| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G057 | A. BUILDING _____ B. WING _____ | 10/26/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAYWOOD COUNTY GROUP HOME #3 | 401 WOODLAWN CIRCLE CLYDE, NC 28721 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 130 | PROTECTION OF CLIENTS RIGHTS<br>CFR(s): 483.420(a)(7)<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.<br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure privacy was maintained for 4 of 5 clients (#1, #2, #3 and #4) during medication administration. The finding is:<br><br>Observation in the group home on 10/26/21 at 7:25 AM revealed client #3 to enter the medication room and to leave the medication room door open. Continued observation at 7:33 AM revealed staff C to observe client #4 walk by the medication room while administering medications to client # 3 and to verbally greet client #4 from the med room with "Good Morning". Further observation revealed staff C to administer all medications to client #3 without closing the medication room door. Observation at 7:40 AM revealed client #1 to enter the medication room and staff C to administer all morning medications to client #1 with the medication room door open.<br><br>Subsequent observation at 7:46 AM revealed client #2 to enter the medication room and staff C to administer morning medications to client #2 with the door to the medication room open. Observation at 7:48 AM revealed staff D to walk into the medication room during medication administration for client #2 and to place the staff's jacket in the room, then exit. Additional observation at 8:06 AM revealed client #4 to enter the medication room and staff C to administer all morning medications to client #4 with the medication room door open. Observation during | W 130 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G057 | A. BUILDING _____ B. WING _____ | 10/26/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAYWOOD COUNTY GROUP HOME #3 | 401 WOODLAWN CIRCLE CLYDE, NC 28721 |

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|---|---|---|---|---|
| W 130 | Continued From page 1<br>the medication pass for client #4 revealed the client to get upset with a client outside the medication room and yell "Calm down, You're too loud".<br><br>Interview with staff C on 10/26/21 revealed she had not been trained to close the door during a medication pass. Interview with the group home manager on 10/26/21 verified the door to the medication room should be closed to limit distractions and ensure privacy while additional training was needed with staff. | W 130 | | |
| W 249 | PROGRAM IMPLEMENTATION<br>CFR(s): 483.440(d)(1)<br><br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record reviews and interview, the facility failed to ensure 1 of 4 sampled clients (#3) received a continuous active treatment program consisting of needed interventions as identified in their habilitation plan. The findings are:<br><br>A. The team failed to ensure a program objective relative to meal preparation was implemented in sufficient frequency to support the need of client #3. For example: | W 249 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G057 | A. BUILDING _____ B. WING _____ | 10/26/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAYWOOD COUNTY GROUP HOME #3 | 401 WOODLAWN CIRCLE CLYDE, NC 28721 |

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|---|---|---|---|---|
| W 249 | Continued From page 2<br><br>Observation upon entry to the group home on 10/25/21 at 4:05 PM revealed client #3 to sit at the dining table in a wheelchair. Continued observation at 5:05 PM revealed the home manager to chop client #3's chicken in the kitchen with a knife while client #3 remained at the table unengaged. Further observation revealed client #3 to remain idle at the table with no interaction from staff from 4:05 PM until dinner was served at 5:10 PM.<br><br>Review of client #3's record on 10/26/21 revealed a habilitation plan dated 4/1/21. Review of client #3's habilitation plan indicated a training program relative to meal preperation that client #3 "will participate in preparing a meal using a food processor at least two times per week, given no more than two verbal prompts and necessary physical prompts to each step of the task analysis for six consecutive months." Continued review of client #3's record revealed an annual nutritional evaluation dated 2/28/21. Review of the nutritional evaluation indicated the client's diet as "facility diet-soft, chopped meats, low sodium, cholesterol controlled, low fat, small portions, nectar thick liquids with 2-100 calories snacks per day. Recommendations indicated the need to continue diet as ordered by SLP, mechanical soft with nectar thick liquids, continue to cut up and chop foods served secondary to chewing problems.<br><br>Interview with the qualified intellectual disabilities professional (QIDP) on 10/26/21 confirmed that client #3's meal preparation program is current. Continued interview with the QIDP confirmed staff should always utilize the food processor as appropriate and as prescribed, as well as offer | W 249 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G057 | A. BUILDING _____ B. WING _____ | 10/26/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAYWOOD COUNTY GROUP HOME #3 | 401 WOODLAWN CIRCLE CLYDE, NC 28721 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 249 | Continued From page 3 | W 249 | | |

the client the opportunity to assist and participate in meal preparation.

B. The team failed to ensure a program objective relative to communication was implemented in sufficient frequency to support the need of client #1. For example:

Observation throughout the 10/25-26/21 survey revealed client #3 to have a communication board hanging on the wall next to the client's recliner. Observation of the communication board revealed the following communication prompts: going out, snack, lunch, dinner, puzzles and restroom. At no time during the 10/25-26/21 survey were staff observed utilizing client #3's communication board.

Review of client #3's record on 10/26/21 revealed a habilitation plan dated 4/1/21. Review of client #3's habilitation plan indicated a training program relative to communiation that "when given a communicative prompt or opportunity, client #3 will use a communication board or device to formulate a request or response 50% of given occurrences." Continued review of client #3's record revealed an expressive communication evaluation dated 3/5/21. Review of the expressive communication evaluation revealed "when given a communication prompt or opportunity, client #3 will use a communication board or device with 6-12 choices, a known hand sign, gesture, or vocalization to formulate a request or response with 70% of given occurrences."

Interview with the qualified intellectual disabilities professional (QIDP) on 10/26/21 confirmed that client #3's communication program is current. Further interview with the QIDP confirmed staff

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G057 | A. BUILDING _____ B. WING _____ | 10/26/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAYWOOD COUNTY GROUP HOME #3 | 401 WOODLAWN CIRCLE CLYDE, NC 28721 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 249 | Continued From page 4<br>should be using client #3's communication board at all opportunities. | W 249 | | |
| W 268 | CONDUCT TOWARD CLIENT<br>CFR(s): 483.450(a)(1)(i)<br><br>These policies and procedures must promote the growth, development and independence of the client.<br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to promote the growth and independence of 3 of 4 sampled clients (#2, #3 and #5) and 1 non-sampled client (#4) in regards to dignity related to the use of incontinence pads. The finding is:<br><br>Observations in the home on 10/25/21 revealed incontinence pads positioned in various seating of living room furniture while seating was not used by clients. Continued observations on 10/25/21 revealed the incontinence pads to remain in seating of the living room recliners throughout the survey observation evening including times when no clients were present in the living room. Additional observations upon entry of the group home on 10/26/21 at 7:00 AM revealed living room recliners to remain covered with incontinence pads although no recliner was in use by any client.<br><br>Interview with the home manager (HM) on 10/26/21 revealed clients #2, #3, #4 and #5 have specific recliners that each client uses. Continued interview with the HM revealed incontinence pads are placed in each recliner to protect the furniture from toileting accidents. Further interview with the HM verified client #2 and #5 have incontinence issues and have | W 268 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G057 | A. BUILDING _____ B. WING _____ | 10/26/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAYWOOD COUNTY GROUP HOME #3 | 401 WOODLAWN CIRCLE CLYDE, NC 28721 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 268 | Continued From page 5<br>training programs to address toileting needs. Subsequent interview with the HM revealed client #3 and #5 did not have toileting programs. Interview with the HM further verified incontinence pads should not be left out at all times. | W 268 | | |
| W 371 | DRUG ADMINISTRATION<br>CFR(s): 483.460(k)(4)<br><br>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.<br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and interview, the system for drug administration failed to assure 2 of 2 clients (#3 and #4) observed during medication administration were provided the opportunity to participate in medication self-administration. The findings are:<br><br>A. The system for drug administration failed to assure client #3 was provided the opportunity to participate in medication self-administration. For example:<br><br>Observation in the group home on 10/25/21 at 4:42 PM revealed client #3 to enter the medication room and to sit in a chair while staff B prepared and administered medication to the client. Continued observation revealed staff B to wash her own hands, reconcile medications from a bubble pack with the medication record, punch a medication for client #3 into a medication cup and feed client #3 medication in yogurt. Staff B was not observed to provide any identification of medication or education regarding purpose or | W 371 | | |

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|---|---|---|---|
| | 34G057 | A. BUILDING _____ B. WING _____ | 10/26/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAYWOOD COUNTY GROUP HOME #3 | 401 WOODLAWN CIRCLE CLYDE, NC 28721 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 371 | Continued From page 6<br>side effects to the client.<br><br>Observation on 10/26/21 at 7:25 AM revealed staff C to administer medications to client #3 in the medication room of the group home. Continued observation revealed staff C to wash her own hands, punch all of client #3's medications into a medication cup, mix medications with a spoonful of yogurt and to feed client #3 all medications. Staff C was not observed to provide any identification of medication or education regarding purpose or side effects to the client. Subsequent observation revealed staff C to administer a fiber powder to client #3 that staff measured from a container, poured into a cup that staff mixed with juice and stirred before handing the cup to the client.<br><br>Review of records for client #3 on 10/26/21 revealed a habilitation plan dated 4/1/21. Continued review of records for client #3 revealed a skill assessment (dated 2021). Review of the 2021 skill assessment revealed client #3 to have independence with eating with a fork and spoon, pulling on/off socks and removing mittens/gloves.<br><br>Interview with the group home manager on 10/26/21 verified client #3 has independence with eating skills and is able to do various tasks independently. Continued interview with the home manager verified although client #3 is capable of participating in various tasks involved in medication administration, the client does not participate due to the concern the client will drop medications on the floor.<br><br>B. The system for drug administration failed to assure client #4 was provided the opportunity to | W 371 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G057 | A. BUILDING _____ B. WING _____ | 10/26/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAYWOOD COUNTY GROUP HOME #3 | 401 WOODLAWN CIRCLE CLYDE, NC 28721 |

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|---|---|---|---|---|
| W 371 | Continued From page 7 | W 371 | | |

participate in medication self-administration. For example:

Observation on 10/25/21 at 4:38 PM revealed client #4 to enter the medication room and to sit in a chair while staff B prepared and administered medication to the client. Continued observation revealed staff B to wash her own hands, reconcile medications from a bubble pack with the medication record, punch a medication for client #4 into a medication cup and the client to take the medication independently. Staff B was not observed to provide any identification of medication or education regarding purpose or side effects to the client.

Observation on 10/26/21 at 8:06 AM revealed staff C to administer medications to client #4 in the medication room of the group home. Continued observation revealed staff C to punch medications into a medication cup, mix medications with a spoonful of yogurt and to feed client #4 all medications. Staff C was not observed to provide any identification of medication or education regarding purpose or side effects to the client. It should be noted client #4 was given the opportunity to identify the name and purpose of (1) medication that staff C punched from a bubble pack.

Review of records for client #4 on 10/26/21 revealed a habilitation plan dated 9/1/21. Continued review of records for client #4 revealed a skill assessment (dated 1/29/2021). Review of the 9/2021 skill assessment revealed client #4 to have independence with eating with a fork and spoon, cuts with a knife and chooses correct utensil to use.

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|---|---|---|---|
| | 34G057 | A. BUILDING _____ B. WING _____ | 10/26/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAYWOOD COUNTY GROUP HOME #3 | 401 WOODLAWN CIRCLE CLYDE, NC 28721 |

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|---|---|---|---|---|
| W 371 | Continued From page 8<br>Interview with the group home manager on 10/26/21 verified client #4 has independence with eating skills and is able to do various tasks independently. Continued interview with the home manager verified although client #4 is capable of participating in various tasks involved in medication administration, the client does not participate due to the concern the client will drop medications on the floor. | W 371 | | |
| W 475 | MEAL SERVICES<br>CFR(s): 483.480(b)(2)(iv)<br><br>Food must be served with appropriate utensils. This STANDARD is not met as evidenced by:<br>Based on observation, record reviews and interview, the facility failed to ensure appropriate utensils were provided during meal time for 5 out of 5 clients. The finding is:<br><br>Observation in the group home of the dinner meal on 10/25/21 revealed the meal to consist of chicken alfredo, a garden salad, green beans and a roll. Continued observation of the dinner meal revealed the place setting for each client to include the following utensils: a fork only for client #1, #2 and #3; a weighted fork only for client #4 and a fork and maroon spoon for client #5.<br><br>Continued observation revealed during the meal for client #4 to request a knife from staff to spread butter on her dinner roll. Further observation revealed staff to provide client #4 with a non-sharp knife that the client used to spread butter on her roll with independence.<br><br>Review of records for client #1 on 10/26/21 revealed a habilitation plan dated 10/1/2021. Continued review of records for client #1 revealed | W 475 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34G057 | A. BUILDING _____ B. WING _____ | 10/26/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAYWOOD COUNTY GROUP HOME #3 | 401 WOODLAWN CIRCLE CLYDE, NC 28721 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 475 | Continued From page 9 | W 475 | | |

a skill assessment dated 2021 that reflected client #1 eats with a spoon, fork and cuts with a knife. Further review of the 2021 skills assessment revealed client #1 is able to choose the correct utensil to use from a place setting.

Review of records for client #2 on 10/26/21 revealed a habilitation plan dated 5/6/2021. Continued review of records for client #2 revealed a skill assessment dated 2021 that reflected client #2 eats with a spoon and fork with the ability to choose the correct utensil to use from a place setting.

Review of records for client #3 on 10/26/21 revealed a habilitation plan dated 4/1/21. Continued review of records for client #3 revealed a skill assessment dated 2021 that reflected client #3 eats with a spoon and fork.

Review of records for client #4 on 10/26/21 revealed a habilitation plan dated 9/1/2021. Continued review of records for client #4 revealed a skill assessment dated 1/29/2021 that reflected client #4 eats with a spoon, fork and cuts with a knife. Further review of the 2021 skills assessment revealed client #1 is able to choose the correct utensil to use from a place setting.

Review of records for client #5 on 10/26/21 revealed a habilitation plan dated 4/1/21. Continued review of records for client #5 revealed a skill assessment dated 1/25/21 that reflected client #5 can use a spoon, fork and knife independently. Further review of the 2021 skills assessment revealed client #5 is able to cut food into appropriate sized bites using a knife and fork independently.

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|---|---|---|---|
| | 34G057 | A. BUILDING _____ B. WING _____ | 10/26/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAYWOOD COUNTY GROUP HOME #3 | 401 WOODLAWN CIRCLE CLYDE, NC 28721 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| W 475 | Continued From page 10<br>Interview with the group home manager revealed full place settings should be provided to all clients. | W 475 | | |