DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G047	B. WING	i		01/	19/2022
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SKILL CI	REATIONS OF CLINT	ON			223 FOREST TRAIL		
					CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	EP Testing Require CFR(s): 483.475(d) §416.54(d)(2), §418 §460.84(d)(2), §482 §483.475(d)(2), §482 §485.625(d)(2), §48 §491.12(d)(2), §494 *[For ASCs at §416 "Organizations" und §485.920, RHCs/F0 Facilities at §494.62 (2) Testing. The [fac to test the emergen must do all of the fo (i) Participate in a fu community-based e (A) When a community-based e (B) If the [facilit natural or man-made activation of the emergen exempt from engage community-based of functional exercise actual event. (ii) Conduct an addi years, opposite the functional exercise	sc IDENTIFYING INFORMATION) ments (2) 3.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 34.102(d)(2), §485.68(d)(2), 35.727(d)(2), §485.920(d)(2), 4.62(d)(2). 5.54, CORFs at §485.68, OPO, der §485.727, CMHCs at QHCs at §491.12, and ESRD 2]: cility] must conduct exercises her gena annually. The [facility] blowing: ull-scale exercise that is every 2 years; or unity-based exercise is not t a facility-based functional ears; or y] experiences an actual de emergency that requires hergency plan, the [facility] is ging in its next required following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing:		i	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
	functional exercise; (B) A mock disaster						
	1		I				

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

TITLE

(X6) DATE

PRINTED: 01/24/2022

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.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G047	B. WING			01/19/2022	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SKILL C	REATIONS OF CLINT	Л			23 FOREST TRAIL CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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
E 039	a facilitator and inclia a narrated, clinically scenario, and a set directed messages, designed to challen (iii) Analyze the [fac maintain documenta exercises, and eme [facility's] emergend *[For Hospices at 4 (2) Testing for hosp patient's home. The exercises to test the annually. The hosp (i) Participate in a f community based e (A) When a commu accessible, conduct functional exercise (B) If the hospice ex- man-made emergent the emergency plan engaging in its next community-based function onset of the emerged (ii) Conduct an add opposite the year the exercise under para is conducted, that n to the following: (A) A second full-so community-based of exercise; or (B) A mock disaste (C) A tabletop exer	udes a group discussion using y-relevant emergency of problem statements, , or prepared questions ige an emergency plan. Sility's] response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed. 18.113(d):] bices that provide care in the e hospice must conduct e emergency plan at least bice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not t an individual facility based every 2 years; or xperiences a natural or ncy that requires activation of n, the hospital is exempt from t required full scale exercise or individual onal exercise following the ency event. ditional exercise every 2 years, he full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited cale exercise that is or a facility based functional	E)39			

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		AND HUMAN SERVICES				FORM	01/24/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G047	B. WING			01/19/2022	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SKILL C	REATIONS OF CLINT	ON			23 FOREST TRAIL CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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
E 039	a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The h exercises to test the year. The hospice (i) Participate in an is community-based (A) When a commu- accessible, conduc- facility-based functi (B) If the hospice er man-made emerge the emergency plar engaging in its next based or facility-based following the onset (ii) Conduct an ador may include, but is (A) A second full-s- community-based or exercise; or (B) A mock disaste (C) A tabletop exer facilitator that include narrated, clinically-r and a set of probler messages, or prepa- challenge an emerge (iii) Analyze the ho- maintain document exercises, and emerge	y-relevant emergency c of problem statements, or prepared questions age an emergency plan. bices that provide inpatient hospice must conduct e emergency plan twice per must do the following: a annual full-scale exercise that d; or unity-based exercise is not a annual individual ional exercise; or xperiences a natural or ency that requires activation of n, the hospice is exempt from t required full-scale community sed functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or rcise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to		039			

Facility ID: 942586

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		AND HUMAN SERVICES				FORM	01/24/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		34G047	B. WING	i		01/	19/2022
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
SKILL CI	REATIONS OF CLINT	ON			223 FOREST TRAIL CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	*[For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [PF conduct exercises to twice per year. The do the following: (i) Participate in an is community-based (A) When a commu- accessible, conduct facility-based function (B) If the [PRTF, Ho actual natural or marequires activation of [facility-based function (B) If the [PRTF, Ho actual natural or marequires activation of [facility] is exempt for required full-scale of facility-based function onset of the emerge (ii) Conduct an and that may include following: (A) A second full-sec community-based of functional exercise; (B) A mock (C) A tabletop e- led by a facilitator at discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the maintain document	1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan e [PRTF, Hospital, CAH] must a annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event. [additional] annual exercise or le, but is not limited to the cale exercise that is or individual, a facility-based f or disaster drill; or exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared I to challenge an emergency e [facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.	E	039			

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		AND HUMAN SERVICES				FORM	01/24/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G047	B. WING	i		01/19/2022	
NAME OF F	PROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
SKILL CF	REATIONS OF CLINT	ON			223 FOREST TRAIL CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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
E 039	exercises to test the annually. The PACE following: (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based function (B) If the PACE exp man-made emerged the emergency plan engaging in its next based or individual, exercise following the event. (ii) Conduct an years opposite the y exercise under para is conducted that m the following: (A) A second full-se community-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator and incl using a narrated, cli scenario, and a set directed messages, designed to challen (iii) Analyze the PA maintain documenta exercises, and eme PACE's emergency *[For LTC Facilities	CE organization must conduct e emergency plan at least E organization must do the a annual full-scale exercise that d; or unity-based exercise is not an annual individual, ional exercise; or periences an actual natural or ency that requires activation of n, the PACE is exempt from t required full-scale community , facility-based functional the onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section hay include, but is not limited to cale exercise that is or individual, a facility based ; or er drill; or rcise or workshop that is led by ludes a group discussion, linically-relevant emergency of problem statements, , or prepared questions hge an emergency plan. ACE's response to and tation of all drills, tabletop ergency events and revise the y plan, as needed.		039	9		

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		AND HUMAN SERVICES				FORM	01/24/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G047	B. WING	i		01/ [.]	19/2022
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SKILL CF	REATIONS OF CLINT	DN			223 FOREST TRAIL CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based functi (B) If the [LTC facility actual natural or marequires activation of LTC facility is exem requires activation of LTC facility is exem required a full-scale individual, facility-based following the onset (ii) Conduct an ador may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator includes narrated, clinically-r and a set of probler messages, or prepa- challenge an emerg (iii) Analyze the [LT and maintain docum exercises, and emerg [LTC facility] facility/ *[For ICF/IIDs at §4 (2) Testing. The ICF to test the emergen The ICF/IID must d	 plan at least twice per year, need staff drills using the ures. The [LTC facility, e following: a annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise. ty] facility experiences an an-made emergency that of the emergency plan, the of the emergency plan, the of the emergency event. At an unual exercise of the emergency event. At an individual, facility based or ased functional exercise that not limited to the following: cale exercise that is or an individual, facility based for er drill; or trise or workshop that is led by a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. TC facility] facility's response to mentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed. e83.475(d)]: F/IID must conduct exercises for year. 	EC	039			

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		AND HUMAN SERVICES				FORM	01/24/2022 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		34G047	B. WING _			01/19/2022				
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
SKILL CI	REATIONS OF CLINT	N			23 FOREST TRAIL LINTON, NC 28328					
(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)) BE	(X5) COMPLETION DATE			
E 039	is community-based (A) When a commu accessible, conduct facility-based functii (B) If the ICF/IID ex man-made emerge the emergency plar engaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi may include, but is (A) A second full-so community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and incl using a narrated, cl scenario, and a set directed messages designed to challen (iii) Analyze the ICF maintain document exercises, and eme ICF/IID's emergence *[For HHAs at §484 (d)(2) Testing. The to test the emergence least annually. The (i) Participate in a fu community-based; (A) When a cor accessible, conduct	d; or unity-based exercise is not t an annual individual, onal exercise; or. speriences an actual natural or ncy that requires activation of n, the ICF/IID is exempt from a required full-scale or individual, facility-based following the onset of the itional annual exercise that not limited to the following: cale exercise that is or an individual, 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 ige an emergency plan. [/IID's response to and ation of all drills, tabletop ergency events, and revise the ey plan, as needed. A.102] HHA must conduct exercises hyper at HHA must do the following: ull-scale exercise that is	E 03	39						

		AND HUMAN SERVICES				FORM	01/24/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G047	B. WING			01/ [.]	19/2022
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SKILL CF	REATIONS OF CLINT	мс			223 FOREST TRAIL CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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
E 039	 (B) If the HHA or man-made emergency pengaging in its next community-based or functional exercise emergency event. (ii) Conduct an addi opposite the year the exercise under parais conducted, that limited to the followin (A) A second functional exercise; (B) A mock disa (C) A tabletop eled by a facilitator a discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the HHZ documentation of al emergency plan, as *[For OPOs at §486 (d)(2) Testing. The following: (i) Conduct a paper workshop at least a led by a facilitator a discussion, using a emergency scenario following: 	experiences an actual natural rgency that requires activation lan, the HHA is exempt from threquired full-scale or individual, facility based following the onset of the itional exercise every 2 years, the full-scale or functional agraph (d)(2)(i) of this section at may include, but is not ing: ill-scale exercise that is or an individual, facility-based for aster drill; or exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared I to challenge an emergency A's response to and maintain II drills, tabletop exercises, and and revise the HHA's is needed.		039			

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CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			FORM MB NO. (X3) DATE	: 01/24/2022 APPROVED . 0938-0391 E SURVEY IPLETED
		34G047	B. WING	;		01/	19/2022
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SKILL CI	REATIONS OF CLINT	ON			223 FOREST TRAIL CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	questions designed plan. If the OPO ex man-made emerge the emergency plar engaging in its next following the onset (ii) Analyze the OPO documentation of a emergency events, OPO's] emergency *[RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the followin (i) Conduct a paper least annually. A tal discussion led by a clinically-relevant en of problem stateme prepared questions emergency plan. (ii) Analyze the RNI maintain document and emergency eve emergency plan, as This STANDARD is Based on record re facility failed to ensi exercise was condu plan (EP). The findi During record revie Preparedness Man 1/12/22, there were training activities fo Interview on 1/19/22	I to challenge an emergency periences an actual natural or ncy that requires activation of n, the OPO is exempt from t required testing exercise of the emergency event. O's response to and maintain II tabletop exercises, and and revise the [RNHCI's and plan, as needed. 748]: RNHCI must conduct e emergency plan. The RNHCI ng: -based, tabletop exercise at bletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or a designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's s needed. s not met as evidenced by: eview and interviews, the ure a facility/community-based ucted to test their emergency	E	039			

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STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G047	B. WING			01/19/2022	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SKILL CI	REATIONS OF CLINT	ON			23 FOREST TRAIL CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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
E 039	Continued From pa training or attendan	-	EC)39			
W 125	(ED) revealed table to be performed to disasters and they o		W 1	125			
	Therefore, the facili individual clients to of the facility, and a including the right to to due process. This STANDARD is Based on observat failed to maintain th	isure the rights of all clients. ity must allow and encourage exercise their rights as clients is citizens of the United States, o file complaints, and the right is not met as evidenced by: tions and interviews, the facility he privacy of 1 of 6 audit cal information. The finding is:					
	12:40 PM, a sign war medication room do client #4's name an read: "[Client #4] now has She is back on 8 PI important that she of her Eliquis/Apixaba sign was undated a signature of the nur An additional obser at 3:00 PM revealed client #4's new medic exterior guest/staff lobby. This signed	s in the home on 1/18/22 at as posted outside the bor, facing the hall revealing id new medication. The sign s a new medication ordered. M med pass, it is very does not miss any doses of in 5 mg tablet twice daily." The and had the electronic rse. vation in the home on 1/18/22 d the identical sign regarding dication was posted on the bathroom door in the main remained on the bathroom r observation on 1/19/22 at					

		AND HUMAN SERVICES				FORM	01/24/2022 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		34G047	B. WING			01/19/2022			
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
SKILL CI	REATIONS OF CLINT	ON	223 FOREST TRAIL CLINTON, NC 28328						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 125	Continued From pa 8:30 AM.	ge 10	W 1	125					
		/18/22 of client #4's physician w order for Eliquis 5 mg was							
	that last week, she instructing her to ha	2 with the supervisor revealed received a call from the nurse ang a sign in visible places to client #4's new medication.							
	when she started h today on 1st shift, s regarding client #4 door and hung on tl The nurse stated th hung on the outside	she had asked the supervisor							
W 249	revealed the facility privacy.		W 2	249					
	formulated a client's each client must re- treatment program interventions and se and frequency to su	rdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program							

Facility ID: 942586

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/24/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G047	B. WING			01/ [,]	19/2022
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SKILL C	REATIONS OF CLINT	ON			23 FOREST TRAIL CLINTON, NC 28328		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	This STANDARD is Based on observation interviews, the facilic clients (#8 and #14 treatment program interventions as ide program plan (IPP) guidance and dome A. During observation client #14 sat at dim to set up the meal f back to client #14 w #14 independently of thickened liquids ar until it reached the had a black line on #14 picked up his of the contents and cond the contents and cond the dist seen client table and picked up belonging to client # Staff H poured 2 ou into the cup of client the mark, until the of #14 was not observe beverage consump monitored. Review on 1/18/22 meal guidelines dat history of rapid cons "[Client #14] tends f at one time. To avo staff should only po [client #14's] cup. Cond rink in his cup, you	s not met as evidenced by: ions, record reviews and staff ity failed to ensure 2 of 6 audit) received a continuous active consisting of needed ntified in the individual in the areas of dining estic skills. The findings are: ons on 1/18/22 at 5:35 PM, ner table while Staff H stood or client #5. Staff H had her while feeding client #5. Client opened two juice packs of nd poured them into his cup brim. The cup was clear and it at the 2 ounce mark. Client up and hurriedly drunk all of oughed twice afterwards. Staff earing some items on the o two empty juice containers #14 and threw them in trash. Inces of a milk supplement t #14 and refilled the cup to container was empty. Client red to cough, when his	W 2	249			

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						FORM	01/24/2022 APPROVED		
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED				
34G047		B. WING			01/19/2022				
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-			
SKILL CI	REATIONS OF CLINT	DN	223 FOREST TRAIL CLINTON, NC 28328						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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	Continued From pa	ge 12	W 2	249					
	Interview on 1/19/22 with the supervisor revealed client #14 cannot drink too much at meals to avoid aspiration. Client #14 needs supervision at meals.								
	12:15 PM, client #8 after consuming his sprayed cleaning so tables and wiped th client #8 to participa on 1/19/22 at 8:55 A breakfast in the din #8 to clear his dishe request that he wipe Staff B came into th then took the clean	ons in the home on 1/18/22 at remained in the dining room s lunch. After lunch, Staff J olution on the dining room he surface. Staff J did not ask ate. An additional observation AM of client #8 eating ing room. Staff M asked client es after his meal, but did not e off the dining room table. he dining room at 9:15 AM, ing solution and proceeded to e, without asking client #8 to							
	training goal dated room table after ver Interview on 1/19/22 client #8 has to be p wipe the dining roor								
W 263	CFR(s): 483.440(f)		W 2	263					
	are conducted only consent of the clien minor) or legal guar This STANDARD is Based on record re	ould insure that these programs with the written informed at, parents (if the client is a rdian. s not met as evidenced by: eview and interviews, the ure a restrictive Behavior							

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		AND HUMAN SERVICES				FORM	: 01/24/2022 APPROVED . 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '			(X3) DATE SURVEY COMPLETED				
34G047		B. WING	i		01/19/2022				
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-			
SKILL C	REATIONS OF CLINT	ON	223 FOREST TRAIL CLINTON, NC 28328						
(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 APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
W 263	Support Plan (BSP) written consent of th 6 audit clients (#2 a A. Review on 1/19/2 8/6/21 revealed he medications: Rispe Seroquel and Hydro revealed an undate initials and no inform for his behavioral re consent notes that the date of the sign Interview on 1/19/22 that at admission, th guardians and disco The director acknow locate a copy of the Interview on 1/19/22 (ED) revealed that a the information on t guardians sign off, copy of the form. B. During observati the survey 1/18/22- gait belt, with a pers The device would a a seated position. Review on 1/18/22 signed by the guard to list a restrictive d movements. Interview on 1/19/22) was conducted with the he guardian. This affected 2 of and #9). The findings are: 22 of client #2's BSP dated was on behavioral ridone, Abilify, Lexapro, oxyzine HCL. Further review ed consent with both guardians mation regarding the reason estrictions and treatment. The it will expire in 6 months from	W 2	263					

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G047		(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-039 (X3) DATE SURVEY	
		IDENTIFICATION NUMBER:		NG	COMPLETED	
		B. WING _		01/19/2022		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SKILL CI	REATIONS OF CLINT	ON		223 FOREST TRAIL CLINTON, NC 28328		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
W 263	Continued From pa	-	W 26	63		
W 340			W 34	40		
	other members of t appropriate protect measures that inclu- training clients and health and hygiene This STANDARD i Based on observa- failed to ensure cor COVID-19 symptor visitors. This had th	s not met as evidenced by: tion and interviews, the facility mplete screening for ms and exposure, for all me potential to effect all clients #6, #7, #8, #9, #10, #11, #12,				
	10:45 AM, Staff C a surveyor to enter an COVID-19. Staff C Supervisor, who wa not done. At 11:30 a the surveyor in the COVID-19 screenin supervisor retrieved the surveyor's body	s at the home on 1/18/22 at answered the door, allowed the nd did not screen for left the lobby to get the as unaware that screening was AM, the supervisor met with office and was informed that ng had not been done. The d the thermometer to record temperature and had the prim with screening questions.				
	she expected which	2 with the supervisor revealed, never staff answering the door een visitors before allowing				
		2 with the nurse revealed, she creen all visitors immediately				

		AND HUMAN SERVICES			FORM	01/24/2022 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PRO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
34G047			B. WING _		01/19/2022			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•			
SKILL C	REATIONS OF CLINT	ON	223 FOREST TRAIL CLINTON, NC 28328					
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
W 340	nurse stated that sh screening procedur pandemic and last	ge 15 n entering the building. The ne offered training on their e at the beginning of the week, when the facility was he for COVID-19 outbreak.	W 34					

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