MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
RS FOR MEDICARE	& MEDICAID SERVICES	-		OMB NC	0. 0938-0391
OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
	34G277	B. WING_		11	R / <b>03/2022</b>
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STREET			306 N MASON STREET APEX, NC 27502		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHO	JLD BE	(X5) COMPLETION DATE
CFR(s): 483.470(g) The facility must fur and teach clients to choices about the u hearing and other of and other devices is interdisciplinary tea This STANDARD is Based on observat confirmed by intervi failed to ensure for access to his eyegla and tolerate his eyeg Observation on 11/3 medication adminis client #2 had recent Interview on 11/3/22 #2 attends a local p had departed for so his eyeglasses. Review on 11/3/22 program plan (IPP) "Adaptive equipment assist with vision." Review on 11/3/22 dated 8/18/22 reveat will be accessible to Formal training will adaptive equipment Professional will im Interview on 11/3/22	<ul> <li>(2)</li> <li>mish, maintain in good repair, o use and to make informed use of dentures, eyeglasses, communications aids, braces, dentified by the mas needed by the client.</li> <li>s not met as evidenced by: tion, record review and iews with staff, the facility 1 of 6 clients (#2) that he had asses and was taught to wear eglasses. The finding is:</li> <li>3/22 at 9:00am, in the locked tration cabinet staff A stated thy obtained his eyeglasses.</li> <li>2 with staff A confirmed client bublic high school and that he chool earlier on 11/3/22 without</li> <li>of client #2's individual dated 4/18/22 revealed, ht: Glasses to be worn daily to be completed for the use of t-glasses. Qualified plement a formal goal."</li> <li>2 with the qualified intellectual onal (QIDP) revealed client #2</li> </ul>	{W 43	36}		
_			TITLE		(X6) DATE
	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER STREET SUMMARY STA (EACH DEFICIENCY REGULATORY OR L SPACE AND EQUID CFR(s): 483.470(g) The facility must fur and teach clients to choices about the u hearing and other of and other devices in interdisciplinary tea This STANDARD is Based on observat confirmed by interv failed to ensure for access to his eyegl and tolerate for access to his eyegl and tolerate his eyegl and tolerate his eyegl and tolerate for so his eyeglasses. Review on 11/3/22 program plan (IPP) "Adaptive equipmen assist with vision." Review on 11/3/22 dated 8/18/22 revea will be accessible to Formal training will adaptive equipmen Professional will im	IDENTIFICATION NUMBER:         34G277         PROVIDER OR SUPPLIER         STREET         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 confirmed by interviews with staff, the facility failed to ensure for 1 of 6 clients (#2) that he had access to his eyeglasses. The finding is:         Observation on 11/3/22 at 9:00am, in the locked medication administration cabinet staff A stated client #2 had recently obtained his eyeglasses.         Interview on 11/3/22 with staff A confirmed client #2 attends a local public high school and that he had departed for school earlier on 11/3/22 without his eyeglasses.         Review on 11/3/22 of client #2's individual program plan (IPP) dated 4/18/22 revealed, "Adaptive equipment: Glasses to be worn daily to assist with vision."         Review on 11/3/22 of the plan of correction (POC) dated 8/18/22 revealed, "All adaptive equipment will be accessible to the person being served. Formal training will be completed for the use of adaptive equipment-glasses. Qualified Professional will implement a formal goal."	RS FOR MEDICARE & MEDICAID SERVICES         Interview of Deficiencies       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MUL         IDENTIFICATION NUMBER:       A. BUILD         34G277       B. WING         PROVIDER OR SUPPLIER       B. WING         STREET       SUMMARY STATEMENT OF DEFICIENCIES       ID         SUMMARY STATEMENT OF DEFICIENCIES       ID         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       FREE         SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)       {W 43         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 confirmed by interviews with staff, the facility failed to ensure for 1 of 6 clients (#2) that he had access to his eyeglasses. The finding is:         Observation on 11/3/22 at 9:00am, in the locked medication administration cabinet staff A stated client #2 had recently obtained his eyeglasses.         Interview on 11/3/22 of client #2's individual program plan (IPP) dated 4/18/22 revealed, "Adaptive equipment: Glasses to be worn daily to assist with vision."         Review on 11/3/22 of the plan of correction (POC) dated 8/18/22 revealed, "All adaptive equipment will be accessible to the person being served. Formal training will be completed for the use of adaptive equipment-glasses.	RS FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (X1) PROVIDENSUPPLERCIA IDENTIFICATION NUMBER.       (X2) MULTIPLE CONSTRUCTION         AB0277       B. WING         346277       STREET         STREET       STREET ADDRESS, CITY, STATE, ZIP CODE 306 N MASON STREET APEX, NC 27502         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG         PROVIDER OR SUPPLIER       PROVIDENS PLAN OF CORRECT (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDENS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APRE DEFICIENCY)         SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)       {W 436}       PROVIDENS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APRE DEFICIENCY)         SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)       {W 436}       PROVIDENS PLAN OF CORRECT (EACH CORRECTION SHOIL CROSS-REFERENCED TO THE APRE DEFICIENCY)         SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)       {W 436}       PROVIDENS PLAN OF CORRECT (EACH CORRECTION SHOIL CROSS-REFERENCED TO THE APRE DEFICIENCY)         SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)       {W 436}       PROVIDENT (CROSS-REFERENCED TO THE APRE DEFICIENCY)         SPACE AND EQUIPMENT 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 confirmed by interviews with staff A stated client #2 had recently obtained his eyeglasses. The func	MENT OF HEALTH AND HUMAN SERVICES       FORM         SF COR MEDICARE & MEDICAID SERVICES       OMB NC         OF DEFICIENCIES       (X1) PROVIDERSUPPLIERCIA       (X2) MULTIPLE CONSTRUCTION       (X3) DA         BROWDER OR SUPPLIER       34G277       B. WING       (X2) MULTIPLE CONSTRUCTION       (X3) DA         STREET       34G277       B. WING       (X1) PROVIDERSUPPLIER       (X2) DA       (X3) DA         STREET       STREET       STREET       PROVIDER'S PLAN OF CORRECTION       (X4) DA         SUMMARY STATEMENT OF DEFICIENCIES       (V4) A36       (V4) A36       (V4) A36       (V4) A36         CFR(s): 483.470 (g)(2)       TAG       PROVIDER'S PLAN OF CORRECTION EACTION SHOLD BE       (V4) A36         SPACE AND EQUIPMENT       {W436}       (W4) A36       (W4) A36       (W4) A36         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 linter/disciplinary team as needed by the client. This STANDARD is not met as evidenced by:       Based on observation, record review and confirmed by leveglasses and was taught to wear and tolerate his eyeglasses. The finding is:       Observation on 11/3/22 with staff A confirmed client #2 attends a local public high school and that he had departed for school eard that he facility failed to rescure on 11/3/22 with outh and the rea

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 11/14/2022

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) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       34G277       B. WING       11/03/2022         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       306 N MASON STREET APEX, NC 27502       306 N MASON STREET         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       (X5)			AND HUMAN SERVICES			FORM	: 11/14/2022 APPROVED . 0938-0391
346277         B. WING         11/03/2022           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS. CITY, STATE, 2P CODE         306 N MASON STREET           MASON STREET         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILL BE RECEDED BY FULL TAG.         IPEEX, NC 27502         COMPETING (EACH OPRECTIVE ACTION SHOULD BE CACO SAREETERENCED TO THE APPROPRIATE DEFICIENCY)         000000000000000000000000000000000000	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ·	E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
MASON STREET     306 N MASON STREET       (Y4) ID PREFX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PRECEDED BY FULL RECULATORY OR ISC IDENTIFYING INFORMATION)     ID PREFX TAG     IPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     (W 436)       (W 436)     Continued From page 1 Further interview revealed a formal written goal had not been written to teach client #2 to tolerate and maintain use of his eyeglasses.     (W 436)     (W 436)       During observations throughout the survey on 8/1/22 and 8/2/22, client #1 was observed to never wear eyeglasses.     (W 436)     (W 436)       Review on 8/2/22 of client #1's vision consultation revealed on 10/29/20, the practioner diagnosed him with Refractive Error, with compound myopic astigmatism in the right and left eyes. It was recommended that client #1 was revealed that olion up annually. An invoice from this appointment documented that a claim was initiated with the insurance to purchase single vision eyeglasses.     Review on 8/2/22 of client #1's individual Program Plan (IPP) dated 4/18/22 revealed that eyeglasses were listed as adaptive equipment to be worn daily to increase vision. The IPP was reviewed and signed by the Qualified Intellectual Disabilities Professional (QIDP) on 4/18/22.     Interview on 8/2/22 with the Site Supervisor (SS) revealed that he had worked at the home for less than a year and never knew that client #1 required eyeglasses.       Interview on 8/2/22 with the CliDP revealed that she had not observed client #1 wearing eyeglasses before and unaware where they were stored.       (W 460)			34G277	B. WING	 		
(X4)[J] TAG       SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG       ID ID TAG       PROVIDER'S PLAN OF CORRECTION PREFIX RECULATIONY OR LSC IDENTIFYING INFORMATION)       ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG       PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)       Comment CORRECTION DEFICIENCY)         {W 436}       Continued From page 1 Further interview revealed a formal written goal had not been written to teach client #2 to tolerate and maintain use of his eyeglasses.       {W 436}       Image: Continued From page 1 Further interview revealed a formal written goal had not been written to teach client #2 to tolerate and maintain use of his eyeglasses.       {W 436}         During observations throughout the survey on 8/1/22 and 8/2/22, client #1 was observed to never wear eyeglasses.       {W 436}         Review on 8/2/22 of client #1 was observed to never wear eyeglasses.       Image: Continued that client #1 wear revealed on 10/29/20, the practioner diagnosed him with Refracting from this appointment documented that a claim was initiated with the insurance to purchase single vision eyeglasses.       Review on 8/2/22 of client #1's individual Program Plan (IPP) dated 4/18/22 revealed that eyeglasses were listed as adaptive equipment to be worn daily to increase vision. The IPP was reviewed and signed by the Qualified Intellectual Disabilities Professional (QIDP) on 4/18/22.         Interview on 8/2/22 with the Site Supervisor (SS) revealed that ha never Knew that client #1 required eyeglasses.         Interview on 8/2/22 with the QIDP revealed that she had not observed client #1 wearing eyeglasses before and unaware where they were stored.         (W 460)	NAME OF F	PROVIDER OR SUPPLIER					
Preferx TAG       (EACH OBJECT CENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         {W 436}       Continued From page 1 Further interview revealed a formal written goal had not been written to teach client #2 to tolerate and maintain use of his eyeglasses.       {W 436}         During observations throughout the survey on 8/1/22 and 8/2/22, client #1 was observed to never wear eyeglasses.       {W 436}         Review on 8/2/22 of client #1 was observed to never wear eyeglasses.       Review on 8/2/22 of client #1 wear eyeglasses and follow up annually. An invoice from this appointment documented that a claim was initiated with the insurance to purchase single vision eyeglasses.         Review on 8/2/22 of client #1's Individual Program Plan (IPP) dated 4/18/22 revealed that eyeglasses were listed as adaptive equipment to be worn daily to increase vision. The IPP was reviewed and signed by the Qualified Intellectual Disabilities Professional (QIDP) on 4/18/22.         Interview on 8/2/22 with the Site Supervisor (SS) revealed that he had worked at the home for less than a year and never knew that client #1 required eyeglasses.         Interview on 8/2/22 with the QIDP revealed that eyeglasses before and unaware where they were stored.       {W 460}	MASON STREET						
Further interview revealed a formal written goal had not been written to teach client #2 to tolerate and maintain use of his eyeglasses.         During observations throughout the survey on 8/1/22 and 8/2/22, client #1 was observed to never wear eyeglasses.         Review on 8/2/22 of client #1's vision consultation revealed on 10/29/20, the practioner diagnosed him with Refractive Error, with compound myopic astigmatism in the right and left eyes. It was recommended that client #1 wear eyeglasses and follow up annually. An invoice from this appointment documented that a claim was initiated with the insurance to purchase single vision eyeglasses.         Review on 8/2/22 of client #1's Individual Program Plan (IPP) dated 4/18/22 revealed that eyeglasses were listed as adaptive equipment to be worn daily to increase vision. The IPP was reviewed and signed by the Qualified Intellectual Disabilities Professional (QIDP) on 4/18/22.         Interview on 8/2/22 with the Site Supervisor (SS) revealed that he had worked at the home for less than a year and never knew that client #1 required eyeglasses.         Interview on 8/2/22 with the QIDP revealed that she had not observed client #1 wearing eyeglasses before and unaware where they were stored.         (W 460)       FOOD AND NUTRITION SERVICES	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
		Further interview rehad not been writte and maintain use of During observations 8/1/22 and 8/2/22, of never wear eyeglas Review on 8/2/22 of revealed on 10/29/2 him with Refractive astigmatism in the recommended that follow up annually, appointment docum initiated with the ins- vision eyeglasses. Review on 8/2/22 of Program Plan (IPP) eyeglasses were liss be worn daily to inc- reviewed and signe Disabilities Profess Interview on 8/2/22 revealed that he hat than a year and new required eyeglasses Interview on 8/2/22 she had not observ eyeglasses before a stored. FOOD AND NUTRI	evealed a formal written goal n to teach client #2 to tolerate f his eyeglasses. s throughout the survey on client #1 was observed to sees. f client #1's vision consultation 20, the practioner diagnosed Error, with compound myopic right and left eyes. It was client #1 wear eyeglasses and An invoice from this nented that a claim was surance to purchase single f client #1's Individual ) dated 4/18/22 revealed that sted as adaptive equipment to rease vision. The IPP was ed by the Qualified Intellectual ional (QIDP) on 4/18/22. with the Site Supervisor (SS) d worked at the home for less ver knew that client #1 s. with the QIDP revealed that ed client #1 wearing and unaware where they were TION SERVICES				

If continuation sheet Page 2 of 6

		AND HUMAN SERVICES				FORM	11/14/2022 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED		
		34G277	B. WING				२ 03/2022		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
MASON	STREET		306 N MASON STREET APEX, NC 27502						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
{W 460}	Each client must re well-balanced diet in specially-prescribed This STANDARD is Based on observat	ceive a nourishing, including modified and	{W 46	60}					
	failed to ensure for dining that his press as written. The findi During observations breakfast, staff A ar	1 of 4 clients (#3) observed cribed diet order was followed							
	juice, and water. During interview on any of the 4 clients modified texture die	11/3/22 staff B was asked if dining for breakfast had ets. Staff B stated that client e cut into bite sized pieces.							
	evaluation dated 4/ prescribed as a reg	of client #3's nutritional 11/22 revealed his diet was jular diet with food cut into bite nacks of choice and portions.							
	8/18/22 revealed, "I assessment on con assessments will be consistency. All peo nourishing, well ball prescribed diets. Al food consistency or	ty's plan of correction dated Nutritionist will complete nsumers. Nutritional e conducted to ensure proper ople served will receive a lanced diet including specially Il staff will be in-serviced on rders. Site Supervisor will week. Qualified Professional ne a week."							

If continuation sheet Page 3 of 6

		AND HUMAN SERVICES				FOR	D: 11/14/2022 M APPROVED O. 0938-0391		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED		
		34G277	B. WING	i		1	R 1/03/2022		
NAME OF	PROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE				
MASON	STREET			3	306 N MASON STREET				
MASON	SIREEI		APEX, NC 27502						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
{W 460}	Interview on 11/3/22 professional (QIDP texture is supposed pieces. A. During lunch obs 8/1/22 at 12:30pm, salad with boiled eg crackers and a des quickly ate his past to reach for the box get more. Staff C si and the Qualified In Professional (QIDP room and suggeste that client #2 be off presented an apple The QIDP asked th client #2 receive an client #2 four addition consumed. Client # tuna salad and was before he was given During dinner obser at a restaurant, clie piece of pizza with bowl of salad. It wa Client #2 quickly co QIDP noticed that h pizza for him since portions of vegetab for more pizza and table, client #2 was	ge 3 2 with the qualified intellectual ) revealed client #3's food 1 to be cut into bite sized servations in the home on client #2 was served tuna gg, pasta, dill pickle, 6 Club ert cup of ice cream. Client #2 a and crackers and attempted to f crackers several times to upervised client #2 as he ate, itellectual Disabilities ) was present in the dining d to the Site Supervisor (SS) ered an apple. The SS and client #2 began eating it. e SS how many crackers did id was told 6. The QIDP gave onal crackers, which he 2 had not attempted to eat the a never encouraged to eat it in extra servings of crackers. rvations on 8/1/22 at 4:40pm nt #2 received an average size cheese and meat along with a s cut into 1-2" size pieces. Insumed his pizza when the he finished before the other suggested to Staff C that she citchen prepare vegetarian he was allowed second les. The QIDP placed an order when she returned to the encouraged to eat his nat he began to consume.	{W 4	60}					

If continuation sheet Page 4 of 6

		AND HUMAN SERVICES				FORM	: 11/14/2022 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		34G277	B. WING	i			R 03/2022
NAME OF	PROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
MASON	STREET			-	306 N MASON STREET APEX, NC 27502		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{W 460}	Client #2 was obse vegetarian pizza on pieces without incid During morning obs 8/2/22 at 7:00am, th his muffin into 6, 1" muffin, grits, grapes without incident. Review on 8/1/22 o revealed staff shou safe rate and take f was permitted to ha of vegetables and f dietary orders dated dining room wall, th remained on a bite unless non-starchy Review on 8/1/22 o box of Club Cracke equaled 4 crackers Interview on 8/2/22 acknowledged clien pieces of the muffin Interview on 8/2/22 she was aware that 2nd servings of foo Interview on 8/2/22 #2 had a tendency was recommended pieces. The nurse s dietary orders did n for bite size pieces,	rved to quickly consume the ice it was cut into bite sized lent. servations in the home on the SS assisted client #2 cut pieces. Client #2 ate his is and yogurt for breakfast, f client #2's IPP dated 4/18/22 ld encourage him to eat at a bite sized pieces. Client #2 ave non-starchy 2nd servings ruits. In addition there were d on 7/18/22 posted on the that confirmed client #2 size diet with no 2nd servings fruits and vegetables. f the nutritional facts on the tris revealed a serving size with the SS revealed that he at #2 did not receive bite size	{W 4	60}			

If continuation sheet Page 5 of 6

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	11/14/2022 APPROVED 0938-0391
			PLE CONSTRUCTION G	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED R	
		34G277	B. WING			≺ )3/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MASON	STREET			306 N MASON STREET APEX, NC 27502		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 460}	stated that client #2 crackers for lunch of slice of pizza. The r and pizza dough we B. During breakfast 8/2/22 at 7:05am, of breakfast meal with client did not consu- breakfast. Review on 8/1/22 of the dining room of t client's current diet, should receive "Pru- breakfast." Interview on 8/2/22 confirmed the poste	age 5 2 should have not receive extra or vegetables served on a 2nd nurse stated that both crackers ere full of carbohydrates. t observations in the home on client #3 consumed his n orange juice and milk. The ime any other beverages at of a list dated 7/18/22 posted in the home included each . Client #3's diet noted he une juice 4 oz daily at t with the QIDP and SS ed diet for client #3 was the ontinues to receive prune juice	{W 460			

Facility ID: 955746

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