PRINTED: 11/09/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		34G177	B. WING _			10/2	26/2022	
	ROVIDER OR SUPPLIER	AL HOME		STREET ADDRESS, CITY, STATE, ZII 235 KINLAW RD FAYETTEVILLE, NC 28301	P CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS		Wo	000				
W 153	for intake #NC001943 substantiated and dei STAFF TREATMENT CFR(s): 483.420(d)(2) The facility must ensumistreatment, neglectinjuries of unknown simmediately to the adofficials in accordance established procedure. This STANDARD is reported all injuries of allegations of mistreatmanagement and to tregistry (HCPR) as re#1, #2, #3 and #4. The Interview on 10/26/22 has worked at the facility and used procedure to spray him while he she had reported this reported to the reside of staff A using profar included yelling at the substantial to the s	are that all allegations of tor abuse, as well as ource, are reported aministrator or to other ewith State law through es. The proof of the with State law through es. The proof of the with State law through es. The proof of the with State law through es. The proof of the with State law through es. The proof of the with State law through es. The proof of the with State law through es. The proof of the with State law through es. The proof of the with State law through estate law the with State law through estate law throug	W 1	53				

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		34G177	B. WING		10/26/2022	
	ROVIDER OR SUPPLIER	IAL HOME	:	STREET ADDRESS, CITY, STATE, ZIP CODE 235 KINLAW RD FAYETTEVILLE, NC 28301	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
W 153	Continued From page	ge 1	W 153	3		
	often yells at the clie that he had confront about 3 weeks ago. had reported this to Further interview reago client #1 woke a yelled out staff A's in him with a water gui revealed staff G ask nightmare and he to bedroom and sprays G stated he had not residential manager #1, #2, #3 and #4 p go to their rooms to also stated about a black eye. Staff G s stated client #1 fell of stated client #1 told in the eye. Staff G s was in the home whallegation, however investigated.	Staff G stated that clients all away from staff A and often get away from him. Staff G month ago, client #1 had a sated management staff out of a chair, however he him that staff D punched him tated the residential manager en client #1 made this it had not been further				
	had witnessed staff around the clients a residential manager staff A was sent hon Staff K stated that s the front closet near was cleaning out that the residential mana before. Staff K state department of social	22 with staff K revealed she A using profanity in the facility and that he had cursed the on October 20, 2022, and he for the rest of the shift. he had located a water gun in the living room when she at closet and that she had told ager she had never seen that d later that week, a I services social worker asked is that client #1 was sprayed				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(X3	OMPLETED
		34G177	B. WING _			C 10/26/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 235 KINLAW RD FAYETTEVILLE, NC 28301	I	10/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 153	was administrative sunever witnessed any facility. Staff A stated mistreated or abused facility. Staff A stated the facility with the climater witnessed any facility. Staff D stated mistreated or abused facility. Staff D also sprofanity in the facility. Interview on 10/26/22 manager (RM) reveaby any of her employ mistreatment to the cocial services (DSS October 24, 2022, abwas sprayed with a wabout staff dumping oplates at meals befor RM stated staff K stawater gun in the front when she was cleani stated she thought it did not remember pu	with staff A revealed he aspension but that he had mistreatment or abuse in the that he had never any of the clients in the he had not used profanity in ents. with staff D revealed he is suspension but that he had mistreatment or abuse in the that he had never any of the clients in the tated he had not used with the clients.	W 1			
	Interview on 10/26/22 intellectual disabilities revealed she was first mistreatment to the company of the compa					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		34G177	B. WING			1	26/2022
	ROVIDER OR SUPPLIER	AL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 235 KINLAW RD FAYETTEVILLE, NC 28301				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
W 154	worker then visited or staff D were identified mistreatment and the administrative leave us could be completed. A QIDP revealed she di working in the facility regarding inconsistent regarding the use of the possible mistreatment. Interview on 10/26/22 director confirmed the allegations of mistreatments at the staff A and staff D wo employment. STAFF TREATMENT CFR(s): 483.420(d)(3). The facility must have violations are thorough This STANDARD is reported all injuries of abuse and neglect. The finding is: Based on record reviews the facility failed to the reported all injuries of allegations of mistreatmanagement and to the registry (HCPR) as relative wor 10/26/22 has worked at the facility revealed she interview revealed she record revealed she interview revealed she interview on 10/26/22 has worked at the facility revealed she interview revealed she interview on 10/26/22 has worked at the facility revealed she interview revealed she interview revealed she interview on 10/26/22 has worked at the facility revealed she interview revealed she interview on 10/26/22 has worked at the facility revealed she interview revealed she intervie	erview revealed the DSS in 10/24/22 and staff A and it as possible perpetrators of y were immediately put on until an internal investigation Additional interview with the id not re-interview all staff or clients that resided there icies in the staff's statements the water gun or staff's to f clients. It with the facility program bey would substantiate the timent to clients and that for the company of the co		154			

CENTER	3 FOR MEDICARE &	WEDICAID SERVICES				OIVID INC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
						(С
		34G177	B. WING			10/	26/2022
NAME OF P	ROVIDER OR SUPPLIER	•		ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
				23	5 KINLAW RD		
THE CAR	TER CLINIC RESIDENTIA	AL HOME		FA	AYETTEVILLE, NC 28301		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
TAG			TAG		DEFICIENCY)		
W 154	Continued From page	e 4	W	154			
	revealed on October	20, 2022, staff A came into					
	the facility and used	profanity with the residential					
	manager in front of the						
		at client #1 had told her staff					
		room and uses a water gun					
	1	e is sleeping. When asked if					
	she had reported this						
	reported to the reside						
	of staff A using profa						
	included yelling at the						
	client #1 reported tha						
	spray him several we	eeks ago. 2 with staff G revealed staff A					
		nts and uses profanity and					
	· ·	ed staff A and told him to stop					
		Staff G also stated that he					
	_	he residential manager.					
		ealed that about 2 weeks					
		p in the middle of the night					
		ame and told him not to soak					
	him with a water gun						
		ed client #1 about this					
	nightmare and he tol	d him staff A comes into his					
	bedroom and sprays	him with a water gun. Staff					
	G stated he had not	reported this to the					
	residential manager.	Staff G stated that clients					
	#1, #2, #3 and #4 pu	II away from staff A and often					
		get away from him. Staff G					
	I .	nonth ago, client #1 had a					
	_	ated management staff					
		ut of a chair, however he					
		nim that staff D punched him					
		ated the residential manager					
		en client #1 made this					
		t had not been further					
	investigated.	2 11 1 11 11					
		2 with staff K revealed she					
	I .	A using profanity in the facility					
	around the clients an	d that he had cursed the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
		34G177	B. WING _			C 10/26/2022
	NAME OF PROVIDER OR SUPPLIER THE CARTER CLINIC RESIDENTIAL HOME (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 154 Continued From page 5 residential manager on October 20, 2022, and staff A was sent home for the rest of the shift. Staff K stated that she had located a water gun in the front closet near the living room when she was cleaning out that closet and that she had told the residential manager she had never seen that before. Staff K stated later that week, a department of social services social worker asked her about allegations that client #1 was sprayed with a water gun. Interview on 10/26/22 with staff A revealed he was administrative suspension but that he had never witnessed any mistreatment or abuse in the facility. Staff A stated that he had never mistreated or abused any of the clients in the facility with the clients. Interview on 10/26/22 with staff D revealed he			STREET ADDRESS, CITY, STATE, ZIP CO 235 KINLAW RD FAYETTEVILLE, NC 28301	DDE	10/20/2022
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 154	residential manager staff A was sent hon Staff K stated that sithe front closet near was cleaning out that the residential manabefore. Staff K state department of social her about allegation with a water gun. Interview on 10/26/2 was administrative so never witnessed any facility. Staff A stated mistreated or abuse facility. Staff A stated the facility with the content of the facility with the content of the facility. Staff D state mistreated or abuse facility. Staff D state mistreated or abuse facility. Staff D also profanity in the facili Interview on 10/26/2 manager (RM) reveated by any of her employmistreatment to the social services (DSS October 24, 2022, a was sprayed with a sabout staff dumping plates at meals befor RM stated staff K stawater gun in the from when she was clean stated she thought it did not remember profile.	on October 20, 2022, and he for the rest of the shift. He had located a water gun in the living room when she at closet and that she had told ager she had never seen that dilater that week, a diservices social worker asked is that client #1 was sprayed by the staff A revealed he suspension but that he had any of the clients in the did he had not used profanity in the did that he had not used profanity in the did that he had not used profanity in the did that he had not used he was pension but that he had a mistreatment or abuse in the did that he had never did any of the clients in the did that he had never did any of the clients in the stated he had not used	W	154		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(
		34G177	B. WING			10/:	26/2022
	ROVIDER OR SUPPLIER FER CLINIC RESIDENTIA	AL HOME		23	TREET ADDRESS, CITY, STATE, ZIP CODE 35 KINLAW RD AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 154	the DSS Social worker 10/23/22. Further inter worker then visited or staff D were identified mistreatment and the administrative leave to could be completed. A QIDP revealed staff C residential manager (report allegations of a neglect immediately, additional training and ensure staff report allegations of an ensure staff report allegations (F): 483.430(f)(1) § 483.430 Condition of staffing. (f) Standard: COVID-staff. The facility must policies and procedur fully vaccinated for County that the section, staff are if it has been 2 weeks completed a primary of COVID-19. The composition series for as the administration of a multi-dose vaccine. (1) Regardless of cliritation of a control of the section of the county of the section.	with the qualified a professional (QIDP) at told of allegations of ients on the facility when exprised the facility on a proview revealed the DSS of 10/24/22 and staff A and a sa possible perpetrators of a ywere immediately put on antil an internal investigation and the professional interview with the same and the professional interview with the same and the professional interview revealed a monitoring was needed to be a m		154			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		34G177	B. WING			C 1 0/26/2022	
	ROVIDER OR SUPPLIER	IAL HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 235 KINLAW RD FAYETTEVILLE, NC 28301		10/26/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 508	care, treatment, or cand/or its clients: (i) Facility employee (ii) Licensed practition (iii) Students, trained (iv) Individuals who cother services for the under contract or by (2) The policies and do not apply to the five telemedicine services and who do not have clients and other state of this section; and (ii) Staff who providing facility that are perfect the facility setting and contact with clients and a minimum, the follow (i) A process for ensurang paragraph (f)(1) of the staff who have pendibeen granted, exeminating a received, at a minimum vaccine, or the first of vaccine prior to staff treatment, or other sits clients;	ity staff, who provide any other services for the facility s; oners; es, and volunteers; and provide care, treatment, or e facility and/or its clients, other arrangement. If procedures of this section collowing facility staff: vely provide telehealth or es outside of the facility setting e any direct contact with earny direct contact with ff specified in paragraph (f)(1) e support services for the formed exclusively outside of and who do not have any direct and other staff specified in his section. If procedures must include, at wing components: uring all staff specified in his section (except for those ing requests for, or who have ptions to the vaccination section, or those staff for ccination must be temporarily tended by the CDC, due to and considerations) have turn, a single-dose COVID-19 dose of the primary or a multi-dose COVID-19	W 50	08			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		240477	P WING			l	0
		34G177	B. WING			10/	26/2022
	ROVIDER OR SUPPLIER FER CLINIC RESIDENTIA	AL HOME		2	STREET ADDRESS, CITY, STATE, ZIP CODE 235 KINLAW RD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 508	transmission and sprewho are not fully vaccivity. A process for trace documenting the COV all staff specified in pasection; (v) A process for trace documenting the COV any staff who have obtained as recommended by (vi) A process by whice exemption from the strequirements based of (vii) A process for trace documenting information who have requested, has granted, an exem COVID-19 vaccination (viii) A process for endocumentation, which clinical contraindication and which supports sexemptions from vaccinant dated by a licensity acting within their reas defined by, and in applicable State and ensuring that such do (A) All information special transportations and the recognized clicontraindications; and the recognized clicontraindications; and	s, intended to mitigate the ead of COVID-19, for all staff cinated for COVID-19; king and securely VID-19 vaccination status of aragraph (f)(1) of this cing and securely VID-19 vaccination status of obtained any booster doses the CDC; ch staff may request an eaff COVID-19 vaccination on an applicable Federal law; cking and securely tion provided by those staff and for whom the facility aption from the staff in requirements; suring that all in confirms recognized ons to COVID-19 vaccines taff requests for medical cination, has been signed eed practitioner, who is not sing the exemption, and who espective scope of practice accordance with, all local laws, and for further cumentation contains: ecifying which of the vaccines are clinically estaff member to receive inical reasons for the definition of the staff member to receive inical reasons for the staff member be	W	508			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G177	B. WING		C 10/26/2022	
	ROVIDER OR SUPPLIER	AL HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 235 KINLAW RD FAYETTEVILLE, NC 28301	10.20.2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
W 508	recognized clinical co (ix) A process for ensister documentation staff for whom COVID temporarily delayed, CDC, due to clinical procession considerations, including individuals with acute COVID-19, and individuals with acute COVID-19, and individuals monoclonal antibodie for COVID-19 treatmed (x) Contingency plans vaccinated for COVID Effective 60 Days Aft (ii) A process for ensignary paragraph (f)(1) of the vaccinated for COVID who have been grant vaccination requirem staff for whom COVID temporarily delayed, CDC, due to clinical procession considerations; This STANDARD is Based on observation interview, the facility procedures for COVID vaccinations and apprinding is: During record review administrator, qualified professional (QIDP) a were asked for the C as well as the approventions.	ents for staff based on the ontraindications; uring the tracking and of the vaccination status of 0-19 vaccination must be as recommended by the orecautions and ding, but not limited to, sillness secondary to duals who received as or convalescent plasma ent; and as for staff who are not fully 0-19. The Publication: uring that all staff specified in as section are fully 0-19, except for those staff ed exemptions to the ents of this section, or those 0-19 vaccination must be as recommended by the orecautions and the track of the section and of the ents of the orecautions and the precautions and the precautions and the precautions and of the precautions. The	W 50	8		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G177	B. WING _			10/	26/2022
	ROVIDER OR SUPPLIER	AL HOME		235 KINLAW R	ESS, CITY, STATE, ZIP CODE RD LE, NC 28301	1 101	20,2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(E/	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD E DSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 508	Review on 10/26/22 of policy dated March 20 wear masks when wo expected to be vaccin resources to obtain a Further review of the management may asl prevent further COVID Additional review on vaccination records a facility had verified va of 9 staff working in the vaccination or exemp following staff working B, staff D, staff E, staff Litterview on 10/26/22 officer and verified will disabilities profession facility had not received vaccination or exemp	of the facility's COVID-19 D22 revealed staff are to orking in the facility and were nated or work with human oproved exemptions. facility's policy revealed of for testing of staff to D-19 outbreaks. 10/26/22 of the COVID-19 and exemptions revealed the occination records for 7 out the facility. There was not tion information for the og in the facility: staff A, staff off F, staff G and staff I. With the human resource the the qualified intellectual al (QIDP) revealed the ed verified COVID-19 tion information for the staff: staff A, staff B, staff D,	W	508			