PRINTED: 08/11/2021 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 | |
|---|--|---|----------------------------|--|-------------------------------|------------|
| | | 34G146 | B. WING | | 08/10/2021 | |
| | PROVIDER OR SUPPLIER SPECIAL CARE | | | STREET ADDRESS, CITY, STATE, ZIP COD 6214 KILMORY DRIVE FAYETTEVILLE, NC 28304 | | 1012021 |
| (X4) ID PREFIX TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX | | (EACH CORRECTIVE ACTION SH | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| | Therefore, the facili treatment and care This STANDARD is Based on observati interviews, the facili was afforded privace 1 of 5 audit clients. During morning obs 8/10/21 at 8:05am, 3 the bathroom for toil toilet, Staff A left the and watched the client and watched the client The staff continued door open for six mi prompts to complete handwashing, etc.). Interview on 8/10/21 toileting, they always watch client #6 becastaff stated, "We have Review on 8/10/21 of Behavior Inventory (at the client has partial the bathroom door for Additional interview of Manager (HM) indicated interview of Manager (H | sure the rights of all clients. Ity must ensure privacy during of personal needs. It not met as evidenced by: ion, record review and ity failed to ensure client #6 by while toileting. This affected The finding is: Pervations in the home on Staff A prompted client #6 to leting. As the client sat on the bathroom door wide open ent from several feet away. It to watch client #6 with the nutes while providing verbal et tasks (i.e. flushing the toilet, with Staff A revealed during is leave the door opened and leave the door opened and leave the smears feces. The verbal to keep a visual on him." If client #6's Adaptive ABI) dated 3/1/18 revealed independence with closing or privacy. In 8/10/21 with the Home leated client #6 does smear | W 13 | | other anal needs. anager | 10/08/2021 |
| | leaving the bathroom | ver, staff should not be n door wide open to monitor | | | | |
| W 159 | him. QIDP | | W 15 | 9 | | |
| BORATORY | DIRECTOR'S OR PROVIDE | RSUPPLIER REPRESENTATIVE'S SIGNA | ATURE | TITLE | - 1 | (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.

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDI | RIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | | |
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| | | 34G146 | B. WING | | 08/10/2021 | |
| | PROVIDER OR SUPPLIER | | | STREET'ADDRESS, CITY, STATE, ZIP CODE 6214 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETION | |
| W 159 | CFR(s): 483.430(a) Each client's active integrated, coordina qualified intellectual This STANDARD is Based on record refacility failed to ensure Disabilities Profession revised the Individual needed to determine objectives, complete annually and monitoridentified programs clients (#2, #4 and #4. Review on 8/10/revealed objectives with 75% independent wearing his eyeglasses for 30 m consecutive months to identify money wireview periods (impreview of progress or revealed the last no 10/30/19. Further modules indicated no objectives. Interview on 8/10/21 was in the process of objectives and no account of the identified. The QIDI interview on the identified. The QIDI interview on the identified. The QIDI interview on the identified. The QIDI interview or interview or the identified. | treatment program must be ated and monitored by a disability professional. It is not met as evidenced by: eviews and interview, the sure the Qualified Intellectual onal (QIDP) reviewed and all Program Plan (IPP) as the progress towards identified the ded IPP meetings at least ored data collection for all at This affected 3 of 5 audit the distribution of the findings are: 21 of client #2's record to brush his teeth thoroughly the ence for 2 consecutive the distribution of the distr | W 15 | W159-A The facility will ensure QP w monitor data collection on brushing timprove wearing eyeglasses, toileting identifying money on monthly basis f client #2 and all client's data collectio will monitor monthly, and RD will mo quarterly. | teeth, g, and or on, QP | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 34G146 | B. WING | | | 08/10/2021 | | |
| | NAME OF PROVIDER OR SUPPLIER EXTRA SPECIAL CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 6214 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | | |
| W 159 | revealed objectives with 75% independer reviews (implement attention span by refor 30 minutes 50% months (implement with 50% independed (implemented 3/1/19 open/close buttons independence for 3 (implemented 3/1/19 open/close buttons independence for 3 (implemented 3/1/19 progress notes for elast notes had been review of objective to data collection for all Interview on 8/10/21 was in the process of objectives and no accomplemented of the process of | t '21. 21 of client #4's record to brush her teeth thoroughly ence for 2 consecutive ed 3/1/19), to improve her emaining on task 2 times daily of the time for 2 consecutive ed 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 written on 11/30/19. Further raining books indicated no all identified objectives. with the QIDP revealed she of reviewing client #4's dditional progress notes had objectives since the date P also acknowledged no data and been provided to staff for | W 15 | W159-B The facility will ensure Comonitor data collection on brush improve attention span by remaitask, toileting, open/close button and identifying money on monthic client #4 and all client's data collewill monitor monthly, and RD will quarterly. | ing teeth, ning on s and snaps y basis for ection. QP | 10/08/2021 | | |
| | revealed objectives with 100% independed reviews (implements eating routine by lay bite with 95% accura (3/1/20), to prepare a independence for 2 (implemented 3/1/20) | 21 of client #5's record to brush his teeth thoroughly ence for 2 consecutive ed 3/1/20), to develop an ing down his fork after each acy for 2 review periods a vegetable with 85% consecutive months b), and to identify money with review periods (implemented) | | W159-C The facility will ensure QP monitor data collection on brushir develop an eating routine by laying fork after each bite, prepare a vegidentifying money on monthly basic client #5 and all client's data collection will monitor monthly, and RD will requarterly. | ng teeth, g down his etable and is for tion, OP | 10/08/2021 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 34G146 | B. WING | | 30 | 08/10/2021 | |
| | PROVIDER OR SUPPLIER SPECIAL CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 6214 KILMORY DRIVE FAYETTEVILLE, NC 28304 | | | | |
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| W 159 | each objective revewritten on 4/30/20. training books indicated identified objectives. Interview on 8/10/21 was in the process objectives and no abeen written on the identified. The QIDI collections sheets have month of August D. Review on 8/9/2 revealed no IPP in the Interview on 8/10/21 Intellectual Disabilities. | eview of progress notes for aled the last notes had been Further review of objective ated no data collection for all. I with the QIDP revealed she of reviewing client #5's additional progress notes had objectives since the date P also acknowledged no data ad been provided to staff for a '21. I of client #2's record the record. via phone with the Qualified the Professional (QIDP) do not have a current IPP as of | W 159 | W159-D The facility will ensure QF and revise the Individual Program needed and complete IPP meeting for client #2 and all clients. QP will monthly, and RD will monitor quar | Plan as annually monitor | 10/08/2021 | |
| W 252 | revealed no IPP in the current IPP was requested at the current IPP was provided. Interview on 8/10/21 indicated 6/26/20 was available for client #4 PROGRAM DOCUM CFR(s): 483.440(e)(Data relative to accompanie at the current IPP was provided in client incompanie at the current IPP was provided in client incompanie at the current IPP was required to accompanie at the current IPP | IENTATION | W 252 | w159-E The facility will ensure QP and revise the Individual Program needed and complete IPP meeting for client #6 and all clients. QP will monthly, and RD will monitor quar | Plan as annually monitor | 10/08/2021 | |

| STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 1000 10 | FIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | | |
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| | | 34G146 | B. WING | | 08 | 08/10/2021 | |
| | NAME OF PROVIDER OR SUPPLIER EXTRA SPECIAL CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 6214 KILMORY DRIVE FAYETTEVILLE, NC 28304 | 1 | 1012021 | |
| (X4) ID PREFIX TAG | /= + ou - o = = | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| W 252 | Continued From pa | ge 4 | W 25 | 52 | | | |
| | Based on record refacility failed to ensuaccomplishment of in the Individual Prodocumented in mea 3 of 5 audit clients (are: A. Review on 8/10/2 revealed objectives with 75% independereviews, to improve wearing his eyeglast time for 2 consecutive with 90% independered and to identify mone for 2 review periods. Objective training bo collection for all identifuterview on 8/10/21 | s not met as evidenced by: views and interviews, the ure data relative to the criteria specified in objectives gram Plan (IPP) was surable terms. This affected #2, #4 and #5). The findings 21 of client #2's record to brush his teeth thoroughly ence for 2 consecutive wearing his eyeglasses by ses for 30 minutes 90% of the ve months, to toilet himself ence for 2 consecutive months by with 50% verbal prompts Additional review of oks indicated no data tified objectives. with the Home Manager collect data using data sheets | | W252-A The facility will ensure all state in-service and retrain on completing decollection on objectives for brushing to improve wearing eyeglasses, toileting, identifying money on monthly basis for client #2 and all client's data collection. Home Manager will monitor weekly, Commonitor bi-weekly. | lata eeth, and or n. | 10/08/2021 | |
| | for each objective; h sheets had been pro- Interview on 8/10/21 Intellectual Disabilities revealed client #2's of available; however, r | via phone with the Qualified es Professional (QIDP) objective data sheets were no completed data sheets | | | | | |
| | revealed objectives t | 1 of client #4's record o brush her teeth thoroughly nce for 2 consecutive | | w252-B The facility will ensure all staff in-service and retrain on completing da collection on objectives for brushing te improve attention span by remaining o task, toileting, open/close buttons and | eth, | 10/08/2021 | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | Access to the second | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 34G146 | B. WING | | 08 | /10/2021 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP 6214 KILMORY DRIVE FAYETTEVILLE, NC 28304 | | 110/2021 | |
| (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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| W 252 | remaining on task 2 50% of the time for toilet herself with 5 consecutive month verbal prompts for be able to open/clo 50% independence Additonal review of indicated no data cobjectives. Interview on 8/10/2 collect data using dhowever, no data coprovided. Interview on 8/10/2 revealed client #4's available; however, were provided for recognitions. | 2 times daily for 30 minutes 2 consecutive months, to 0% independence for 2 s, to identify money with 75% 2 consecutive months, and to se buttons and snaps with for 3 consecutive months. objective training books ollection for all identified 1 with the HM revealed staff ata sheets for each objective; ollection sheets had been 1 via phone with the QIDP objective data sheets were no completed data sheets eview. | W 2 | and identifying money on mont client #4 and all client's data co Home Manager will monitor we monitor bi-weekly. | llection. | | |
| | with 100% independence reviews, to develop down his fork after for 2 review periods 85% independence and to identify mone review periods. Additaining books indicidentified objectives Interview on 8/10/2 collect data using data. | to brush his teeth thoroughly dence for 2 consecutive an eating routine by laying each bite with 95% accuracy to prepare a vegetable with for 2 consecutive months, by with 75% accuracy for 2 ditonal review of objective ated no data collection for all to with the HM revealed staff at a sheets for each objective; ollection sheets had been | | w252-C The facility will ensin-service and retrain on corcollection on objectives for develop an eating routine by fork after each bite, prepare identifying money on month client #5 and all client's data Home Manager will monitor monitor bi-weekly. | mpleting data brushing teeth, y laying down his a vegetable and ally basis for collection. | 10/08/2021 | |
| | Interview on 8/10/21 | via phone with the OIDP | | | , | | |

| W 252 Continued From revealed client #8 available; however were provided for | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 34G146 | B. WING | | 0.5 | 3/10/2021 | |
| | | | | STREET ADDRESS, CITY, STATE, ZIF 6214 KILMORY DRIVE FAYETTEVILLE, NC 28304 | CODE | 5/10/2021 | |
| PREFIX | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| W 257 | revealed client #5's available; however, were provided for re PROGRAM MONIT CFR(s): 483.440(f)(The individual progral least by the qualified professional and revolut not limited to sitt failing to progress to after reasonable efform. This STANDARD is Based on record refacility failed to ensure Plan (IPP) was revied determine progress. This affected 3 of 5 at The findings are: A. Review on 8/10/2 revealed objectives the waring his eyeglass eyeglasses for 30 miconsecutive months toilet himself with 90% of the provided the province of the provided the provi | objective data sheets were no completed data sheets eview. ORING & CHANGE 1)(iii) am plan must be reviewed at dimental retardation vised as necessary, including, pations in which the client is evard identified objectives orts have been made. not met as evidenced by: views and interview, the re the Individual Program eved and revised to towards identified objectives. audit clients (#2, #4 and #5). 11 of client #2's record obrush his teeth thoroughly nce for 2 consecutive ed 4/26/18), to improve | W 25 | W257-A The facility will ens review and revise to determ towards identified objective teeth, improve wearing eyes and identifying money on m client #2 and all clients. QP w | sure QP will nine progress es on brushing glasses, toileting, nonthly basis for will write | 10/08/2021 | |
| | to identify money with review periods (imple review of progress no revealed the last note 10/30/19. | n 50% verbal prompts for 2 emented 3/1/19). Additional otes for each objective es had been written on with the Qualified Intellectual | | monthly progress notes on pobjectives. QP will monitor rewill monitor quarterly. | progress toward monthly, and RD | | |
| | | | | All and the second seco | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 34G146 | B. WING | | 0 | 08/10/2021 | |
| | PROVIDER OR SUPPLIER SPECIAL CARE | | | STREET ADDRESS, CITY, STATE, ZIP CO 6214 KILMORY DRIVE FAYETTEVILLE, NC 28304 | | 0/10/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | X (EACH CORRECTIVE ACTION | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| W 257 | Disabilities Professi in the process of reand no additional provide written on the object. B. Review on 8/10/revealed objectives with 75% independence for 30 minutes 50% months (implemented with 50% independence for 30 minutes 50% months (implemented 3/1/19 verbal prompts for 20 (implemented 3/1/19 open/close buttons a independence for 3 (implemented 3/1/19 progress notes for elast notes had been Interview on 8/10/21 was in the process objectives and no according to the process of | onal (QIDP) revealed she was viewing client #2's objectives rogress notes had been tives since the date identified. 21 of client #4's record to brush her teeth thoroughly ence for 2 consecutive ed 3/1/19), to improve her maining on task 2 times daily of the time for 2 consecutive ed 3/1/19), to toilet herself ence for 2 consecutive months at the consecutive months encountered to and snaps with 50% consecutive months and snaps with 50% consecutive months encountered to an encountered | W 2 | W257-B The facility will ensur review and revise to determin towards identified objectives teeth, improve attention spar on task, toileting, open/close snaps and identifying money of basis for client #4 and all clien write monthly progress notes toward objectives. QP will mo and RD will monitor quarterly. | ne progress on brushing by remaining buttons and on monthly its. QP will on progress nitor monthly, | 10/08/2021 | |
| | revealed objectives the with 100% independent reviews (implemented eating routine by laying bits with 95% accurated (3/1/20), to prepare a independence for 2 of (implemented 3/1/20, 75% accuracy for 2 minus for | 21 of client #5's record to brush his teeth thoroughly tence for 2 consecutive and 3/1/20), to develop an ang down his fork after each acy for 2 review periods at vegetable with 85% consecutive months becomes a vegetable with 85% consecutive months consecutive | | w257-C The facility will ensure review and revise to determine towards identified objectives of teeth, develop an eating routin down his fork after each bite, pugetable and identifying mone basis for client #5 and all client write monthly progress notes of toward objectives. QP will mone and RD will monitor quarterly. | e progress on brushing ne by laying orepare a ey on monthly is. QP will on progress | 10/08/2021 | |

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| 150 3400 950 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | PROVIDER OR SUPPLIER SPECIAL CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 6214 KILMORY DRIVE FAYETTEVILLE, NC 28304 | 1 00 | 710/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE | D BE | (X5) COMPLETION DATE |
| W 257 | each objective revewritten on 4/30/20. Interview on 8/10/20 was in the process objectives and no abeen written on the identified. PROGRAM MONIT CFR(s): 483.440(f)(d) At least annually, the must be revised, as process set forth in This STANDARD is | aled the last notes had been I with the QIDP revealed she of reviewing client #5's dditional progress notes had objectives since the date ORING & CHANGE 2) e individual program plan appropriate, repeating the paragraph (c) of this section. not met as evidenced by: | W 25 | | | |
| | failed to ensure the I was revised at least 5 audit clients. (#2 a A. Review on 8/9/21 revealed no IPP in the Interview on 8/10/21 Intellectual Disabilities revealed client #2's I June of 2020; however held since then. B. Initial review on 8 revealed no IPP in the current IPP was requipled atted 6/26/20 www. | view and interview, the facility individual Program Plan (IPP) annually. This affected 2 of and #6). The findings are: of client #2's record are record. via phone with the Qualified as Professional (QIDP) ast IPP meeting was held in a rer, no meeting had been /10/21 of client #6's record are record. After the most lested by the surveyor, a lested by the surveyor, a lested by the surveyor, a lested by the surveyor are phone with the QIDP | | W260-A The facility will ensure QP reclient #2 and all clients IPP's annually needed. QP will monitor monthly, and will monitor quarterly. W260-B The facility will ensure QP reclient #6 and all clients IPP's annually needed. QP will monitor monthly, and will monitor quarterly. | or as | 10/08/2021 |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 34G146 | B. WING_ | | ns. | /10/2021 |
| | OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 6214 KILMORY DRIVE FAYETTEVILLE, NC 28304 | 1 00 | 710/2021 |
| (X4) PREF TAC | EIX (EACH DEFICIENC | 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 |
| | available for client DRUG USAGE CFR(s): 483.450(e Drugs used for cormust be used only client's individual p specifically towards elimination of the bare employed. This STANDARD i Based on record refailed to ensure a defor 2 of 5 audit clier as an integral part of (IPP). The findings A. Review on 8/10/0 orders dated 7/1/21 for Melatonin 3mg, 6:30pm. Additional Intervention Plan (Eobjectives to decrea non-compliance, phyocalizations, falling touching, false accuprofanity, self-injury tantrums, public material formal active treating a formal active treating touching and Clainappropriate behave a formal active treating touching active treating touching active treating active tre | vas the most current IPP #6. (2) Itrol of inappropriate behavior as an integral part of the rogram plan that is directed the reduction of and eventual ehaviors for which the drugs s not met as evidenced by: eview and interview, the facility rug used to manage behaviors its (#3 and #4) was used only of his Individual Program Plan are: (21 of client #3's physician's - 10/1/21 revealed an order take 1 tablet at bedtime, review of the client's Behavior IP) dated 2/5/21 revealed ase behaviors of ysical aggression, loud to the floor, inappropriate isations, running away, property destruction, sturbation and stealing. e plan identified the use of | W 26 | | ssed in | 10/08/2021 |

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| W 312 | Intellectual Disabilitic confirmed client #3 however, the medic formal active treatm. B. Review on 8/10/0 orders dated 7/1/21 for Clonidine HCL, mouth 3 times daily client's Behavior Intellectual 1/7/21 revealed objection on-compliance, spitting, running away vocalizations, falling touching, false accutemper tantrums/crystealing. Further revuse of Aripiprazole a inappropriate behave a formal active treatuse of Clonidine to a Interview on 8/10/21 confirmed client #4 is behavior; however, tin a formal active tree NURSING SERVICE CFR(s): 483.460(c)(| 1 via phone with the Qualified ies Professional (QIDP) ingests Melatonin for sleep; ation is not included in a nent plan. 21 of client #4's physician's - 10/1/21 revealed an order 1 mg tablet, take 1 tablet by Additional review of the ervention Plan (BIP) dated ectives to decrease behaviors physical aggression, Pica, ay from staff, loud to the floor, inappropriate sations, property destruction, ring, smearing feces and food view of the plan identified the and Vyvanse to address iors. The plan did not include ment program to include the address client #4's behaviors. via phone with the QIDP ngests Clonidine for the medication is not included eatment plan. ES 5)(i) set include implementing with the interdisciplinary team, re and preventive health de, but are not limited to taff as needed in appropriate | W 34 | W312-B The facility will ensure all to manage behaviors are addresse #4 and all clients Behavior Interveif on physician order. QP will monimonthly, and RD will monitor quar | d in client ntion Plan tor | 10/08/2021 | |

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| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COE 6214 KILMORY DRIVE FAYETTEVILLE, NC 28304 | | 710/2021 |
| (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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| | This STANDARD is Based on observation interviews, the facility were sufficiently tracurrent COVID-19 the appropriate uses specific directions of The findings are: A. Upon arrival to t | itions, record review and ity failed to ensure all staff ined to implement the facility's visitor screening process, on of face masks and to follow or dispensing medicatons. The home on 8/9/21 at 21 at 5:50am, staff invited the ome. The surveyor's ken; however, no health is were asked or forms letion. The facility's COVID-19 ted, "All staff and visitors must ening checklist." Additional list noted the following: The washed their hands or ed hand rub on entry? The surveyor's all if they have any of the expression of the facility's COVID-19 ted, "All staff and visitors must ening checklist." Additional list noted the following: The washed their hands or ed hand rub on entry? The washed with a person(s) with 9?" The with the Residential Director in to a temperature check, the generalized be utilized. | W 34 | W340-A The facility will ensure be in-service and train on imple current COVID-19 screening che visitor and staff. Home Manage weekly QP will monitor Bi-week monthly. | ementing the ecklist for er will monitor | 10/08/2021 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|--|-----|---|----------------------------|----------------------------|
| 20.00 | | 34G146 | B. WING | | | ns | 3/10/2021 |
| NAME OF PROVIDER OR SUPPLIER EXTRA SPECIAL CARE | | | | 621 | REET ADDRESS, CITY, STATE, ZIP CODE 4 KILMORY DRIVE YETTEVILLE, NC 28304 | 1 00 | 10/2021 |
| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| W 340 | mask covering her home, Staff B was a During additional of throughout the surv removed their face | nswered the door without a face. Upon entry into the also observed without a mask. Deservations in the home ey, various staff repeatedly mask in common areas of the | W3 | 340 | W340-B The facility will ensure all strin-service and re-train on wearing far appropriately and making sure mask worn while in the facility. Home Mar will monitor weekly, QP will monitor Weekly | ce mask are ager | 10/08/2021 |
| 2 | Interview on 8/10/22 staff are required to working in the home revealed she had pure to the staff are required to the staf | mask improperly below their their chin. I with Staff A confirmed all wear a face mask while a. Additional interview alled her face mask below her is causing her eye glasses to | | | | | |
| | entry door of the hor required. All employ to wear face mask of Another sign posted "Notice: Please wea of the facility's COVI "All individuals enter wear a face covering surgicalWe have in | of a sign posted on the side me revealed, "Face mask yees and visitors are required or protective face covering." I inside the home noted, or a mask." Additional review ID-19 training book indicated, ring into the facilities must g i.e. masks-cloth or implemented universal use of tople, visitors and staff, while | | | | | |
| | (HM) confirmed all s required to wear a fa noted if a staff needs could step outside. C. During observation administration in the | with the Home Manager taff working in the home are ace mask on duty. The HM is to remove their mask, they ons of medication home on 8/9/21 at 4:03pm, ottle of Carafate 1g, used a | | | W340-C The facility will ensure all staf in-service and retrain on how to admi medication as written on physician on Medical Coordinator and Home mana monitor weekly, QP and RN will monit monthly. | nister der. ger will | 10/08/2021 |

| T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|---|--|---|--|
| | 34G146 | B. WING _ | | 90 | /10/2021 | |
| PROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP CO 6214 KILMORY DRIVE FAYETTEVILLE, NC 28304 | DE | 710/2021 | |
| (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION S | HOULD BE | (X5) COMPLETION DATE | |
| syringe to obtain 4m client to ingest the mobservation of the mobservation. Interview on 8/9/21 susually shakes up the dispensing. Interview on 8/10/21 confirmed the Carafidispensing as the mobservation of the bottle. DRUG ADMINISTRACER(s): 483.460(k)(structure) and the physician's order. This STANDARD is Based on observation interview, the facility received his medicate physician's orders. To observed receiving mobserved receiving mobserved and of Erypimedications. At 6:06 consuming his dinner. Review on 8/10/21 of orders dated 7/1/21 - | and of the liquid and assisted a medication. Closer medication bottle noted, with Staff D revealed he me medication prior to with the Medical Coordinator ate should be shaken prior to edication tends to seperate in ATION 1) administration must assure ministered in compliance with s. not met as evidenced by: on, record review and failed to ensure client #6 ion in accordance with This affected 1 of 3 clients medications. The finding is: of medication administration 1 at 4:13pm, client #6 ed 200mg/5ml and other ipm, client #3 began real. f client #6's physician's 10/1/21 revealed an order | | W368 The facility will ensure all sta service and retrain on how to admi medication as written on physician client #6 and all clients. Medical Co | nister order for ordinator | 10/08/2021 | |
| times a day "with a m | real". | | | | | |
| | PROVIDER OR SUPPLIER SUMMARY STAY (EACH DEFICIENCY REGULATORY OR LS Continued From page syringe to obtain 4m client to ingest the mobservation of the mean syringe to obtain 4m client to ingest the mobservation of the mean syringe to obtain 4m client to ingest the mobservation of the mean syringe to obtain 4m client to ingest the mobservation of the mean syringe to obtain 4m client to ingest the mobservation of the mean syringe to obtain 4m client to ingest the mean syringe to obtain 4m client to ingest the mean syringe to obtain 4m client to ingest the medication observation interview, and the physician's order. This STANDARD is Based on observation interview, the facility received his medication observed receiving medications. At 6:06 consuming observations in the home on 8/9/2 ingested 3ml of Erypmedications. At 6:06 consuming his dinner. Review on 8/10/21 of orders dated 7/1/21 - for Eryped 200mg/5m | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 syringe to obtain 4ml of the liquid and assisted a client to ingest the medication. Closer observation of the medication bottle noted, "Shake well". Interview on 8/9/21 with Staff D revealed he usually shakes up the medication prior to dispensing. Interview on 8/10/21 with the Medical Coordinator confirmed the Carafate should be shaken prior to dispensing as the medication tends to seperate in | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 syringe to obtain 4ml of the liquid and assisted a client to ingest the medication. Closer observation of the medication bottle noted, "Shake well". Interview on 8/9/21 with Staff D revealed he usually shakes up the medication prior to dispensing. Interview on 8/9/21 with the Medical Coordinator confirmed the Carafate should be shaken prior to dispensing as the medication tends to seperate in the bottle. DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure client #6 received his medication in accordance with physician's orders. This affected 1 of 3 clients observed receiving medications. The finding is: During observations of medication administration in the home on 8/9/21 at 4:13pm, client #6 ingested 3ml of Eryped 200mg/5ml, client #3 began consuming his dinner meal. Review on 8/10/21 of client #6's physician's orders dated 7/1/21 - 10/1/21 revealed an order for Eryped 200mg/5ml, take 3ml by mouth four | SPECIAL CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 syringe to obtain 4ml of the liquid and assisted a client to ingest the medication. Closer observation of the medication bottle noted, "Shake well". Interview on 8/9/21 with Staff D revealed he usually shakes up the medication prior to dispensing as the medication tends to seperate in the bottle. DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure client #6 received his medication in accordance with physician's orders. This softence is a service of the service and retrain on how to administration in the home on 8/9/21 at 4:13pm, client #6 ingested 3ml of Eryped 200mg/5ml and other medications. At 6:06pm, client #3 began consuming his dinner meal. Review on 8/10/21 of client #6's physician's orders dated 7/1/21 - 10/1/21 revealed an order for Eryped 200mg/5ml, take 3ml by mouth four | SHAMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 syringe to obtain 4ml of the liquid and assisted a client to ingest the medication. Closer observation of the medication bottle noted, "Shake well". Interview on 8/9/21 with Staff D revealed he usually shakes up the medication prior to dispensing as the medication tends to seperate in the bottle. DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. W 368 W | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|--|------|--|----------------------------|----------------------|
| | | 34G146 | B. WING | | | 08. | 10/2021 |
| | PROVIDER OR SUPPLIER SPECIAL CARE | | | 6214 | EET ADDRESS, CITY, STATE, ZIP CODE KILMORY DRIVE ETTEVILLE, NC 28304 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | (X5) COMPLETION DATE | |
| W 368 | Continued From pa | ge 14 | W 3 | 68 | | | |
| W 369 | confirmed the Erype meal as ordered. | | W 3 | 69 | | | |
| | that all drugs, include | g administration must assure ling those that are re administered without error. | | | W369 The facility will ensure all staff | i i | |
| | Based on observati interviews, the facilit medications were as | on, record review and ty failed to ensure all dministered without error. clients observed receiving anding is: | | | service and retrain on how to adminis medication as written on physician or client #3 and all clients. Medical Coord and Home manager will monitor weel and RN will monitor monthly. | ter der for dinator | or 10/08/2021 |
| | in the home on 8/10 self-administered tw | of medication administration /21 at 7:50am, client #3 o sprays of Fluticasone ostril 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 d Fluticasone 50mcg, use nostril daily (Right nostril). | | | | | |
| W 436 | | MENT | W 43 | 36 | | | |
| | The facility must furn | nish, maintain in good repair, | | | | | |

| | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | | E SURVEY MPLETED |
|--|---|--|---|---|------------------------------------|----------------------------|
| | | 34G146 | B. WING | | 08/ | 10/2021 |
| NAME OF PROVIDER OR SUPPLIER EXTRA SPECIAL CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 6214 KILMORY DRIVE FAYETTEVILLE, NC 28304 | 1 30, | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| W 436 | choices about the u hearing and other c and other devices ic interdisciplinary tear | use and to make informed se of dentures, eyeglasses, ommunications aids, braces, | W 43 | 36 | 1 | |
| | Based on observation interviews, the facility clients (#4 and #6) to make informed of devices identified as Program Plan (IPP) A. During 3 of 3 me | ty failed to ensure 2 of 5 audit were provided with and taught noices about the use of a needed in the Individual and The findings are: | | | | |
| | built-up handled fork knife. Review on 8/10/21 c orders dated 7/1/21 | ent #4 was provided with a c and a regular spoon and of client #4's physician's - 10/1/21 revealed an order d knife "with built up" handles. | | W436-A The facility will ensure clients are provided with adaptive equipment to meet the needs of ea Medical Coordinator will monitor will monitor Bi-wee QP will monitor monthly. | e ch client. eekly, | 10/08/2021 |
| | Medical Coordinator | with the Home Manager and revealed no built-up handle available in the home and rdered. | M | | | |
| | the survey on 8/9 - 8 eye glasses. Client assisted to wear eye Review on 8/10/21 of 6/26/20 (most recent | f client #6's IPP dated t plan) revealed, "[Client #6's] | | w436-B The facility will ensure QP of program on wearing eyeglasses for and all clients that have problems wearing eyeglasses. QP will in-service re-train staff on running the program prompting client #6 and other client program is not running to wear eyeg Home Manager will monitor weekly | client #6 vith ce and n and s when | 10/08/2021 |
| | | s time and continues to wear lasses full timeHowever. | | will monitor monthly. | and QP | |

PRINTED: 08/11/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 34G146 B. WING 08/10/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6214 KILMORY DRIVE EXTRA SPECIAL CARE** FAYETTEVILLE, NC 28304 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 436 | Continued From page 16 W 436 [Client #6] does not like to wear his eye glasses full time..." The plan identified a need to "Wear eye glasses but need prompts to keep them on." Interview on 8/10/21 with the Home Manager and Medical Coordinator indicated client #6 does not like to wear his eye glasses when offered and has worked on training to wear them for a time period.



August 19, 2021

Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

Re: Recertification Completed August 9-10, 2021

Extra Special Care, 6214 Kilmory Dr., Fayetteville, NC 28304

Provider Number: 34G146 MHL Number: MHL 026-947

Dear Wilma Worsley-Diggs:

Enclosed you will find corrections of the deficiencies cited listed on the Statement of Deficiencies Form.

If you have any questions, please contact our office at (910) 491-2352 or mobile phone (910) 978-3675 or email: asia_parker@yahoo.com

Sincerely,

Asia Parker

Qualified Professional

Melody Thomas Residential Director