DEPART		APPROVED					
CENTERS FOR MEDICARE & MEDICAID SERVICES					C	MB NO.	0938-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
34G164		B. WING			01/05/2022		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
а јаск	WALL GROUP HOME	:			213 MOSS SPRINGS ROAD		
				-	ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 249	PROGRAM IMPLE CFR(s): 483.440(d)		W 2	249			
	formulated a client's each client must re- treatment program interventions and se and frequency to su objectives identified plan. This STANDARD is Based on observat	rdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the I in the individual program s not met as evidenced by: ions, record reviews and ity failed to ensure 4 of 6					
	client's (#2, #3, #4, active treatment pro individual support p A. The facility failed	#5) received a continuous ogram as identified in their lan (ISP). The findings are: I to ensure a training objective paration was implemented for					
	client #2. For exam Evening observatio 1/4/22 revealed clie activities prior to the medication adminis completing a puzzle Continued observat prepare the dinner was client #2 prom opportunity to partic Morning observatio 1/5/22 revealed clie a shower, and rece breakfast meal. Co						
		ER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE		(X6) DATE

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

PRINTED: 01/11/2022

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				FORM	01/11/2022 APPROVED			
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED					
		34G164	B. WING	i		01/(	05/2022			
NAME OF F	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-				
А ЈАСК	WALL GROUP HOME	<u>=</u>	1213 MOSS SPRINGS ROAD ALBEMARLE, NC 28001							
(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 249	entirety. At no time provided the opport preparation. Review of client #2' an ISP dated 6/1/2' a training objective meal preparation w 12 consecutive mon training objective in participate in daily r information/instruct cookware, and assi prepare the meal ite Interview with the q professional (QIDP objectives for client interview with the G have offered opport preparation as press B. The facility failed relative to meal pre- client #3. For exam	was client #2 prompted or tunity to participate in meal 's record on 1/5/22 revealed 1. Review of the ISP indicated that client #2 will assist with vith no more than 3 prompts for nths. Continued review of the adicated client #2 will meal preparation, read the tions, get the needed ist with steps needed to em. uualified intellectual disabilities 0 on 1/5/22 verified the training t #2 were current. Continued QIDP confirmed staff should tunities to participate in meal scribed.	W 2	249	DEFICIENCY)					
	1/4/22 revealed clie activities prior to the group sensory activitablet, and watching Continued observat prepare the dinner was client #3 prompoportunity to partic	ent #3 to engage in various e dinner meal that included a vity, an interactive game on his g TV in the living room. tion revealed staff D to meal in its entirety. At no time pted or provided the cipate in meal preparation.								
	1/5/22 revealed clie	ons in the group home on ent #3 to transition between his ving room prior to the								

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		AND HUMAN SERVICES				FORM	01/11/2022 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ì í			(X3) DATE SURVEY COMPLETED					
		34G164	B. WING	;		01/05/2022				
NAME OF PRO\	VIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE					
A JACK WA	LL GROUP HOME	E	1213 MOSS SPRINGS ROAD ALBEMARLE, NC 28001							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
breasta enii pro prea Re an a tr pre wit Co ind rea Inte pro obj inte har me C. rela clie Ev 1/4 act gro wa obs me pro Data No 1/5	aff A to prepare the tirety. At no time of ovided the opport eparation. A ISP dated 3/1/21 training objective eparing a meal ited th 3 or less prompontinued review of dicated client #3 v ad instructions with the quick of client erview with the quick offered opport erview with the Q ve offered opport eal preparation as The facility failed lative to meal pre- ent #4. For examponent for the servation 4/22 revealed client tivities prior to the oup sensory active atching TV in the I servation reveale eal in its entirety. A compted or provide in the servation for provide prining observation for the servation for the servat	ntinued observations revealed he breakfast meal in its was client #3 prompted or tunity to participate in meal 's record on 1/5/22 revealed 1. Review of the ISP indicated that client #3 will assist staff in em twice weekly for dinner pts for 12 consecutive months. If the training objective will gather needed items and ith staff assistance. ualified intellectual disabilities ) on 1/5/22 verified the training :#3 were current. Continued 2IDP confirmed staff should tunities to participate in the s prescribed. If to ensure a training objective paration was implemented for ple: ns in the group home on ent #4 to engage in various e dinner meal that included a <i>i</i> ty, completing a puzzle, and living room. Continued ed staff D to prepare the dinner At no time was client #4 ed the opportunity to	W 2	249						

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		AND HUMAN SERVICES				FORM	01/11/2022 APPROVED 0938-0391			
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		34G164	B. WING	i		01/	05/2022			
NAME OF I	PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-				
А ЈАСК	WALL GROUP HOME	<u>.</u>	1213 MOSS SPRINGS ROAD ALBEMARLE, NC 28001							
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W 249	meal. Continued ob prepare the breakfa time was client #4 p opportunity to partic Review of client #4' an ISP dated 8/1/21 a training objective preparing a menu if prompts for 12 cons review of the trainin will choose an item item(s) and cookwa required to prepare Interview with the q professional (QIDP objectives for client interview with the G have offered opport preparation as press D. The facility failed relative to meal pre client #5. For exam Evening observatio 1/4/22 revealed clie activities prior to the group sensory activitablet, watching TV in his room. Continue staff D to prepare th At no time was client opportunity to partic Morning observatio	observations revealed staff A to ast meal in its entirety. At no prompted or provided the cipate in meal preparation. As record on 1/5/22 revealed 1. Review of the ISP indicated that client #4 will assist in tem daily with 3 or less secutive months. Continued ng objective revealed client #4 to prepare, retrieve the are, and engage in the steps the item. Unulified intellectual disabilities ) on 1/5/22 verified the training #4 were current. Continued DIDP confirmed staff should tunities to participate in meal scribed. A to ensure a training objective paration was implemented for	W 2	249						

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A JACK	WALL GROUP HOME	1			213 MOSS SPRINGS ROAD ALBEMARLE, NC 28001		
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W 249	observations reveal breakfast meal in its client #5 prompted participate in the me Review of client #5' an ISP dated 9/1/21 a training objective meal preparation w 12 consecutive mon training objective re their schedule, gath follow directions in preparing a menu its Interview with the q professional (QIDP objectives for client interview with the Q	led staff A to prepare the s entirety. At no time was or provided the opportunity to eal preparation. 's record on 1/5/22 revealed 1. Review of the ISP indicated that client #5 will participate in rith no more than 4 prompts for nths. Continued review of the evealed client #5 will check her needed materials, and completing all steps in tem(s). yualified intellectual disabilities b) on 1/5/22 verified the training t #5 were current. Continued QIDP confirmed staff should tunities to participate in meal	W 2	249			

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