08-30-321 13:20 FROM-

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

P0003/0007 F-366 FORM APPROVED OMB NO. 0938-0391

T-425

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G066	8. WING		08/18/2021
4 1	PROVIDER OR SUPPLIER	arace (Magas	:   :	STREET ADDRESS, CITY, STATE, ZIP CODE 2533 ROLLINGS MEADOWS DRIVE RALEIGH, NC. 27603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 COMPLÉTION
W 368		(1) g administration must assure	W 368	W 368 This deficiency will be correct the following actions:	ted by 10.17.202
	that all drugs are ac the physician's orde	Iministered in compliance with ers.		A. The nurse will ensure of the individuals phy	. 1
	Based on observat interview, the facility were administered in	s not met as evidenced by: ions, record review and y failed to ensure medications n accordance with physician's ed 1 of 6 audit clients (#5).		orders are current.  B. The nurse will ensure staff are in-serviced or ensuring medications administered as writte the physician's orders.	n are en on
	in the home on 8/18 observed to adminis	s of medication administration 3/21 at 6:52am, Staff A was ster Dorzol/Timol 22.3/6.8 eye nediately administer Timol		C. Client #5 physicians of will be reviewed with ensure they are admit correctly.  D. RN will monitor and	staff to nistered
	Orders dated 7/15/2 Dorzol/Timol 22.3/6 twice daily. Wait 3-5	of client #5's Physician's 21 revealed an order for .8, "Instill 1 drop in each eye i minutes between two eye .5%, "Instill 1 drop in both		document on this model. Site Supervisor will mand document on the time a week.  F. Clinical Supervisor will monitor and document on the conditions are week.	onitor is one Il ent on
	confirmed Staff A sl	I with the facility nurse nould have waited 3-5 minutes ing the first and second eye		this one time a week	
	FOOD AND NUTRI CFR(s): 483.480(a)		W 460		
	Each client must red well-balanced diet in specially-prescribed	cluding modified and		RECEIVED  By DHSR Mental Health Licensure & Certification	on at 3:05 pm, Aug 30, 202
	· · · · · · · · · · · · · · · · · · ·				
*BORATOR	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURA /	Man Manage	SIANIANI

Any deficiency statement ending with an asterisk (\*) the bits of description of the institution may be excussed above an eliciosable 90 days other safeguards provide sufficient protection to the payents. 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.

08-30-'21 13:20 FROM-

T-425

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES P0004/0007 F-366 FORMAPPROVED OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	,	34G066	B. WING		08/18/2021	
	PROVIDER OR SUPPLIER		1 2	STREET ADDRESS, CITY, STATE, ZIP CODE 2533. ROLLINGS MEADOWS DRIVE RALIEIGH, NC 27603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE: COMPLETION.	
W 460	Continued From pa		W 460	Sign and the second sec		
	Based on observatinterviews, the facilication of the control of th	s not met as evidenced by: lons, record reviews, and ity failed to ensure 3 of 6 audit #6) received their specially ndicated. The findings are:		W 460 This deficiency will be correct the following actions:	10.17.2021 ted by	
	A. During observati 12:15pm, client #3 Client #3's meal co sandwiches that ha	ons in the home on 8/17/21 at was observed eating lunch.		A. All ISP's will be review B. All ISP's will be update the Clinical Supervisor address the current no	ed by to eeds	
	4:48pm revealed cl given ground taco r tomatoes and sour that had been partia	ions in the home on 8/17/21 at ient #3 eating dinner. He was neat, lettuce, cheese, cream on top of nacho chips ally crushed while some were it #3 also received a Boost ifth dinner.		training objectives that to be put in place to not identified needs  C. Clent #5 will have spetraining objectives to identified needs  D. Clinical Supervisor will	cific meet	
	7:55am revealed cl #3 was given waffle	s in the home on 8/18/21 at ent #3 eating breakfast. Client is that were in larger than 1 strawberries, scrambled eggs ment.		serviced all staff on the updated ISP's and proj documentation. E Site Supervisor will mo and document on this time a week	nitor	
	program plan (IPP) order that consists	of client #3's individual dated 3/4/21 revealed a diet of regular, seconds as eces 1/2 to 3/4 inches, not to		F. Clinical Supervisor will monitor and documen time a week		
	Evaluation dated 2/ regular, double port pieces, 1/2 to 3/4 in	of client #3's Nutritional 2/21 revealed a diet order of ions at all meals, bite size ch pieces, not to exceed 1 container three times a day				

08-30-'21 13:21 FROM-DEPARTMENT OF HEALTH AND HUMAN SERVICES T-425 P0005/0007 F-366

FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			AB NO.	B NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
J W .		34G066 · · · ·	B. WING		<u>.</u>	08/1	8/2021	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	TREET ADDRÉSS, CITY, STA	TE, ZIP CODE	a dia		
ROLLING	G MEADOWS	177 Baring Box		533 Rollings Meadows Raleigh, NC 27603	S DRIVE	Spirit Sign		4, 1) - , , , , ,
(X4) ID PREFIX " TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLA (EACH CORRECTIVI GROSS-REFERENCED DEFIC	EACTION SHOULD	BE: 💛	COMPLETION:	
		***************************************	ļ					
W 460	Continued From pa	ge 2	W 460					
		1 with the Qualified Intellectual onal (QIDR) confirmed client				, }	en e	
		been given any foods larger dicated by his diet order.		大学を表示し、 ・・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・ ・				* :
,	B. During abanasi	one in the home on 9/47/94 of				u - u + de abblicata trasco		
	4:48pm; client #6 w Client #6's meal co	ons in the home on 8/17/21 at as observing eating dinner.				,		
· · · · · · · · · · · · · · · · · · ·	4:54pm, Staff C wa	se and black beans. At s observed to offer client #6 food, which she placed on top			****			
	of the nachos, taco	meat, cheese and lettuce.						, ·
	7:55am revealed cli	ons in the home on 8/18/21 at ent #6 eating breakfast. ved to put a packet of Swiss	;					
	Miss hot chocolate	in a mug, and pour Whole into the mug. Client #6 was	· 	and the second		1		
	observed to drink th	•			e e e e e e e e e e e e e e e e e e e			2. * 2. *
	2/24/21 revealed a	of client #6's IPP dated diet order that consists of outs, dairy, turkey and						
	mustard.							ts 1.
	Evaluation dated 2/2 consists of regular,	of client #6's Nutritional 2/21 revealed a diet that allergic to nuts, dairy, turkey						
	and mustard.	I with the QIDP confirmed			in Section 1			•
4	client #6 should not	have been given sour cream, er diet order indicates.			e de Souvenies		· · · · · · · · · · · · · · · · · · ·	ij ii
	4:48pm, client #5 w	ons in the home on 8/17/21 at as observed eating dinner. as observed eating dinner.					Take to the second of the seco	

08-30-'21 13:21 FROM-

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

T-425 P0006/0007 F-366

FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
The Transfer	10 H	144.55 <b>34G066</b> 1995	B. WING	<u>an in the state of the state o</u>	08/18/2021	
NAME OF F	PROVIDER OR SUPPLIER	Programme and the second	s	TREET ADDRESS, CITY, STATE, ZIP CODE	e, na stako 🚧 u	
ور در	S MEADOWS	gram graden	2	533 ROLLINGS MEADOWS DRIVE		
ROLLING	5 MEADOWS		-	RALEIGH, NC 27603		
(X4) ID		TEMENT OF DEFICIENCIES	ID 🔌	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE	
	٠, ٠,	·		DEFICIENCY)		
					;	
W 460	Continued From pa	ge 3	W-460		,	
		se and black beans. At				
Na i		s observed to offer client #6		ारक को नवस के उन्हें के किस है।		
		food, which she placed on top		Charge and the Control of the		
		meat and black beans which	1 5			
		cally softened to a ground 4pm, Staff D was observed to				
1		ese into client #5's bowl of	!			
, ,		nos. The lettuce and cheese			Ý	
	was not mechanica			The second of the second of	. ,	
		A STATE OF THE STA		The term of the term of the production		
4		of client #5's IPP dated	,			
		diet that consists of regular	<b>!</b>			
		soft, ground in processor for				
	a few seconds.	·				
	Review on 8/18/21	of client #5's Nutritional			3	
		5/21 revealed a diet that	*	W 473		
4,	consists of regular	calorie, mechanical soft,	•	This deficiency will be correcte	d by 10.17.2021	
••		r for a few seconds and thin		the following actions:	~ ~ ·	
	liquids.			file miniming actions:		
, ,	Intra-Sauce and 0/40/9	d with the OIDD confirmed that	. "	A. Site Supervisor will ens	ure	
,		1 with the QIDP confirmed that ese should have been		that all staff are in-servi		
		ned to a ground consistency.		on the proper meal ser		
W 473	MEAL SERVICES		W 473	guidelines to ensure th	vice (afriall	
** -170	CFR(s): 483.480(b)			guidennes to ensure un	heina	
				proper techniques are	ואכוווא	
• .	Food must be serve	ed at appropriate temperature.		used to include the		
		1. A		temperature in which t	ine,	
	I many a section as a same of the page of	n de grande de la companya del companya del companya de la company		food is being served.		
		s not met as evidenced by:		B. Site Supervisor will mo	nitor	
	Dased on observa	tions, interviews and record ailed to ensure all foods were		and document that thi		
	served at an appro	priate temperature. This		occurring one time a v	veek	
	potentially affected	all clients residing in the home		C. Clinical Supervisor will	المراز في المستشور	
	(#1, #2, #3, #4, #5	and #6). The findings are:		monitor and documen		
		A Committee of the State of the Committee of the Committe		this is occurring one ti	me a	
*	A. During observati	ions in the home on 8/17/21 at	1 1 - <b>6</b> ,	week		
		Parks that I steel by	N 1	o de la prima de la companya de la		

08-30-'21 13:22 FROM-

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

T-425 P0007/0007 F-366

FORMAPPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILOIN	G	. CON		
	en e	34G066	B. WING_	ne po ne i disentante de la companione d	بشما	an in Anda	*1 ·
NAME OF E	- PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		18/2021	
	A CONTRACTOR WAS A CONTRACTOR OF THE CONTRACTOR		1	2533 ROLLINGS MEADOWS DRIVE		in the second of the second of	a ser established
ROLLING	MEADOWS	Section To any		RALEIGH, NC 27603			
(X4) 10		TEMENT OF DEFICIENCIES	100)			(X6)	i ju i spori
PREFIX TAG		MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX	CROSS REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	COMPLETION 4	iggalina i Punkansense ili
W 473	Continued From pa	na A	:::: W 47:	<b>5</b>	***************************************		in Perecuta
1 3 F (27 F Sec.)	."	W-	See Sel MA 44 to		1 / V V V V		
ا کا مامین میں اور داد پرتران		d client #1 were observed 4:18pm, Staff C was observed	Acres Marie	Maria			
		aco meat with aluminum foil				r i SM (r i 1994) L i stranskira	A201. s
		on the stove. At 4:33pm, Staff				t in the contract of the contr	*(
.,		pour the taco meat into a		The second of the second secon			0.0
,		over it with aluminum foil and					
	•	he counter. At 4:48pm, the					
		ed to the clients. At no time		The first section of the section of			1.00
. !	(	e of the taco meat checked		in the second of		!	11, 517
i ,	nor was the taco m				•	:	
	And the second second	Solve the state of		A STATE OF THE STA	-	4.1	
	B. During observati	ons in the home on 8/17/21 at		• .		5 2 1	
		guardian was observed to		A Company of the Company	•	1 3 M 1 W	:S
		container of Chinese beef and	1 1			4,5 , 5,	r cos
		The container was placed in					
;		4:48pm, Staff D was observed	,				No. of the
		beef and broccoli with rice.				:	:
,		temperature of the beef and					1
'	broccoff with rice ch	necked nor was it reheated.	11.		* 1 · 1		× .₹%•
		and the second s	h	and the second s		1 (1 to 1	
1		ions in the home on 8/18/21 at					117
*		d client #2 were observed					` 1
		tfast meal, which consisted of dwaffles. At 7:12am, the	1	and the second transfer of the second transfe			,
		d waffles were placed in a					
		n aluminum foil. At 7:55am,					
		s were served to the clients.	,			, , .	
ļ		temperature of the eggs and		g Carry			
	waffles checked no						
II		,	1				
; ;	Interview on 8/18/2	1 with the Qualified Intellectual		The AMERICAN STREET	•	, ,	
	Disabilities Profess	ional (QIDP) confirmed the		The state of the s		er gregger in e	
	temperature of the	foods should have been	•				
		od should have been reheated	1	di kabupatèn da da da kabupatèn da da kabupatèn da da kabupatèn da kabupatèn da kabupatèn da kabupatèn da kabu	;	-51,5°	
area in the	if needed.	Barrier Witting and Marketine and the	8 - 2 - 6 8 - 1 - 1	antin anglik di Afrika na mangania da a mili da		$(x_1, x_2, \dots, x_{n-1}, x_n)$	
							4
				the state of the s			1
				Community of the Control of the Cont		1. 10.55	: S 🛊 N

## August 30, 2021

Justin Foster
Facility Consultant 1
Mental Health Licensure & Certification Section
2718 Mail Service Center
Raleigh, NC 27699-2718
252.343.6939 M
919.715.8078 F

Re: Survey Completed August 18, 2021 Rolling Meadows Group Home 2533 Rolling Meadows Drive Raleigh, NC 27603 Provider Number 34G066 MHL#-092-045

## Dear Mr. Foster

We appreciate the courtesy extended by you while surveying the Rolling Meadows Group Home, North Carolina.

As Indicated the Plan of Correction, we have will have the deficiencies corrected for the Followup Survey Conducted on **August 18**, **2021** it will be completed by **October 17**, **2021**.

We are committed to providing the highest possible care for the people we serve at Rolling Meadows Group Home.

If you have any questions, please contact Cynthia Bradford, Associate Executive Director at 984.205.2630 ext. 238.

Kind Regards

Ganita Jefferson, Program Manager Community Alternatives North Carolina- Raleigh Region 1001 Navaho Drive, suite 101 Raleigh, NC, 27609 919.559.0709 984.205.2630 ext. 405 juanita.jefferson@rescare.com