PRINTED: 01/21/2022 FORM APPROVED OMB NO. 0938-0391

AND DIAN OF CORRECTION INDENTIFICATION NUMBER:		` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G177	B. WING			01/	20/2022
	ROVIDER OR SUPPLIER	AL HOME		235	REET ADDRESS, CITY, STATE, ZIP CODE 5 KINLAW RD YETTEVILLE, NC 28301	•	
(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
E 039	CFR(s): 483.475(d)(2) §416.54(d)(2), §418.2 §460.84(d)(2), §482.2 §483.475(d)(2), §484.4 §485.625(d)(2), §484.6 *[For ASCs at §416.5 "Organizations" unde §485.920, RHCs/FQF Facilities at §494.62]: (2) Testing. The [facility to test the emergency must do all of the following for the following facility of the facility of	and the second s	E	039			
_ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(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 AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G177	B. WING _			01/	20/2022	
	ROVIDER OR SUPPLIER	L HOME		STREET ADDRESS, 235 KINLAW RD FAYETTEVILLE,	, CITY, STATE, ZIP CODE	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI: TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD I -REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 039	a facilitator and include a narrated, clinically-r scenario, and a set of directed messages, or designed to challenge (iii) Analyze the [facilit maintain documentatic exercises, and emerge [facility's] emergency *[For Hospices at 418 (2) Testing for hospic patient's home. The lexercises to test the eannually. The hospic (i) Participate in a full community based ever (A) When a community community based ever (B) If the hospice experimental emergency plan, the emergency plan and the emerge	les a group discussion using elevant emergency problem statements, reprepared questions an emergency plan. by's] response to and on of all drills, tabletop ency events, and revise the plan, as needed. 1.113(d):] 1.113(d)	E	39				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G177	B. WING		01/20/2022	
	ROVIDER OR SUPPLIER TER CLINIC RESIDENTI	AL HOME	:	STREET ADDRESS, CITY, STATE, ZIP CODE 235 KINLAW RD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
E 039	directed messages, designed to challeng (3) Testing for hospic care directly. The hospice of exercises to test the year. The hospice of the year. The hospice of the year of year	relevant emergency of problem statements, or prepared questions e an emergency plan. ces that provide inpatient ospice must conduct emergency plan twice per nust do the following: annual full-scale exercise that or ity-based exercise is not an annual individual nal exercise; or or periences a natural or cy that requires activation of the hospice is exempt from required full-scale community ed functional exercise if the emergency event. Itional annual exercise that ot limited to the following: ale exercise that is a facility based functional drill; or ise or workshop led by a es a group discussion using a elevant emergency scenario, statements, directed ed questions designed to ency plan. pice's response to and tion of all drills, tabletop gency events and revise the	E 039			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G177	B. WING		01/20/2022		
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E 039	conduct exercises to twice per year. The do the following: (i) Participate in an a is community-based; (A) When a commun accessible, conduct a facility-based function (B) If the [PRTF, Hos actual natural or mar requires activation of [facility] is exempt from the required full-scale confacility-based function onset of the emerger (ii) Conduct an and that may include following: (A) A second full-scale community-based or functional exercise; (B) A mock (C) A tabletop exiled by a facilitator and discussion, using a memergency scenario statements, directed questions designed to plan. (iii) Analyze the maintain documental	184(d), Hospitals at §485.625(d):] IF, Hospital, CAH] must test the emergency plan [PRTF, Hospital, CAH] must annual full-scale exercise that or ity-based exercise is not an annual individual, and exercise; or spital, CAH] experiences an annual emergency that the emergency plan, the omengaging in its next mmunity based or individual, and exercise following the ney event. [additional] annual exercise or , but is not limited to the ale exercise that is individual, a facility-based or disaster drill; or kercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency [facility's] response to and cition of all drills, tabletop gency events and revise the plan, as needed.	E 03	9			

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		34G177	B. WING		01/20/2022		
	ROVIDER OR SUPPLIER TER CLINIC RESIDENT	TAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 235 KINLAW RD FAYETTEVILLE, NC 28301		•		
(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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
E 039	exercises to test the annually. The PACE following: (i) Participate in an is community-based (A) When a community-based function (B) If the PACE exposed function (II) Conduct an years opposite the yexposed function (II) Conduct an years opposite the yexposed function (II) Conduct an years opposite the yexposed function (III) Conduct an years opposite the yexposed function (III) Conduct an years opposite the yexposed function (III) Conduct an years opposite the yexposite (A) A second full-scommunity-based of functional exercise (B) A mock disaste (C) A tabletop exertal facilitator and inclusing a narrated, cliscenario, and a set directed messages, designed to challen (III) Analyze the PAmaintain documental exercises, and eme PACE's emergency	CE organization must conduct a emergency plan at least annual full-scale exercise that d; or nity-based exercise is not an annual individual, onal exercise; or eriences an actual natural or ncy that requires activation of a, the PACE is exempt from required full-scale community facility-based functional ne onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section ay include, but is not limited to cale exercise that is a rindividual, a facility based or r drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. CE's response to and ation of all drills, tabletop regency events and revise the plan, as needed.	E 039				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED			
		34G177	B. WING	····	01/	/20/2022
	ROVIDER OR SUPPLIER	L HOME	1	STREET ADDRESS, CITY, STATE, ZIP CODE 235 KINLAW RD FAYETTEVILLE, NC 28301	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	test the emergency princluding unannounce emergency procedure ICF/IID] must do the f (i) Participate in an a is community-based; (A) When a community accessible, conduct a facility-based function (B) If the [LTC facility] actual natural or man requires activation of LTC facility is exempt required a full-scale of individual, facility-base following the onset of (ii) Conduct an additionary include, but is not (A) A second full-scale community-based or a functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator includes a narrated, clinically-rel and a set of problem messages, or prepare challenge an emerge (iii) Analyze the [LTC and maintain docume exercises, and emerge [LTC facility] facility's *[For ICF/IIDs at §483 (2) Testing. The ICF/II to test the emergency The ICF/IID must do for the second results of the content of	an at least twice per year, and staff drills using the es. The [LTC facility, collowing: Innual full-scale exercise that for ey-based exercise is not in annual individual, all exercise. If acility experiences an emade emergency that the emergency plan, the from engaging its next community-based or ed functional exercise the emergency event. In annual exercise that it limited to the following: the exercise that is an individual, facility based exercise that is an individual, facility based exercise that is en individual, facility based exercise that is led by group discussion, using a event emergency scenario, estatements, directed en questions designed to exercise the emergency plan, as needed. S.475(d)]: ID must conduct exercises plan at least twice per year.	E 03			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	T Y		(X3) DATE SURVEY COMPLETED		
		34G177	B. WING	B. WING		01/20/2022	
	ROVIDER OR SUPPLIER	AL HOME	•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 35 KINLAW RD TAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	accessible, conduct a facility-based function (B) If the ICF/IID expersion man-made emergency the emergency plan, engaging in its next recommunity-based or functional exercise for emergency event. (ii) Conduct an additionary include, but is not (A) A second full-scal community-based or functional exercise; or (B) A mock disaster of (C) A tabletop exercise a facilitator and includusing a narrated, cliniscenario, and a set of directed messages, or designed to challenge (iii) Analyze the ICF/II maintain documentati exercises, and emergicifor ICF/IID's emergency *[For HHAs at §484.1 (d)(2) Testing. The Hito test the emergency least annually. The Hito test the emergency least annually l	ty-based exercise is not an annual individual, all exercise; or. eriences an actual natural or by that requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based Illowing the onset of the onal annual exercise that of limited to the following: e exercise that is an individual, facility-based or rill; or see or workshop that is led by des a group discussion, cally-relevant emergency of problem statements, or prepared questions e an emergency plan. ID's response to and on of all drills, tabletop plan, as needed. O2] HA must conduct exercises of plan at HA must do the following: e-scale exercise is not munity-based exercise is not	E	039			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G177	B. WING			01/3	20/2022
	ROVIDER OR SUPPLIER	L HOME		STREET ADDRESS, CITY, STATE, ZIP COI 235 KINLAW RD FAYETTEVILLE, NC 28301)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
E 039	or man-made emerge of the emergency platengaging in its next recommunity-based or if functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under paragis conducted, that limited to the following (A) A second full-community-based or a functional exercise; of (B) A mock disass (C) A tabletop exted by a facilitator and discussion, using a nate emergency scenario, statements, directed in questions designed to plan. (iii) Analyze the HHA'd documentation of all of emergency events, and emergency plan, as in a figure of the emergency following: (i) Conduct a paper-by workshop at least and discussion, using a nate emergency scenario, using a nate emergency scenario, using a nate emergency scenario,	experiences an actual natural ancy that requires activation in, the HHA is exempt from equired full-scale individual, facility based allowing the onset of the conal exercise every 2 years, full-scale in or functional raph (d)(2)(i) of this section at may include, but is not in individual, facility-based in the different exercise that is an individual, facility-based in the different exercise or workshop that is includes a group exercise or workshop that is includes a group exercise or workshop that is includes a group exercise or workshop exercises, and individual, facility-relevant and a set of problem exercises, and individual, tabletop exercises, and individual exercises and individual exercise exercises and individual exercises and individual exercises and individual exercise exercise exercises and individual exercises and individual exercises and individual exercises and individual exercises and individ	E	039			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X	3) DATE SURVEY COMPLETED
		34G177	B. WING _			01/20/2022
	ROVIDER OR SUPPLIER TER CLINIC RESIDENTIA	AL HOME	•	STREET ADDRESS, CITY, STATE, ZIP (235 KINLAW RD FAYETTEVILLE, NC 28301	CODE	
(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 X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
E 039	questions designed to plan. If the OPO experimental plan is next refollowing the onset of (ii) Analyze the OPO's documentation of all temergency events, and OPO's] emergency plan *[RNCHIs at §403.74 (d)(2) Testing. The RI exercises to test the emust do the following (i) Conduct a paper-bleast annually. A table discussion led by a factinically-relevant emof problem statement prepared questions demergency plan. (ii) Analyze the RNHO maintain documentation and emergency plan, as in This STANDARD is in Based on document facility failed to ensuring tabletop exercises Preparedness (EP) potentially affected cl. #6. The finding is:	challenge an emergency eriences an actual natural or by that requires activation of the OPO is exempt from equired testing exercise the emergency event. It is response to and maintain tabletop exercises, and and revise the [RNHCl's and an, as needed. 18]: NHCl must conduct emergency plan. The RNHCl is ased, tabletop exercise at etop exercise is a group acilitator, using a narrated, ergency scenario, and a set is, directed messages, or esigned to challenge an including the RNHCl's response to and in on of all tabletop exercises, its, and revise the RNHCl's review and interviews, the efacility/community-based to test their Emergency lan were conducted. This itents #1, #2, #3, #4, #5 and the facility's EP plan dated	E	039		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		34G177	B. WING _			01/20/2022	
	ROVIDER OR SUPPLIER	IAL HOME	•	STREET ADDRESS, CITY, STATE, ZIP CODE 235 KINLAW RD FAYETTEVILLE, NC 28301		,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
E 039	Continued From pag	ge 9	E	039			
W 242	intellectual disabilitie Program Director co		W 2	242			
	those clients who lar skills essential for pr (including, but not lir personal hygiene, do bathing, dressing, gr of basic needs), unti that the client is dev acquiring them. This STANDARD is Based on record re interdisciplinary tear	am plan must include, for ck them, training in personal rivacy and independence mited to, toilet training, ental hygiene, self-feeding, rooming, and communication I it has been demonstrated elopmentally incapable of not met as evidenced by: view and interview the in failed to assess identified roming for 1 of 3 audit clients					
	behavior inventory (of client #3's adaptive ABI) dated 8/19/21 revealed ng and personal hygiene on npleted.					
	#3 requires physical	with staff A revealed client assistance and verbal select clean clothing, apply his teeth.					
	#3 needs a lot of ver physical assistance complete basic groo to ensure he does a	with staff B revealed client rbal reminders and some from direct care staff to ming and personal care tasks thorough job of bathing, selecting clean clothing and					

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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	ROVIDER OR SUPPLIER	AL HOME		2:	TREET ADDRESS, CITY, STATE, ZIP CODE 35 KINLAW RD AYETTEVILLE, NC 28301		
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 242 W 254	disabilities profession Director revealed this have been completed Additional interview of	with the qualified intellectual al (QIDP) and the Program ABI for client #3 should I in the area of grooming. onfirmed client #3 is not ently has a training objective g his teeth.		242			
	contribute to an overa client's ongoing level This STANDARD is r Based on record revi qualified intellectual of (QIDP) failed to revie	lisabilities professional					
	support program (BSI addressed the target non-compliance, self-aggression, property for food and running the BSP incorporates the						
	Director confirmed the over the past year bu reviewed to determine	e if client #3 was making Further interview confirmed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		34G177	B. WING _			01/20/2022
	ROVIDER OR SUPPLIER	AL HOME		STREET ADDRESS, CITY, STATE, ZIP C 235 KINLAW RD FAYETTEVILLE, NC 28301	ODE	
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIA	
W 254	1/7/21 revealed it add of non-compliance, so spitting, profanity and program incorporates Hydroxyzine, Risperd The last psychology p 1/15/21. Interview on 1/20/22 Director confirmed the over the past year bur eviewed to determine significant progress. If there were no recent 1/15/21 by the Psychology progress of food stees elf-injurious behavior falling to the floor. The use Haldol, Abilify an psychology progress. Interview on 1/20/22 Director confirmed the over the past year bur eviewed to determine	of client #4 BSP dated dressed the target behaviors elf-injurious behavior, lying, severe disruption. This the use of Fluoxetine, al, Cogentin and Topamax. progress note was dated with the QIDP and Program at they had collected data t this data had been e if client #4 was making Further interview confirmed progress notes since plogist. of client #5's BSP dated dressed the target aling, physical aggression, r, disruptive behavior and s program incorporates the d Clonidine. The last note was dated 1/15/21. with the QIDP and Program at they had collected data t this data had been e if client #5 was making Further interview confirmed progress notes since plogist.	W 2			
** 255	CFR(s): 483.440(f)(1)		V V Z			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
34G177		B. WING		_	01/20/2022			
NAME OF PROVIDER OR SUPPLIER THE CARTER CLINIC RESIDENTIAL HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 235 KINLAW RD FAYETTEVILLE, NC 28301				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	((EACH CORRE CROSS-REFERE	PROVIDER'S PLAN OF CORRECTION (X5 COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
W 255	least by the qualified professional and revisibut not limited to situate successfully complete identified in the indivitable. This STANDARD is a Based on record revigualified intellectual of (QIDP) failed to ensure objective in the area of changed in response completion. This affer (#5). The finding is: Review on 1/19/22 of program plan (IPP) distraining program that teeth with 50% indepreview sessions. This on 3/1/21. Review of revealed the following 4/2021: 50% 5/2021: 75% 6/2021: 80% 7/2021: 100% 8/2021: 90% 10/2021	intellectual disability sed as necessary, including, ations in which the client has ed an objective or objectives dual program plan. not met as evidenced by: ew and staff interview, the lisabilities professional re client #5's training of brushing his teeth was to him meeting criteria for octed 1 of 3 audit clients client #5's individual ated 8/18/21 revealed a requires client #5 brush his endence for 2 consecutive a program was implemented the progress summaries g: with the qualified intellectual al (QIDP) and the Program ent #5 met criteria for jective in May 2021. Further	W	255				
W 369	DRUG ADMINISTRA CFR(s): 483.460(k)(2	-	W	369				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
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W 369	Continued From pag	e 13	W 36	9			
	that all drugs, including self-administered, and This STANDARD is Based on observation interview, the facility medications were ad This affected 1 of 3 or receiving medications. During observations on 1/20/22 at 6:13 and 2 mg. (1), Cogentin 0 (1/2), Haldol 5 mg. (1). These medication water. Review on 1/20/22 of 12/21/21 for client #5 medications were to Abilify 2 mg. (1), Cogenting. (1), Cogenting. (1), Cogenting. (1), and Flutical (1) puff to each nostres in terview on 1/20/22 #5 is to receive Flution needed when he exhibited in the self-administration of the self-administration	e administered without error. not met as evidenced by: ons, record review and failed to ensure all ministered without error. dients (#5) observed s. The finding is: of medication administration of staff C administered Abilify forms. (1), Clonidine 0.1mg. of and Hydroxyzine 10mg. of the physician orders dated of revealed the following be administered at 6am: entin 0.5mg. (1), Clonidine of mg. (1), Hydroxyzine of mg. (1), Hydroxyzine of mg. (1), Hydroxyzine of mg. (1), Hydroxyzine of masal spray 50mcg.					