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

PRINTED: 10/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G224	A. BUILDING ______ B. WING ______	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LANE	534 COUNTRY LANE HOLLY SPRINGS, NC 27540

(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 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the governing body failed to ensure each client had the right to their own personal hygiene equipment. This affected 2 of 4 audit clients (#2 and #3). The findings are: During observations in the home on 10/19/21 from 10:13am - 10:18am, Staff A retrieved an electric razor from the locked medication storage area and used it to assist two clients to shave. Immediate interview with the staff indicated a single shaver is used for several clients in the home and is kept in the medication closet. Additional interview revealed clients do not have their own electric razors for individual use because some of them had been getting broken up. Further interview indicated an electric razor is used for one client and sanitized before being used with another client. The staff also indicated this has been a practice in the home for quite some time. Review on 10/20/21 of client #2's Community/Home Life Assessment (CHLA) dated 6/1/21 revealed he maintains his shaving supplies with verbal cues. Review on 10/20/21 of client #3's CHLA dated 2/11/21 revealed he maintains his shaving supplies with verbal cues. Interview on 10/20/21 with the Home Manager (HM) confirmed only two clients in the home have	W 104	W.104 This deficiency will be corrected by the following actions: A. The home will be well maintained with necessities – for the people served to have all the items to completed all self-care B. All will have their own personal razors and they be readily available for the people served as well as staff. C. If warranted the behavior support plans will be reviewed and modified to meet the need of all people served, D. If warranted restrictions will be added and reviewed at Human right committee E. Management will ensure home has items needed in home. F. If a modification or change takes place with Behavior Support Plan, staff will be in-services. G. Staff will be in-service on the use of all personal hygiene items. H. Site Supervisor will monitor one time a week. I. Qualified Professional will monitor one time a week	12.17.2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cynthia Bradford	Asso Exe. Director	10/26/2021

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.

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

PRINTED: 10/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G224	A. BUILDING ______ B. WING ______	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LANE	534 COUNTRY LANE HOLLY SPRINGS, NC 27540

(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 104	Continued From page 1 personal shavers while the others share a single shaver which is cleaned between uses. Interview on 10/20/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she was not aware all of the clients did not have their own personal electric shavers.	W 104		
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 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, record reviews and interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of cooking skills. This affected 2 of 4 audit clients (#3 and #4). The findings are: A. During dinner preparation in the home on 10/19/21 at 5:08pm, Staff B proceeded to gather all necessary items to prepare a frozen package of chicken stir fry with vegetables and pasta on the stove. During this time, client #3 set the table or stood nearby watching. Client #3 was not prompted or assisted to perform any cooking tasks.	W 249	W249 This deficiency will be corrected by the following actions: A. All ISP will be reviewed by the qualified personnel B. Community and home life assessment will be completed on each person served C. Each person will be assessed for their ability to increase independence to assist with meal preparation D. All people served will be afford continuous active treatment E. ALL consumer will be afford an opportunity to actively participate in preparing meals. F. All people served will be afforded food options within their dietary needs or restrictions. G. All orders will be reviewed and discussed at the monthly core team/quarterlies/annual ISP H. Staff will be in serviced on all activities treatment guidelines to ensure that all persons served are afforded the opportunity to be as independent as possible. I. Site Supervisors will monitor one time a week. J. Qualified Professional will monitor one time a week	12.17.2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G224	A. BUILDING ______ B. WING ______	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LANE	534 COUNTRY LANE HOLLY SPRINGS, NC 27540

(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 2	W 249		

Interview on 10/19/21 with Staff B revealed clients in the home do participate with cooking tasks and several of them, including client #3, used to work at a bakery.

Review on 10/20/21 of client #3's Community/Home Life Assessment (CHLA) dated 2/11/21 revealed he can independently make and pack lunches, use measuring/mixing spoons/devices and prepare foods with no cooking. The CHLA also indicated he can independently use a toaster, microwave and coffeemaker; however, physical assistance is needed to operate the stove/oven.

Interview on 10/19/21 with client #3 revealed he likes to cook and used to cook his own meals when he lived in an apartment.

Interview on 10/20/21 with the Qualified Intellectual Professional (QIDP) confirmed clients should be offered the opportunity to cook given assistance from staff.

B. During observations throughout the survey on 10/19 - 10/20/21, client #4 repeatedly indicated to staff that he wanted coffee by pointing to the kitchen and vocalizing.

During observations in the home on 10/19/21 at 8:30am and 10/20/21 at 8:13am, Staff A and Staff C operated a single cup coffeemaker to make client #4 a cup of coffee. The staff then added cream and sugar and presented the cup of coffee to the client as he sat waiting at the dining room table. Client #4 was not prompted or assisted to make his own coffee.

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

PRINTED: 10/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G224	A. BUILDING ______ B. WING ______	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LANE	534 COUNTRY LANE HOLLY SPRINGS, NC 27540

(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 3 Interview on 10/19/21 and 10/20/21 with Staff A revealed client #4 "loves some coffee". Additional interview indicated, with staff monitoring, the client can operate the coffeemaker and make his own coffee. Review on 10/20/21 of client #4's IPP dated 1/8/21 revealed he "likes to drink soda and coffee". Additional review of a Nutritional Evaluation 10/12/20 noted, "He loves coffee." Further review of client #3's CHLA dated 1/8/21 indicated he can independently use a coffeemaker. During an interview on 10/20/21, the QIDP acknowledged client #4 should be able to assist with making his own coffee.	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 interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 4 audit clients (#3). The finding is: Review on 10/19/21 of client #3's Behavior Support Plan (BSP) dated 8/3/21 revealed an objective to exhibit 1 or fewer episodes of inappropriate verbalizations per month for 12 consecutive months. The BSP incorporated the use of Zyprexa, Depakote and Namenda. Additional review of the record did not include	W 263	W.263 This deficiency will be corrected by the following actions A. An Addendum will be added to ISP to meet the current needs of the people being served. B. All consents will be signed and in place before the implementation of plan. C. All consents will be current and updated annual or as needed for changes in plan. D. Qualified Professional will monitor monthly E. Qualified Professional will update annual or as needed	12.17.2021

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

PRINTED: 10/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G224	A. BUILDING ______ B. WING ______	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LANE	534 COUNTRY LANE HOLLY SPRINGS, NC 27540

(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 4 written informed consent from the guardian for client #3's restrictive BSP. Interview on 10/20/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the written informed consent had been sent to client #3's guardian; however, it had not been returned as of the date of the survey.	W 263		
W 362	DRUG REGIMEN REVIEW CFR(s): 483.460(j)(1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure pharmacy reviews for 2 of 4 audit clients (#2 and #3) included sufficient information regarding each client's drug regime. The findings are: Review on 10/19/21 of records for client #2 and client #3 revealed pharmacy reviews dated 9/11/20, 3/5/21, 6/8/21, and 9/7/21, respectively. Each documented pharmacy review indicated the following: "MRR note on file" along with a signature. No other information was included. Interview via phone on 10/20/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she was not sure what was meant by "MRR note on file". Interview via phone on 10/20/21 with the facility's nurse confirmed the pharmacy review notes do not provide sufficient information regarding each	W 362	W.362 This deficiency will be corrected by the following actions: A. All Pharmacy review orders will be reviewed. B. The Pharmacy reviews will be quarterly and will include sufficient information regarding the consumer drug regime. C. The team will ensure that all reviews are discussed at the monthly core team/quarterlies/annual ISP. D. RN will review monthly E. Qualified Professional will monitor one time a week	12.17.2021

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

PRINTED: 10/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G224	A. BUILDING ______ B. WING ______	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LANE	534 COUNTRY LANE HOLLY SPRINGS, NC 27540

(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 362	Continued From page 5 client's current drug regime.	W 362		
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure food substitutions and foods actually served were documented. The finding is: During dinner observations in the home on 10/19/21 at 5:38pm, clients consumed chicken stir fry, choice of apple sauce or fruit cup, a powdered drink and water. During breakfast observations in the home on 10/20/21 at 7:50am, clients consumed a single waffle, toast, sausages, a powdered drink and water. Review on 10/19/21 of the dinner menu posted in the kitchen revealed the following: No tomato sauce baked spaghetti, Italian zucchini, fruit of choice, sugar free low calorie powdered drink. Review on 10/20/21 of the breakfast menu posted in the kitchen revealed the following: Pancakes (frozen), skim milk, whole wheat bread, margarine and orange juice. Review of the substitutions list located in the back of the menu book revealed no documentation of food substitutions since 2016. Interview on 10/5/21 with the Home Manager (HM) revealed food substitutions are generally	W 481	W.481 This deficiency will be corrected by the following actions: A. All menus will be reviewed. B. Dietitian will be consulted if warranted to address food items that are listed-- that may not be readily available C. Dietitian to provide healthy alternatives/ substitution D. A record will be kept of all food substitutions for the home. E. Staff to be in service on client rights--to have a well balance meal. F. Staff to be in serviced on menu items and substitutions list and documentation. This training will include, but not be limited to diets, proper meal preparation, and appropriate meal substitutions. G. Site Supervisor will monitor one time a week. H. Qualified Professional will monitor monthly	12.17.2021

PRINTED: 10/21/2021
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G224	A. BUILDING ______ B. WING ______	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LANE	534 COUNTRY LANE HOLLY SPRINGS, NC 27540

(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 481	Continued From page 6 documented in a book located in the kitchen. Interview on 10/20/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed staff in the home should be documenting food substitutions.	W 481		