS, CITY, STATE, ZIP CODE       6214 KILMORY DRIVE         FAYETTEVILLE, NC 28304       FAYETTEVILLE, NC 28304         NT OF DEFICIENCIES       ID         PREFIX       PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY         IT PE PRECODED BY FULL       NC 252         W 252       W 252         met as evidenced by: ss and interviews, the tata relative to the ria specified in objectives n Pian (IPP) was bible terms. This affected #4 and #5). The findings         f client #2's record rrush his teeth thoroughly for 2 consecutive months th 50% verbal prompts biff for 2 consecutive months th 50% verbal prompts biff or 0 data dollection ad.         phone with the Qualified trofessional (QDP) cive data sheets were completed to the trooughly for 2 consecutive

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		AND HUMAN SERVICES				FORM	08/11/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G146	B. WING			08/	10/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
EXTRA S	SPECIAL CARE				214 KILMORY DRIVE AYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 252	remaining on task 2 50% of the time for toilet herself with 50 consecutive months verbal prompts for 2 be able to open/clos 50% independence Additonal review of indicated no data co objectives. Interview on 8/10/2 collect data using d however, no data co provided. Interview on 8/10/2 revealed client #4's available; however, were provided for re C. Review on 8/10/ revealed objectives with 100% indepen- reviews, to develop down his fork after for 2 review periods 85% independence and to identify mon- review periods. Ad training books indic identified objectives Interview on 8/10/2 collect data using d however, no data co provided.	<ul> <li>2 times daily for 30 minutes</li> <li>2 consecutive months, to</li> <li>0% independence for 2</li> <li>s, to identify money with 75%</li> <li>2 consecutive months, and to</li> <li>se buttons and snaps with</li> <li>for 3 consecutive months.</li> <li>objective training books</li> <li>ollection for all identified</li> <li>1 with the HM revealed staff</li> <li>ata sheets for each objective;</li> <li>ollection sheets had been</li> <li>1 via phone with the QIDP</li> <li>objective data sheets were</li> <li>no completed data sheets</li> <li>eview.</li> <li>/21 of client #5's record</li> <li>to brush his teeth thoroughly</li> <li>dence for 2 consecutive</li> <li>an eating routine by laying</li> <li>each bite with 95% accuracy</li> <li>s, to prepare a vegetable with</li> <li>for 2 consecutive months,</li> <li>ey with 75% accuracy for 2</li> <li>ditonal review of objective</li> </ul>	W 2	52			

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		AND HUMAN SERVICES			FORM A	08/11/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		34G146	B. WING		08/1	0/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EXTRA S	PECIAL CARE			214 KILMORY DRIVE AYETTEVILLE, NC 28304		
(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 APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 252 W 257	revealed client #5's available; however, were provided for re	objective data sheets were no completed data sheets	W 252 W 257			
W 201	CFR(s): 483.440(f) The individual prog- least by the qualifie professional and re but not limited to sit failing to progress t		VV 257			
	Based on record re facility failed to ensu- Plan (IPP) was revi- determine progress	s not met as evidenced by: eviews and interview, the ure the Individual Program ewed and revised to towards identified objectives. audit clients (#2, #4 and #5).				
	revealed objectives with 75% independence reviews (implement wearing his eyeglas eyeglasses for 30 m consecutive months toilet himself with 9 consecutive months to identify money w review periods (imp review of progress revealed the last not 10/30/19.	<ul> <li>(21 of client #2's record to brush his teeth thoroughly ence for 2 consecutive ted 4/26/18), to improve sees by wearing his ninutes 90% of the time for 2 s (implemented 4/26/18), to 0% independence for 2 s (implemented 4/26/18) and ith 50% verbal prompts for 2 olemented 3/1/19). Additional notes for each objective otes had been written on</li> <li>1 with the Qualified Intellectual</li> </ul>				

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		AND HUMAN SERVICES	1			FORM	: 08/11/2021 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		34G146	B. WING			08/	10/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
EXTRA S	SPECIAL CARE				6214 KILMORY DRIVE FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 257	in the process of re and no additional pr written on the object B. Review on 8/10/ revealed objectives with 75% independer reviews (implemented attention span by re for 30 minutes 50% months (implemented 3/1/1 verbal prompts for 2 (implemented 3/1/1 open/close buttons independence for 3 (implemented 3/1/1 progress notes for 6 last notes had beer Interview on 8/10/2 was in the process objectives and no a been written on the identified. C. Review on 8/10/2 revealed objectives with 100% independente eating routine by lay bite with 95% accur (3/1/20), to prepare independence for 2 (implemented 3/1/2 75% accuracy for 2	ge 7 ional (QIDP) revealed she was viewing client #2's objectives rogress notes had been ctives since the date identified. /21 of client #4's record to brush her teeth thoroughly ence for 2 consecutive ted 3/1/19), to improve her emaining on task 2 times daily of the time for 2 consecutive red 3/1/19), to toilet herself ence for 2 consecutive months 9), to identify money with 75% 2 consecutive months 9), and to be able to and snaps with 50% consecutive months 9). Additonal review of each objective revealed the n written on 11/30/19. 1 with the QIDP revealed she of reviewing client #4's additional progress notes had objectives since the date /21 of client #5's record to brush his teeth thoroughly dence for 2 consecutive ted 3/1/20), to develop an ying down his fork after each racy for 2 review periods a vegetable with 85% consecutive months 0), and to identify money with review periods (implemented review of progress notes for	W	257			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/11/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		34G146	B. WING			08/ <sup>,</sup>	10/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
EXTRA S	PECIAL CARE				214 KILMORY DRIVE AYETTEVILLE, NC 28304		
(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 257	Continued From pa	ge 8	W 2	257			
	each objective reve written on 4/30/20.	aled the last notes had been					
	was in the process objectives and no a been written on the	1 with the QIDP revealed she of reviewing client #5's dditional progress notes had objectives since the date					
W 260	identified. PROGRAM MONIT CFR(s): 483.440(f)	ORING & CHANGE (2)	W 2	260			
	must be revised, as	e individual program plan appropriate, repeating the paragraph (c) of this section.					
	Based on record re failed to ensure the was revised at leas	s not met as evidenced by: eview and interview, the facility Individual Program Plan (IPP) t annually. This affected 2 of and #6). The findings are:					
	A. Review on 8/9/2 revealed no IPP in t	1 of client #2's record the record.					
	Intellectual Disabilit revealed client #2's	1 via phone with the Qualified ies Professional (QIDP) last IPP meeting was held in ever, no meeting had been					
	revealed no IPP in t current IPP was rec	8/10/21 of client #6's record the record. After the most quested by the surveyor, a was provided. No current IPP					
	Interview on 8/10/2	1 via phone with the QIDP					

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES	1		-	1 APPROVE 0. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
		34G146	B. WING _		08	/10/2021
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP C		
EXTRA S	SPECIAL CARE			6214 KILMORY DRIVE FAYETTEVILLE, NC 28304		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
W 260	Continued From pa	age 9	W 26	60		
	available for client	vas the most current IPP #6.				
W 312	DRUG USAGE CFR(s): 483.450(e)	)(2)	W 31	2		
	must be used only client's individual pr specifically towards	trol of inappropriate behavior as an integral part of the rogram plan that is directed the reduction of and eventual ehaviors for which the drugs				
	Based on record re failed to ensure a d for 2 of 5 audit clier	s not met as evidenced by: eview and interview, the facility lrug used to manage behaviors nts (#3 and #4) was used only of his Individual Program Plan are:				
	orders dated 7/1/21 for Melatonin 3mg, 6:30pm. Additional Intervention Plan (E objectives to decre- non-compliance, pl vocalizations, falling touching, false acco profanity, self-injury tantrums, public ma	nysical aggression, loud g to the floor, inappropriate usations, running away, y, property destruction, asturbation and stealing. ne plan identified the use of onidine to address				

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PRINTED: 08/11/2021 FORM APPROVED

		AND HUMAN SERVICES			FORM	08/11/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		34G146	B. WING		08/ <sup>,</sup>	10/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
EXTRA S	PECIAL CARE			6214 KILMORY DRIVE FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 312	Interview on 8/10/2 Intellectual Disabilit confirmed client #3 however, the medic formal active treatm B. Review on 8/10/ orders dated 7/1/21 for Clonidine HCL, mouth 3 times daily client's Behavior Int 1/7/21 revealed obj of non-compliance, spitting, running aw vocalizations, falling touching, false accu temper tantrums/cr stealing. Further re use of Aripiprazole inappropriate behave a formal active trea use of Clonidine to Interview on 8/10/2 confirmed client #4 behavior; however, in a formal active tre NURSING SERVIC CFR(s): 483.460(c) Nursing services m other members of t appropriate protecti measures that inclu	1 via phone with the Qualified ties Professional (QIDP) ingests Melatonin for sleep; cation is not included in a nent plan. /21 of client #4's physician's 1 - 10/1/21 revealed an order .1 mg tablet, take 1 tablet by 7. Additional review of the tervention Plan (BIP) dated fectives to decrease behaviors . physical aggression, Pica, /ay from staff, loud g to the floor, inappropriate usations, property destruction, ying, smearing feces and food eview of the plan identified the and Vyvanse to address viors. The plan did not include the and Vyvanse to address viors. The plan did not include the address client #4's behaviors. 1 via phone with the QIDP ingests Clonidine for the medication is not included teatment plan. CES 0(5)(i) must include implementing with the interdisciplinary team, ive and preventive health ude, but are not limited to staff as needed in appropriate	W 312	2		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/11/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G146	B. WING		08/ <sup>,</sup>	10/2021
NAME OF I	PROVIDER OR SUPPLIER		\$	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
EXTRA S	PECIAL CARE			6214 KILMORY DRIVE FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 340	This STANDARD is Based on observat interviews, the facili were sufficiently tra current COVID-19 v the appropriate use specific directions f The findings are: A. Upon arrival to t 10:25am and 8/10/2 surveyor into the ho temperature was ta screening questions presented for comp Review on 8/10/21 training book indica go through the scree review of the check "1. Has this individ used a alcohol-base 2. Ask the individua following respirator 1. Fever 2. Sore Throat 3. Cough 4. New Shortnet 3B. Ask if they have confirmed COVID-1 Interview on 8/10/2 confirmed in additio COVID-19 screenin for all visitors to the	s not met as evidenced by: ions, record review and ity failed to ensure all staff ined to implement the facility's visitor screening process, on o of face masks and to follow or dispensing medicatons. he home on 8/9/21 at 21 at 5:50am, staff invited the ome. The surveyor's ken; however, no health s were asked or forms of the facility's COVID-19 ted, "All staff and visitors must ening checklist." Additional list noted the following: ual washed their hands or ed hand rub on entry? al if they have any of the y symptoms? ess of Breath ture and document results e worked with a person(s) with 19?" 1 with the Residential Director on to a temperature check, the ng checklist should be utilized	W 340			

Facility ID: 944892

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		AND HUMAN SERVICES				FORM	: 08/11/2021 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY IPLETED
		34G146	B. WING			08/	10/2021
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
EXTRA S	SPECIAL CARE				214 KILMORY DRIVE AYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 340	<ul> <li>10:25am, Staff A ar mask covering her home, Staff B was</li> <li>During additional of throughout the surv removed their face home or wore their nose or over/under</li> <li>Interview on 8/10/2 staff are required to working in the hom- revealed she had p nose because it wa fog up.</li> <li>Review on 8/10/21 entry door of the hor required. All emploi to wear face mask Another sign posted "Notice: Please weat of the facility's COV "All individuals enter wear a face coverint surgicalWe have facemasks for all p in the facility."</li> <li>Interview on 8/10/2 (HM) confirmed all required to wear a face could step outside.</li> <li>C. During observation in the</li> </ul>	hiswered the door without a face. Upon entry into the also observed without a mask. observations in the home rey, various staff repeatedly mask in common areas of the mask improperly below their their chin. 1 with Staff A confirmed all o wear a face mask while e. Additional interview ulled her face mask below her s causing her eye glasses to of a sign posted on the side one revealed, "Face mask opees and visitors are required or protective face covering." d inside the home noted, ar a mask." Additional review (ID-19 training book indicated, ring into the facilities must of i.e. masks-cloth or implemented universal use of eople, visitors and staff, while 1 with the Home Manager staff working in the home are face mask on duty. The HM ds to remove their mask, they	W	340			

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		AND HUMAN SERVICES & MEDICAID SERVICES			RINTED: 08/11/2021 FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED		
		34G146	B. WING		08/10/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
EXTRA S	PECIAL CARE			5214 KILMORY DRIVE FAYETTEVILLE, NC 28304	
(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 APPROPI DEFICIENCY)	BE COMPLETION
W 340	client to ingest the r observation of the r "Shake well". Interview on 8/9/21 usually shakes up t dispensing. Interview on 8/10/2 confirmed the Cara dispensing as the n the bottle. DRUG ADMINISTR CFR(s): 483.460(k) The system for drug that all drugs are ac the physician's order This STANDARD is Based on observat interview, the facility received his medica physician's orders. observed receiving During observations in the home on 8/9/ ingested 3ml of Ery medications. At 6:0 consuming his dinn Review on 8/10/21 orders dated 7/1/21	ATION (1) g administration must assure diministered in compliance with ers. s not met as evidenced by: ion, record review and y failed to ensure client #6 ation in accordance with This affected 1 of 3 clients medications. The finding is: s of medication administration 21 at 4:13pm, client #6 ped 200mg/5ml and other 06pm, client #3 began er meal. of client #6's physician's - 10/1/21 revealed an order ion, take 3ml by mouth four	W 340		
	times a day "with a				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/11/2021 APPROVED 0938-0391
		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G146	B. WING		08/10/2021	
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	1	
EXTRA S	PECIAL CARE			214 KILMORY DRIVE AYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 368	Continued From pa	ge 14	W 368			
W 369	Interview on 8/10/21 with the Medical Coordinator confirmed the Eryped should be given with a meal as ordered. DRUG ADMINISTRATION CFR(s): 483.460(k)(2)		W 369			
	that all drugs, includ	g administration must assure ling those that are ire administered without error.				
	Based on observat interviews, the facili medications were a	s not met as evidenced by: ion, record review and ty failed to ensure all dministered without error. clients observed receiving inding is:				
	in the home on 8/10 self-administered tv	s of medication administration 0/21 at 7:50am, client #3 vo sprays of Fluticasone nostril and one sprays of the ft notstril.				
	orders dated 7/1/21 Fluticasone 50mcg daily (Left nostril) an	of client #3's physician's - 10/1/21 revealed orders for use two sprays in each nostril nd Fluticasone 50mcg, use nostril daily (Right nostril).				
W 436		PMENT	W 436			
	The facility must fur	nish, maintain in good repair,				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/11/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		34G146	B. WING			08/	10/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EXTRA S	PECIAL CARE				214 KILMORY DRIVE AYETTEVILLE, NC 28304		
(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 436	and teach clients to choices about the u hearing and other of and other devices in	use and to make informed use of dentures, eyeglasses, communications aids, braces,	W 4	36			
	Based on observat interviews, the facili clients (#4 and #6) to make informed c	s not met as evidenced by: ions, record reviews and ity failed to ensure 2 of 5 audit were provided with and taught hoices about the use of s needed in the Individual ). The findings are:					
	on 8/9 - 8/10/21, cli	eal observations in the home ent #4 was provided with a k and a regular spoon and					
	orders dated 7/1/21	of client #4's physician's - 10/1/21 revealed an order d knife "with built up" handles.					
	Medical Coordinato	1 with the Home Manager and r revealed no built-up handle e available in the home and ordered.					
	the survey on 8/9 -	ions in the home throughout 8/10/21, client #6 did not wear #6 was not prompted or e glasses.					
	6/26/20 (most recein vision is stable at th	of client #6's IPP dated nt plan) revealed, "[Client #6's] nis time and continues to wear glasses full timeHowever,					

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		AND HUMAN SERVICES				FORM	08/11/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G146	B. WING			08/10/2021	
NAME OF I	PROVIDER OR SUPPLIER	·			TREET ADDRESS, CITY, STATE, ZIP CODE		
EXTRA S	SPECIAL CARE				214 KILMORY DRIVE AYETTEVILLE, NC 28304		
(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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 436	[Client #6] does not full time" The pla eye glasses but net Interview on 8/10/2 Medical Coordinato like to wear his eye	age 16 t like to wear his eye glasses in identified a need to "Wear ed prompts to keep them on." 1 with the Home Manager and or indicated client #6 does not glasses when offered and has to wear them for a time period.	W 4	136			

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