STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G241	A. BUILDING _____ B. WING _____	01/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARCHES-HORIZONS RESIDENTIAL CARE CENTER	5900 BETHABARA PARK BOULEVARD WINSTON SALEM, NC 27106

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure privacy during medication administration for 3 of 10 clients (#3, #4, #6 and #7). The finding is: Afternoon observations in the facility on 1/24/22 at 4:26 PM revealed the nurse to enter client #6's room to participate in medication administration. Continued observations revealed the nurse to administer medications to client #6 in the doorway with the door open. Further observations revealed the nurse to provide medication education to client #6 which could be heard as staff and client #8 were in the hallway. At no point during the observation did the nurse offer privacy to client #6 during medication administration by closing the door. Observations in the facility on 1/24/22 at 4:40 PM revealed the nurse to enter client #3's room to prepare the client for medication administration. Continued observations revealed the nurse to position client #3 in a recliner facing the door, lift her shirt and administer medications through a g-tube with the door wide open while client #1 remained in the room as staff passed by the door. At no point during the observation did the nurse close the door and remove client #1 from the room to ensure privacy during medication administration. Observations in the facility on 1/24/22 at 4:47 PM revealed the nurse to enter client #7's room and	W 130	RECEIVED FEB 23 2022 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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W 130	Continued From page 1 prepare her for medication administration. Continued observations revealed the nurse to lift client #7's shirt and administer medications to client #7 through her g-tube with the room door wide open. At no point during the observation was client #7 offered privacy during medication administration. Observations in the facility on 1/24/22 at 4:55 PM revealed the nurse to enter client #4's room to administer medications. Continued observations revealed the nurse to administer medications and provide medication education to client #4 with the room door wide open while client #9 remained in the room. Observations revealed various staff to enter and exit the room during medication administration for client #4. At no point during the observation did the nurse close the door and remove client #9 from the room to ensure privacy during medication administration. Interview with the facility nurse on 1/25/22 revealed that she was confused about whether the clients' doors should be closed during medication administration since the clients were in their rooms. Continued interview with the nurse revealed that the facility protocol is to pull the clients out of the day room and take each client to their room individually to administer medications with the door closed to ensure privacy. Interview with the Director of Nursing (DON) on 1/25/22 revealed that the nurse should have closed the door during medication education and administration for all clients. Continued interview with the DON revealed all staff have been trained to respect the privacy of all clients during medication administration. Interview with the qualified intellectual disabilities professional	W 130	All nursing/medical staff will be retrained on Client Rights. to will ensure privacy. Retraining to be completed by March 1.	

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W 130	Continued From page 2 (QIDP) and DON verified there have been no changes to the facility's medication administration protocol. The QIDP and DON confirmed during the interview that staff will receive in-service training on respecting the privacy of clients during medication administration.	W 130		
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 observation, record review and interview, the facility failed to ensure adaptive equipment was in good repair for 1 of 3 clients (#4). The finding is: Observation in the facility on 1/24/22 at 4:34 PM revealed client #4 to be in the bedroom and sitting in client's wheelchair listening to music on the iPad. Continued observation revealed client #4 to have both feet placed on a pillow while sitting in client's wheelchair. Further observation on 1/24/22 at 4:41 PM revealed client #4 to wear AFOs on both feet. Subsequent observation revealed client #4's right AFO to be worn and the left AFO to not be secured due to Velcro being worn. Review of the records for client #4 on 1/25/22 revealed an IPP dated 10/26/21. Review of the IPP revealed a recommendation to repair AFO's or consider new ones. Continued review of IPP revealed a physical therapy evaluation dated	W 436	Reached out to a new AFO vendor. Has an appointment 3/2/2022 for AFO repair at 8am.	

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W 436	Continued From page 3 10/22/21. Further review of client #4's physical therapy evaluation revealed that client #4 wears AFO's during daytime hours and when standing. Subsequent review of client #4's physical therapy evaluation revealed that client #4's current AFO's are worn and in need of new Velcro/Rivet replacement or to be molded for new ones. Interview with qualified intellectual disabilities professional (QIDP) verified the 10/26/21 IPP for client #4 was current. Continued interview with the QIDP verified that the facility is in the process of trying to find a new Orthosis. Further interview with QIDP confirmed that the facility had not repaired or replaced the prescribed AFO's for client #4.	W 436		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure evacuation drills were held at least quarterly for each shift of personnel. The finding is: Review of the facility fire drill reports on 1/24/22 revealed from January 2021 to December 2021, three out of four quarterly periods were missing the required fire drills. Further review revealed no evidence of second or third shift drills conducted during the second quarter, no evidence of first or second shift drills conducted during the third quarter, and no evidence of second or third shift drills conducted during the fourth quarter. Interview with the qualified intellectual disabilities professional (QIDP) on 1/25/22 confirmed there	W 440	Notebook with drills updated will drills easier to decipher per shift + quarter. Drills include STAFF Running drill, staff participating in drill + location of drill. Updated 2/18/22.	

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W 440	Continued From page 4 was no evidence the facility had completed the required fire drills for the review period. Continued interview with the QIDP confirmed fire drills should have been conducted quarterly for each shift of personnel.	W 440		