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T-086 P0003/0004 F-779

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

PRINTED: 02/16/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G224	8. WING			R 02/16/2022		
NAME OF F	PROVIDER OR SUPPLIER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 534 COUNTRY LANE HOLLY SPRINGS, NC 27540					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC (DENTIFYING INFORMATION)				· · · · · · · · · · · · · · · · · · ·			(X5) COMPLETION DATE	
	INITIAL COMMENTS A revisit was conducted on 2/16/22 for deficiencies previously cited on 10/19 - 10/20/21. All previously cited deficencies have been corrected, however, one new deficiency was cited. The facility remains out of compliance. PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 2 audit clients (#1 and #4) had the right to access their personal grooming items. The finding is: During morning observations in the home on 2/16/22 at 7:09am, two electric razors were noted in the medication closet as Staff A was in the process of administering client's medications. Once the staff finished dispensing medications, the razors were locked in the medication closet. Immediate interview with Staff A revealed the razors belong to client #1 and client #4. Additional interview with Staff B also indicated the razors belong to client #1 and client #4 and they were kept in the medication closet because they "need assistance" to use them. Further interview revealed "it's been that way for as long as I've been working here." Review on 2/16/22 of client #1's Individual Program Plan (IPP) dated 7/12/21 indicated under Possessions that he "is aware of what		W	W 137 W.137 This deficiency will be correthe following actions: A. All personal items will given to each personal asket returned to the peopserved C. If there are any right restrictions, they will presented to HRC. D. All rights will be revied. E. IDT will meet to discopersonal items will stheir safety F. Staff will be in service items being stored. G. People served will be serviced on where the will be located and the assess them H. Site Supervisor will no one time a week. J. Qualified Profession.		e erved. vill be being e ved s how ed for on all r items w to		
LABORATOR	Y DIRECTOR'S OR PROVI	DERYSUPPLIER REPRESENTATIVE'S SIG	NATURE .		TITLE		(X6) DATE	

Any deficiency statement ending with advasterisk (*) 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.

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: FHKF12

Facility ID: 921705

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G224	B. WING			R 02/16/2022	
NAME OF PROVIDER OR SUPPLIER COUNTRY LANE				STREET ADDRESS, CITY, STATE, ZIP 534 COUNTRY LANE HOLLY SPRINGS, NC 27540	CODE	<u>V4/</u>	10/2022
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROVIDENCY)			(XS) COMPLETION DATE
W 137	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP			