STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	**8609 STONEGATE DR RALEIGH, NC 27615**

(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 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that all staff were competent in transporting clients in wheelchairs in the van. This affected 1 of 5 audit clients (#5). This finding is: During observations on 2/15/22 at 12:45 pm and 2/16/22 at 9:45 am, Staff A pushed Client #5's wheelchair up a ramp into the van. There were four straps attached to the floor of the van. Staff A took both straps at the rear of the wheelchair and latched the strap to a metal bar between the spoke of the tire and the wheelchair frame. The two straps in the front of the wheelchair, were latched to a short metal bar, outside of the side panel underneath the arm pads. Client #5 wore a seatbelt in his wheelchair. The van was not equipped with any shoulder strap for the wheelchair. Review on 2/16/22 of a Sign-In Sheet for "On the job driver safety training" on 2/20/21 revealed the course was taught by the site supervisor (SS) and only Staff C was in attendance. The course went over, how to use the wheelchair lift and the location of wheelchairs and the tie downs. Interview on 2/15/22 with Staff A revealed that Client #5 was in a loaner chair which did not have the hooks that she would normally apply the van straps to tether the chair. Staff A stated Client #5 had been using a loaner chair since last year.	W 189		

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
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	**8609 STONEGATE DR RALEIGH, NC 27615**

(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 189	Continued From page 1	W 189		

Staff A revealed she had worked in the home for 8 years and was trained by a former manager and was given a print out with instructions on how to secure the wheelchair inside of the van.

During an interview on 2/15/22 with the SS revealed that when she was hired a year ago, she viewed transportation training on the modular on the computer. The SS stated that she attaches the rear floor straps to the wheels of Client #5's wheelchair and places the front straps to a bar on the wheelchair. The SS does not use footrests on Client #5's chair during transport but was told yesterday by the PT that footrests were required.

Interview on 2/15/22 with Staff C revealed when she was hired last year, another staff trained her how to secure the wheelchair in the van. Staff C stated she was not required to watch a training video on transporting wheelchairs. Staff C demonstrated that she places the rear floor straps in the van on the rear frame of Client #5's wheelchair that's underneath the seat. Staff C also revealed that she only uses footrests for Client #5's wheelchair if he is going to travel off the van.

Review on 2/16/22 of the physical therapy progress note dated 2/14/22 revealed the Physical Therapist (PT) arrived at the home to assess Client #5's wheelchair which was loaned to him last year. The PT found the wheelchair to be in need of repairs specifically: the buckle on the left strap of the seatbelt was missing; staff tied the two straps together to secure the seatbelt. In addition, the PT noted the right wheel lock required adjustment and tightening; and both footrests were missing. The PT observed Client #5 slide forward on the seat cushion with his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	**8609 STONEGATE DR RALEIGH, NC 27615**

(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 189	Continued From page 2	W 189		

sitting position creating a higher position with his hips than his knees, which contributed to him sliding forward. The PT discussed her concerns with the Qualified Intellectual Disabilities Professional (QIDP) and SS.

Interview on 2/15/22 with the PT revealed that during her initial assessment on 2/14/22 for Client #5's wheelchair she determined that he needed his seat cushion lowered to adjust his hips so he does not slide out of the wheelchair. He also needed footrests on wheelchair to prevent injuries to his feet. The PT could not be certain if Client #5 would remain seated in his wheelchair if the van came to a hard stop or had an impact collision. The PT stated that the governing board for transportation services recommends a shoulder strap in the vans but it may not be required. The staff are usually trained by the van company to demonstrate how to secure the client and wheelchair in the van. The PT noticed that the van did not have adjustable locks on the floor to secure different types of wheelchairs and the loaner wheelchair did not have the bracket to latch locks to secure the wheelchair. The PT recommended that staff wound the straps in the van around the equipment several times to prevent any "give" with the wheelchair moving during transport.

Interview on 2/16/22 with the Program Manager (PM) revealed that all new hires are required to complete a 40 hours module course on transportation. Staff are quizzed and must pass the test before they can work with clients in the home. The training was repeated annually. The PM stated that staff should not be trained by other staff, that was the purpose of having the training on the module. The PM acknowledged that if the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 189	Continued From page 3 staff passed the course, it should assure the staff are competent to transport clients in the van.	W 189		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure the interdisciplinary team completed preliminary accurate assessments within 30 days after admission. This affected 2 newly admitted audit clients (#3 and #4). The findings are: A. Review on 2/15/22 of Client #4's individual program plan (IPP) dated 10/28/21 revealed he was admitted to the facility on 9/21/21. Further review of Client #3's record revealed that no assessments were obtained in the areas of physical therapy (PT), vision and audiological within 30 days of admission. B. Review on 2/15/22 of client #3's individual program plan (IPP) dated 8/9/21, revealed he was admitted to the facility on 7/9/21. Further review of client #3's IPP revealed the interdisciplinary team did not include assessments of an audiological exam, physical	W 210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 210	Continued From page 4 therapy assessment and ophthalmology exam within 30 days of admission. Interview on 2/15/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that the team had not completed assessments in the areas of PT, vision and audiological within 30 days of admission. The QIDP said the PT evaluation was not done because of scheduling issues with the PT. Interview on 2/16/22 with the nurse, she acknowledged the vision exam for Client #3 late but completed on 11/1/21. The nurse acknowledged the audiological exam has yet to be scheduled. Interview on 2/16/22 with the Program Manager (PM), she acknowledged the former physical therapist (Former PT) used to be under contract. The PM revealed starting in September 2021, she became aware Former PT was not performing her duties. Staff in the homes had reported to the PM that Former PT was not returning calls or completing assessments. The Former PT contract ended this month, was not renewed. The facility assigned some physical therapy evaluations to a PT from another region. The PM acknowledged Client #3's admission physical therapy evaluation was not completed after he was admitted on 7/9/21.	W 210		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 5 interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure each client received continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the area of mealtime guidelines. This affected 1 of 5 audit clients (#3). The findings is: During observations at a restaurant on 2/15/22 at 1:00 pm, Client #3 was observed to overstuff his mouth with chicken quesadillas and not take sips of liquids between bites. Staff A sat next to Client #3 but did not prompt him to slow down or take more sips. During dinner observations in the home on 2/15/22 at 6:00 pm, Client #3 was served whole chicken nuggets, cooked vegetable medley, mashed potatoes and 2 cups of thinned liquids to drink. Client #3 did not cut up the chicken nuggets but ate his food at a slower pace. He would occasionally take sips of liquids but saved the majority of the liquids for the end of his meal to drink all at once. Client #3 was observed to have cough sporadically during his meal. Staff A and Staff B were supervising the clients at dinner and were not observed reminding Client #3 to take more sips in between his bites. Review on 2/15/22 of Client #3's IPP dated 8/9/21 revealed Client #3 was independent at meals and staff should cue him to eat at a slow rate. An	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 6 additional review of a Swallow Study on 12/21/21 revealed Client #3 would swallow multiple times attempting to clear mouth. The study recommended he should receive small bites, then sips, eating slowly. Interview with the nurse on 2/16/22 revealed Client #3 should be reminded by staff during meals to take sips with bites to prevent aspiration.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that they had consent from 1 of 5 audit clients (#3) who represented himself, as guardian. The finding is: Review of client #3's Individual Program Plan (IPP) dated 8/9/21, revealed that he did not have a legal guardian. He functioned in the moderate range of intellectual functioning, wore a pace maker due to chronic systolic congestive heart failure and ventricular tachycardia. The record indicated that on 8/9/21, his mother signed a consent to allow restrictive interventions by the facility, to use locks on the pantry, refrigerator, freezer and to install alarms on all the doors. The restrictive interventions were applied to all clients in the homes with guardian consents. Interview on 2/15/22 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that he assumed the mother was the guardian because	W 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 263	Continued From page 7 the client had previously resided with his mother and she signed under role of guardian on admission papers. The QIDP stated that is there was no evidence that the mother was the legal guardian, the facility should have had Client #3 sign all of his paperwork. Interview with the Program Manager (PM) on 2/16/22 revealed that she sent Client #3's mother admission papers last summer and assumed she was the guardian. The PM acknowledged if the mother was not the legal guardian, the facility should have had Client #3 sign all of his papers and restrictions.	W 263		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that initial evaluations were referred to specialists for completion. This affected 1 of 5 audit clients (#3). The findings is: Review on 2/15/22 of Client #3's Individual Program Plan (IPP) revealed he was admitted to the home on 7/9/21. Client #3 has bilateral hearing loss and have not been scheduled for an audiological exam. A further review of the nurse comprehensive assessment dated 11/12/21, the nurse commented an audiological exam was needed. There was no evidence Client #3 had an audiological exam. Interview with the nurse on 2/16/22 revealed that she was aware the audiological exam had not been done last year. The nurse did not have a	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 331	Continued From page 8 record of any scheduled appointments that the audiological was completed.	W 331		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all staff were sufficiently trained to implement the facility's current COVID-19 visitor screening process and in the proper wearing of masks. The finding is: A. Upon arrival to the home on 2/15/22 at 10:00 am and 2/16/22 at 6:20 am, staff invited surveyors into the home. The surveyors' temperatures were taken but no visitor screening tool questionnaire forms were presented for completion. Interview on 2/15/22 with Staff A revealed the COVID-19 visitor screening consists of temperature checks and staff are no longer required to complete a questionnaire regarding COVID-19. Interview on 2/15/22 with Qualified Intellectual Disabilities Professional (QIDP) revealed staff are required to screen visitors by doing temperature checks and having visitors complete a COVID-19 questionnaire prior to allowing entry into the home.	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 340	Continued From page 9 Interview on 2/16/22 with the nurse revealed the expectation for visitors to gain entry into the home would be that staff complete a temperature check, the visitor wears a mask and the visitor screening tool is completed. B. Throughout the survey 2/15/22-2/16/22, the Site Supervisor (SS) wore her face mask loosely fitted on her face which caused it to fall beneath her nose. An additional observation on 2/15/22 of the QIDP wearing his face mask beneath his nose on various occasions. Interview with the QIDP on 2/15/22 revealed that he was aware the face mask should be worn covering the nose and acknowledged that his had fell down off his nose a few times. Interview with the nurse on 2/16/22 revealed that staff have been trained to wear face masks over nose and under chin.	W 340		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to furnish 1 of 5 audit clients (#5) a wheelchair in good repair. The finding is: During observations in the home throughout the survey 2/15/22-2/16/22, Client #5 sat in a	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 436	Continued From page 10 standard wheelchair, that had a missing left arm pad, with a screw exposed; no foot rests, plus a seatbelt that fit tight on the weight with no adjustable strap. Client #5 sat slouched in the wheelchair, with his tailbone rarely making contact with the back cushion. Client #5 had to reposition himself in the chair throughout the day. Client #5 used his feet to propel the chair and leaned over the right side of the chair. Client #5 did not look comfortable in the chair, slouched down in the seat with his legs turned to the right, instead of aligned center. Review of medical supply invoices for Client #5 revealed the former Physical Therapist (Former PT) ordered a standard 18" wheelchair on 10/28/20. A further review revealed On 5/6/21 an order was placed for 1 wheelchair cushion size 18 x 16, solid seat insert rigidiz 18 x 16 and 2 arm pads. Review of a physical therapy progress note dated 2/14/22, the Physical Therapist (PT) arrived at the home to assess Client #5's wheelchair which was loaned to him last year. The PT found the wheelchair to be in need of repairs specifically: the buckle on the left strap of the seatbelt was missing; staff tied the two straps together to secure the seatbelt. In addition, the PT noted the right wheel lock required adjustment and tightening; both footrests were missing. The PT observed Client #5 slide forward on the seat cushion with his sitting position creating a higher position with his hips than his knees, which contributed to him sliding forward. The PT deemed the footrests as necessary when Client #5 was transported in the van. The PT discussed her concerns with the Qualified Intellectual Disabilities Professional (QIDP) and Site	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	**8609 STONEGATE DR RALEIGH, NC 27615**

(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 436	Continued From page 11 Supervisor (SS). Interview on 2/15/22 with Staff A revealed that Client #5 was using a loaner chair and the Former PT assessed him yesterday for new equipment but did not make any repairs. Interview on 2/15/22 with Staff B revealed that if Client #5 just rides in the van they do not install the footrests, however, if he is getting off the van and they have to transport him, then the footrests were applied. Interview on 2/15/22 with Staff C revealed that Client #5 received a new wheelchair about a year ago but has had several replacements due to broken parts. Staff C stated that the side panels and arm pads on the wheelchair getting damaged from Client #5 leaning over them sides. Interview on 2/15/22 with Site Supervisor (SS) revealed that she did not use footrests on Client #5's but was told yesterday by the PT that they were needed during transport and the extra footrests found in his room were not made for his current wheelchair. Interview on 2/15/22 with the PT revealed she was asked to do an assessment on 2/14/22 for repairs for Client #5's wheelchair since a previous request to replace the chair was denied by Medicare last year. The PT wanted to return on 2/22/22 to lower the seat cushion to prevent Client #5 from sliding forth in the chair, add footrests and make repairs to the arm pad, seatbelt and wheel locks. Interview on 2/16/22 with the Program Manager (PM) revealed they had ongoing problems since	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 436	Continued From page 12 September 2021, getting PT #1 to provide physical therapy services. The facility decided to not renew the their contract and had the PT from their other region come to evaluate repairs to Client #5's wheelchair.	W 436		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 5 audit clients (#2 and #3) received their specially prescribed diet as indicated. The findings are: A. During observations at a restaurant on 2/15/22 at 1:00 pm, Client #3 was served chicken and cheese quesadilla that were cut into 1" pieces and also had cinnamon twists that ranged in size from 3-4 inches. Client #3 was observed to overstuff his mouth, but did not have any negative outcome during the meal. An additional observation at dinner in the home on 2/15/22 at 6:00 pm, revealed Client #3 being served whole chicken nuggets, mashed potatoes and cooked vegetable medley. Client #3 consumed his chicken nuggets whole and was noted to cough sporadically during the meal. During breakfast observations in the home on 2/16/22 at 7:15 am, Client #3 was served 2 waffles, scrambled eggs and applesauce. Staff A used a rocker knife to assist Client #3 to cut the	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	**8609 STONEGATE DR RALEIGH, NC 27615**

(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 460	Continued From page 13	W 460		

waffles into large wedge pieces and syrup was added to the waffles. Client #3 fed himself, often having 1-2 pieces off waffles on his fork.

Review of a Swallow Study performed on 12/22/21 for Client #5 revealed he had oropharyngeal dysphasia and should receive a mechanical soft diet. The consistency should be like mashed potatoes, banana pudding and can add broth and milk liquids to ease swallow.

Interview on 2/16/22 with Staff A revealed that the waffles were not processed and were cut into pieces. Staff A was also aware that dietary orders written 1/6/22 posted on the dining room wall prescribed a mechanical soft diet for Client #3.

Interview on 2/16/22 with the nurse, she revealed mechanical soft diets should be processed to make the food easier to swallow and not get stuck in throat. The nurse stated that regular quesadillas, cinnamon twists and whole chicken nuggets would need to be processed for anyone on a mechanical soft diet. Waffles were okay to eat if pulsed a few times in a food processor to soften.

Interview on 2/16/22 with the Program Manager (PM) revealed that she did not think unprocessed chicken quesadillas, whole cinnamon twists, whole waffles and whole chicken nuggets were allowed on a mechanical soft diet. The PM stated that there were guidelines and diagrams at the house to assist staff with preparing modified diets.

B. During observations in the home on 2/15/22 at 6:15 pm, Client #2 was observed eating dinner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	**8609 STONEGATE DR RALEIGH, NC 27615**

(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 460	Continued From page 14 which consisted of chicken nuggets, mashed potatoes and vegetable medley. The chicken nuggets were served and eaten whole. Additional observations in the home on 2/16/22 at 7:05 am revealed Client #2 eating breakfast which consisted of 3 waffles, scrambled eggs and a cup of mandarin oranges. The waffles were served and eaten whole. Review on 2/16/22 of Client #2's record revealed a nutritional evaluation dated 12/16/21 that states, "1800 calories, coarsley chopped and not to exceed 1/2" pieces." Interview on 2/16/22 with Staff A revealed the diet posted in the kitchen is current and should be followed. Interview on 2/16/22 with PM revealed Client #2's diet would not allow whole chicken nuggets nor waffles to be served.	W 460		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a	W 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 508	Continued From page 15 multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care,	W 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 508	Continued From page 16 treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and	W 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	8609 STONEGATE DR RALEIGH, NC 27615

(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 508	Continued From page 17 (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to develop policies and procedures which include contingency plans for staff who are not fully vaccinated for COVID-19. The findings are: Review on 2/16/22 of a list of facility's employees vaccination statuses listed 11 staff who were fully vaccinated, 2 unvaccinated staff with religious exemptions and 1 staff not vaccinated. The	W 508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G293	A. BUILDING _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEGATE	**8609 STONEGATE DR RALEIGH, NC 27615**

(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 508	Continued From page 18 facility had not drafted an Employee Vaccination policy or contingency plans. Interview on 2/14/22 with the Human Resource Specialist (HRS) revealed that she was unaware of any new vaccination mandates and she only was responsible for tracking vaccination statuses. Interview on 2/16/22 with the Program Manager (PM) revealed that she studies new information on the Center for Medicare and Medicaid Services (CMS) website and learned about the new vaccine mandate in December 2021 and confirmed that their corporate office had received the memo from CMS. The PM did not have an updated policy and did not know how they were handling unvaccinated staff who did not have an exemption.	W 508		