PRINTED: 10/08/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE COM A. BUILDING			(X3) DATE COMP	SURVEY LETED			
		34G009	B. WING			10/	05/2021
NAME OF PI	ROVIDER OR SUPPLIER			570	REET ADDRESS, CITY, STATE, ZIP CODE 09 US 70 EAST OLDSBORO, NC 27534		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 186	staff to manage and saccordance with their accordance with their birect care staff are don-duty staff calculate period for each defined. This STANDARD is raced an observation confirmed by interview failed to ensure there assist 3 of 6 audit clied documented in their in (IPP) specifically related to included in their in (IPP) specifically related to the findings. The findings. A. During observation #1 from 4:20pm until seated at a table in a offered several activity which included coloring drawing and recognized signs. She was not of to the toilet and or to hours and 10 minutes moved in her chair arresting her head on the staff in this classroom surveyor asked the quality disabilities profession in classroom #1, if she buring further observents the QIDP assisted Clitable in a chair at a derecliner, climbed into	ide sufficient direct care supervise clients in individual program plans. defined as the present ed over all shifts in a 24-hour ed residential living unit. In the met as evidenced by: Ins, record reviews and ws with staff, the facility were sufficient staff to ents (#1, #27 and #29) as individual program plans ting to repositioning and include: Ins on 10/4//21 in classroom 6:30pm, Client #1 was chair at a desk. Staff D ites to her during this time ing pictures with crayons, ring pictures of manual effered the opportunity to go change her position for two is. At 6:00pm, Client #1 and tried to sit sideways, the armrest. There were 2 in to 10 individuals. The	W	186			
APORATORY	NIDECTOR'S OR PROVINER/S	SLIPPLIER REPRESENTATIVE'S SIGNATURE			TITI F		(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.

AND DUAN OF CODDECTION TO THE PROPERTY OF THE		I ' '		(X3) DATE SURVEY COMPLETED		
		34G009	B. WING		10/05/2021	
	A. BUILDING A. BUILDING B. WING ME OF PROVIDER OR SUPPLIER ALNUT CREEK STREET ADDRESS, CITY, STATE, ZIP CODE 5709 US 70 EAST GOLDSBORO, NC 27534 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 5709 US 70 EAST GOLDSBORO, NC 27534 PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	10.00.202				
(X4) ID PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
W 186	When the surveyor Client #1 had not be to the toilet since 4: Immediate interview 6:30pm revealed the chronically understaworking in the class several direct support The QIDP stated she checked all clients is accidents before the 3:30pm. Interview on 10/4/2 to offer Client #1 the every hour but frequency hour sexpressions and so communicate. Furtheshe has needs to in on an informal toiled increased toileting at the IPP revealed Client #1 in as her gait is unstead assistance to walk sexpressions to walk sexpressions and so communicate.	left the classroom at 6:30pm een given the opportunity to go 20pm. If with the QIDP on 10/4/21 at at the facility has been affed and that she was sroom because they had out staff to call out of work, he thought first shift had in classroom #1 for toileting ey departed their shift at If with Staff D revealed staff try e opportunity to go to the toilet wently she declines or waves of Client #1's IPP dated he has profound intellectual werbal, uses gestures, facial me sign language to her review of the IPP revealed approve self help skills and is ting schedule because of accidents. Additional review of itent #1 is currently not do to go to the toilet ould be offered the opportunity. The IPP indicated that staff ent if she waved them away with any requests related to Subsequent review of the IPP is ambulatory with assistance ady. She requires staff	W 186			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUNG	JCTION	(X3) DATE COMF	SURVEY PLETED
		34G009	B. WING _			10	(05/2021
NAME OF PR	ROVIDER OR SUPPLIER		•	5709 US 70	DRESS, CITY, STATE, ZIP CODE DEAST DRO, NC 27534	·	
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W 186	IPP is current and of frequent opportunit interview confirmed chronically understashift staff were being assist with staff shows assist with staff did not not show as sitting on the stopped into her row another bedroom to would have to wait. The table of the staff around assist staff around 6: revealed in general client #1 up first in ambulatory and process.	ator, confirmed that Client #1's Client #1 should be offered ies to go to the toilet. Further I the facility had been affed and that on 10/5/21 third in a called into work early to ortages. I the facility had been affed and that on 10/5/21 third in a called into work early to ortages. I the facility on 10/5/21 third in a called into work early to ortages. I the facility on 10/5/21 third in a called into work early to ortages. I the facility on 10/5/21 third in a called into work early to ortages. I the facility on 10/5/21 third in a called into work early to ortages. I the facility on 10/5/21 third in a called into work early to ortages. I the facility on 10/5/21 third in a called into work early to ortages. I the facility in a called into work early to ortage in a called i	W	186			
	Review on 10/5/21 9/15/21 revealed sh disabilities, is non v	of Client #1's IPP dated ne has profound intellectual verbal, uses gestures, facial ome sign language to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		ILTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED		
		34G009	B. WING _			10	/05/2021
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, 5709 US 70 EAST GOLDSBORO, N	CITY, STATE, ZIP CODE C 27534		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 186	communicate. Furth she has needs to im on an informal toile increased toileting at the IPP revealed Cliexpressing the need consistently and sho to toilet every hour. Interview on 10/5/2′ (Staff B) indicated the every 30 minutes to be changed. She in assigned responsib getting her up, drescurrently working alindividuals. Addition asked Staff G to assigned the every 30 minutes to be changed individuals. Addition asked Staff G to assigned responsib getting her up, drescurrently working alindividuals. Addition asked Staff G to assigned the every 30 minutes with the every 30 minutes to be change his position wetness or dryness 4:20pm-6:30pm. Did by staff E and the fact classroom #1 with 1 wheelchairs for modenteral feedings. Stip between 6:00-6:30pf facility QIDP with 10 Client #27 sat in his assisted with consustaff E. At no time did he taken to his bedricheck to see if he needs to see if he needs to see if he needs to increase the every staff E.	der review of the IPP revealed aprove self help skills and is ting schedule because of accidents. Additional review of tient #1 is currently not do to go to the toilet build be offered the opportunity. If with the shift supervisor that all clients are checked ensure they do not need to dicated she had been tility for assisting Client #1 in sed on 10/5/21 but she was sone in classroom #1 with 7 that interview revealed she sist Client #1 with her morning the still a lot of individuals to	W	86			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G009	B. WING		10/05/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 5709 US 70 EAST GOLDSBORO, NC 27534	·
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
W 186	Continued From page	e 4	W 18	6	
	shift supervisor indical chronically understaff checked all clients for soiling before they let indicated any client with changed would be to interview confirmed the became fussy when he wheelchair but that he wheelchair for 30 min. Review on 10/5/21 of 5/10/21 revealed he in Profound Intellectual Quadriplegia, Cerebrical dislocated left hip. Further IPP confirmed he requestivities of dally living be offered frequent of out of his wheelchair. D. During observation from 3:00-4:00pm and classroom #1, Client with her bilateral hand the recliner with a land during these observation bathroom or bedroom dryness or offered the position. Interview with interview who was the shift suphad been chronically shift had checked all possible soiling before	F Client #27's IPP dated s non ambulatory, has Disabilities, Spastic al Palsy and a Chronically orther review of Client #27's uires assistance with all g, is non-verbal and should pportunities to be positioned			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G009	B. WING			10/05/2021	
NAME OF PE	ROVIDER OR SUPPLIER			57	TREET ADDRESS, CITY, STATE, ZIP CODE 709 US 70 EAST OLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 186	9/11/21 revealed she Disabilities, Spastic C dislocated hips, Dysp gastrostomy. Further that Client #29 depen her with all daily living verbal. Interview on 10/5/21 of facility had been chro all clients should be re client toileting needs simmediately. STAFF TRAINING PF CFR(s): 483.430(e)(1) The facility must prov initial and continuing of the employee to perform efficiently, and competed the employee to perform efficiently, and competed the standard continuing of the employee to perform efficiently, and competed the standard continuing of the employee to perform efficiently, and competed the standard continuing of the employee to perform efficiently. This affected the standard continuing of the employee to perform efficiently. This affected the finding is: During observations in 4:30-6:00 pm, Client of the dadaptive equipment of the equipment of the employee to perform the finding is: During observations in 4:30-6:00 pm, Client of the equipment of the employee to perform the finding is: During observations in 4:30-6:00 pm, Client of the equipment of the employee to perform the employee to perform efficiently the employee to perform efficiently. This affected the employee to perform efficiently the employee to perform efficiently the employee to perform efficiently, and competed the employee to perform efficiently t	Client #29's IPP dated has Profound Intellectual quadriplegia, Bilateral hagia and has a review of the IPP confirmed ds on direct staff to assist geneeds and that she is non with the QIDP confirmed the nically understaffed and that epositioned frequently any should be attended to ROGRAM COGRAM COGRA		189			

AND DIAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		34G009	B. WING		10/05/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5709 US 70 EAST GOLDSBORO, NC 27534	,
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
W 189	table to feed him. Cli good head control. Since the back of Client #2 fed him and gave him. Record review on 10. Therapy Evaluation of had minimal head coposition maintained. The response by the to adjust the neck resisting under head in The response by the to adjust the neck resisting under head in The response by the to adjust the neck resisting under head in The response by the to adjust the neck resisting under head in PT on 9/16/21. Interview on 10/5/21 #26's head had the test fed. Staff B had obsess with his head down, out of his mouth. State Client #26's head in ensure he would not Interview on 10/5/21 #26 has had the same admission. The PT is school expressed coused on the wheelch chair and found that to support Client #26 from lean must be back in the same admission to the shoulder straps in Client #26 from lean must be back in the same and the same admission.	aught Client #26 to the dinner ent #26 did not demonstrate, staff B placed her left hand on 6's head to stabilize it as she in a cup to drink fluids. 1/5/21 of Client #26's Physical on 10/12/20 revealed he only entrol, with brief midline Client #26's head was noted side. Wheelchair Concern Form for 0/21 reported his "head est and arm under arm rest." Physical Therapist (PT) was set and use tray to help keep work was performed by the with Staff B revealed Client endency to drop down when erved that if Client #26 is fed the food contents would spill iff B stated she supported place during the meal to	W 18	39	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG	_	(X3) DATE S COMPLE	
		34G009	B. WING _			10/0	5/2021
WALNUT	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT 5709 US 70 EAST GOLDSBORO, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BI FERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 189	in wheelchair and use The PT said this was should know this "bef floor."	tion, how to position clients the adaptive equipment. a general policy and staff fore they're even on the	W				
W 249	each client must rece treatment program co interventions and ser and frequency to sup) isciplinary team has ndividual program plan, ive a continuous active	W2	.49			
	Based on observation interviews, the facility clients (#1 and #27) of treatment program conterventions and servindividual program particularly following repositioning schedules. The finding A. During observation #1 from 3:30pm-4:00 6:30pm, Client #1 was at a desk. Staff D offeduring this time which with crayons, drawing manual signs. She was opportunity to go to the significant of the state o	vices as identified in the in (IPP) in the area of g guidelines and toileting gs include: as on 10/4/21 in classroom pm and 4:20pm until s seated at a table in a chair ered several activities to her included coloring pictures g and recognizing pictures of					

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		34G009	B. WING _			10/05/2021	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZII 5709 US 70 EAST GOLDSBORO, NC 27534	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
W 249	sit sideways, resting. There were 2 staff i individuals. The sur intellectual disabilition was working in class Client #1. The QIDF across the room to acovered her up in the #1 was asleep in the offered the opportunt toileting. Interview on 10/4/2 confirmed Client #1 go to the bathroom frequent toileting across gestures, facial language to commuliary revealed she has kills and is on an in because of increase Additional review of currently not express toilet consistently and opportunity to toilet indicated that staff waved them away are requests related to Subsequent review ambulatory with assunsteady. She requests related to subsequent distances.	hoved in her chair and tried to g her head on the armrest. In this classroom to 10 In this classist In this could assist In this could assist In this could assist In this classist of a blanket and the recliner, got a blanket and the recliner. By 6:30pm, Client In the recliner but had not been the recliner but had not been the thin this to go to the bathroom for In this sing the need to go to the thin this sing the need to go to the thin this sing the need to go to the thin this sing the need to go to the thin this sing the need to be patient if she and go back to her with any	W	249			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		34G009	B. WING _			10/05/2021	
NAME OF F	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZI 5709 US 70 EAST GOLDSBORO, NC 27534	P CODE		
(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 X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
W 249	disabilities profession should offer Client # hour for toileting to 10/5/21 at 7:30am, with his meal, scoop and helping him brithe finished his mea #27's wheelchair to and clamped a beau wheelchair tray. At a upset, trying to know his wheelchair tray, told Client #27 he wafter his meal to be explained that Clien positioned in his whof time. Review on 10/5/21 sylonger to 10/5/21 revealed he which should be ador indicating he is unchecklist indicated #27 is thirsty, check staff should assess changed, check to sinside of his shoes, area is too loud or if review confirmed if he will vocalize, cry hand. Interview on 10/5/22 worker, who is actin Client #27's IPP is considered.	onal (QIDP) confirmed staff #1 frequent opportunities every prevent toileting accidents. ons in classroom #1 on Staff B assisted Client #27 oing his food with his spooning his food to his mouth. After I, Staff B propelled Client the middle of classroom #1 disassistive device onto his 8:20am, Client #27 became ock over the assistive device on vocalizing and crying. Staff B would have to wait 30 minutes repositioned. Staff B would have to wait 30 minutes repositioned. Staff B would have to wait 30 minutes repositioned. Staff B would have to wait 30 minutes repositioned. Staff B would have to wait 30 minutes repositioned. Staff B would have to wait 30 minutes repositioned. Staff B with #27 does not like to be seeichair for extended periods at the staff should assess if Client was a comfort checklist dressed when he is vocalizing noomfortable (undated). The staff should assess if Client at the staff should assess if Client was a curled up check to see if he is wet or soiled, if his position needs to be see if his toes are curled up check to see if the immediate of Client #27 is hungry. Further Client #27 is uncomfortable, and sometimes try to bite his and sometimes try to bite his with the facility social gadministrator, confirmed current and staff should be uidelines and programs.	W 2	249			