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

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ <i>'</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G177	B. WING			l	26/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE CAR	TER CLINIC RESIDENTIA	AL HOME			5 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 000	INITIAL COMMENTS		W	000			
W 153		OF CLIENTS	W	153			
	mistreatment, 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 refully #1, #2, #3 and #4. The Interview on 10/26/22 has worked at the facinterview revealed shapelling at clients #1, #1, revealed on October the facility and used promanager in front of the interview revealed that A comes into his bed to spray him while he she had reported this reported to the reside of staff A using profamincluded yelling at the	ource, are reported ministrator or to other e with State law through es. not met as evidenced by: ews and interviews with a to ensure direct care staff funknown source and tment, abuse and neglect to he health care personnel equired. This affected clients he finding is: I with staff J revealed she elility less than a year. Further e has witnessed staff A and #6. Further interview 20, 2022, staff A came into profanity with the residential ecclients. Additional at client #1 had told her staff froom and uses a water gun is sleeping. When asked if the stated she had antial manager the incidents with the clients which em and the incident that the staff A used a water gun to					

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		L IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G177	B. WING			C 10/26/2022	
	ROVIDER OR SUPPLIER	AL HOME	STREET ADDRESS, CITY, STATE, ZIP CO 235 KINLAW RD FAYETTEVILLE, NC 28301		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
W 153	Continued From pag	e 1	W 15	3			
	often yells at the clie that he had confront about 3 weeks ago. had reported this to a Further interview revago client #1 woke u yelled out staff A's nahim with a water gun revealed staff G asknightmare and he tol bedroom and sprays G stated he had not residential manager. #1, #2, #3 and #4 pugo to their rooms to also stated about a relack eye. Staff G st stated client #1 fell of stated client #1 fell of stated client #1 told in the eye. Staff G st was in the home who allegation, however investigated. Interview on 10/26/2 had witnessed staff around the clients are	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 the residential manager. ealed that about 2 weeks p in the middle of the night ame and told him not to soak a Additional interview ed client #1 about this d him staff A comes into his him with a water gun. Staff reported this to the Staff G stated that clients and staff A and often get away from staff A and often get away from him. Staff G month ago, client #1 had a lated management staff ut of a chair, however he him that staff D punched him lated the residential manager en client #1 made this thad not been further. 2 with staff K revealed she A using profanity in the facility and that he had cursed the on October 20, 2022, and					
	Staff K stated that she the front closet near was cleaning out that the residential mana before. Staff K stated department of social	ne for the rest of the shift. The had located a water gun in the living room when she to closet and that she had told ger she had never seen that dilater that week, a services social worker asked as that client #1 was sprayed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		34G177	B. WING _			C 10/26/2022
	ROVIDER OR SUPPLIER TER CLINIC RESIDENT	IAL HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 235 KINLAW RD FAYETTEVILLE, NC 28301	'	10/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 153	Continued From pag	ge 2	W 1	53		
	was administrative is never witnessed any facility. Staff A state mistreated or abuse facility. Staff A state the facility with the control of the facility with the control of the facility with the control of the facility. Staff D state mistreated or abuse facility. Staff D also profanity in the facility. Staff D also profanity in the facility. Staff D also profanity in the facility in the facility. Staff D also profanity in the facility any of her emplor mistreatment to the social services (DSS October 24, 2022, as was sprayed with a about staff dumping plates at meals before RM stated staff K st water gun in the from when she was clear stated she thought in did not remember profuse and wonder came from. Interview on 10/26/2 intellectual disabilities revealed she was fill mistreatment to the	and any of the clients in the double had not used profanity in clients. 22 with staff D revealed he we suspension but that he had ay mistreatment or abuse in the double that he had never do any of the clients in the stated he had not used ity with the clients. 22 with the residential aled she had never been told yees of any allegations of clients until, a department of Si social worker asked her on about allegations that client #1 water gun and allegations client #1 and client #2's fore they were finished. The lated that she had located a fint closet near the living room and any out the closet. The RM to was strange because she urchasing that for leisure ared where the water gun				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		34G177	B. WING_		10	/26/2022	
	ROVIDER OR SUPPLIER FER CLINIC RESIDENTIA	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	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 153	10/23/22. Further interworker 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 inconsisten regarding the use of the possible mistreatment. Interview on 10/26/22 director confirmed the allegations of mistreatment. 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 taff, the facility failed reported all injuries of allegations of mistreatmanagement and to the registry (HCPR) as relative worked at the facility revealed she interview revealed she interview revealed she interview in the registry was revealed she interview reveal	rview revealed the DSS in 10/24/22 and staff A and if as possible perpetrators of ity were immediately put on intil an internal investigation Additional interview with the id not re-interview all staff or clients that resided there cies in the staff's statements he water gun or staff's it of clients. I with the facility program bey would substantiate the itment to clients and that include be terminated from OF CLIENTS) The evidence that all alleged	W ·				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD			Ι,	C
		34G177	B. WING				26/2022
NAME OF P	ROVIDER OR SUPPLIER	•	•	8	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CAR	TER CLINIC RESIDENT	TAL HOME		2	35 KINLAW RD		
THE CAR	TER CLINIC RESIDENT	IAL HOME		F	FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 154	the facility and used manager in front of interview revealed to A comes into his be to spray him while his he had reported the reported to the reside of staff A using profit included yelling at the client #1 reported the spray him several will literview on 10/26/20 often yells at the client that he had confron about 3 weeks agound reported this to Further interview reago client #1 woke yelled out staff A's right him with a water guing revealed staff G asknightmare and he to be droom and spray G stated he had not residential manager #1, #2, #3 and #4 pigo to their rooms to also stated about a black eye. Staff G sisted client #1 fell stated client #1 fel	or 20, 2022, staff A came into I profanity with the residential the clients. Additional hat client #1 had told her staff droom and uses a water gun he is sleeping. When asked if is, she stated she had dential manager the incidents anity with the clients which hem and the incident that hat staff A used a water gun to weeks ago. 22 with staff G revealed staff A ents and uses profanity and ted staff A and told him to stop Staff G also stated that he the residential manager. Wealed that about 2 weeks up in the middle of the night name and told him not to soak in. Additional interview sed client #1 about this old him staff A comes into his is him with a water gun. Staff	W	154			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G177	B. WING		C 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	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION	
W 154	staff A was sent hon Staff K stated that s the front closet near was cleaning out that the residential manabefore. Staff K stated department of social her about allegation with a water gun. Interview on 10/26/2 was administrative s 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 stated mistreated or abused facility. Staff D stated mistreated or abused facility. Staff D also profanity in the facility. Staff D also profanity in the facility manager (RM) reveal by any of her emploom mistreatment to the social services (DSS October 24, 2022, and	on October 20, 2022, and the for the rest of the shift. The 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 discription social worker asked is that client #1 was sprayed by the suspension but that he had any of the clients in the did he had not used profanity in clients. The suspension but that he had any of the clients in the did he had not used profanity in clients. The suspension but that he had any of the clients 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 did that he had never did any of the clients in the stated he had not used	W 154			
	plates at meals before RM stated staff K st water gun in the from when she was clear stated she thought it did not remember possible.	client #1 and client #2's bre they were finished. The ated that she had located a nt closet near the living room ning out the closet. The RM t was strange because she urchasing that for leisure red where the water gun				

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		34G177	B. WING _			10/	26/2022
	ROVIDER OR SUPPLIER TER CLINIC RESIDENTIA	AL HOME		2	TREET ADDRESS, CITY, STATE, ZIP CODE 35 KINLAW RD AYETTEVILLE, NC 28301		
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W 154	the DSS Social worker 10/23/22. Further inter worker then visited or staff D were identified mistreatment and the administrative leave us could be completed. A QIDP revealed staff C residential manager (report allegations of an eglect immediately, additional training and ensure staff report allending and neglect immediated COVID-19 Vaccination CFR(s): 483.430 Condition of staffing. (f) Standard: COVID-staff. The facility must policies and procedur fully vaccinated for Country that the section, staff are if it has been 2 weeks completed a primary of COVID-19. The composition of a staff and in the administration of a multi-dose vaccine. (1) Regardless of cliritation of control of the section of the control of the con	with the qualified a professional (QIDP) at told of allegations of ients on the facility when a rvisited the facility on a rview 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 Additional interview with the Additional interview revealed a monitoring was needed to be a mon		508			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		34G177	B. WING _			C 10/26/2022
	ROVIDER OR SUPPLIER	L HOME		STREET ADDRESS, CITY, STATE, ZIP CO 235 KINLAW RD FAYETTEVILLE, NC 28301	DDE	10/20/2022
(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 (X (EACH CORRECTIVE ACTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 508	to the following facility care, treatment, or oth and/or its clients: (i) Facility employees (ii) Licensed practition (iii) Students, trainees (iv) Individuals who prother services for the under contract or by of the contract of the under contract or by of the contract of the under contract or by of the policies and protection of the under contract of the under contract or by of the policies and protection of the policies and protection of the facility who provide facility that are perform the facility setting and contact with clients and paragraph (f)(1) of thi (3) The policies and paragraph (f)(1) of thi staff who have pendir been granted, exemparequirements of this swhom COVID-19 vacced delayed, as recomme clinical precautions and received, at a minimular vaccine, or the first do vaccination series for vaccine prior to staff pareatment, or other series its clients;	restaff, who provide any her services for the facility hers; and volunteers; and rovide care, treatment, or facility and/or its clients, other arrangement. Forcedures of this section lowing facility staff: ely provide telehealth or outside of the facility setting any direct contact with specified in paragraph (f)(1) support services for the med exclusively outside of the who do not have any direct and other staff specified in sesection. Forcedures must include, at wing components: ring all staff specified in sesection (except for those and requests for, or who have the tions to the vaccination ection, or those staff for contaction must be temporarily noted by the CDC, due to and considerations) have m, a single-dose COVID-19 one of the primary a multi-dose COVID-19	W 5	508		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		34G177	B. WING _			C 10/26/2022	
	ROVIDER OR SUPPLIER	AL HOME		STREET ADDRESS, CITY, STATE, ZIP COD 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 PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 508	transmission and spri who are not fully vacci (iv) A process for trace documenting the CO' all staff specified in p section; (v) A process for trace documenting the CO' any staff who have of as recommended by (vi) A process by white exemption from the s requirements based of (vii) A process for trace documenting informate who have requested, has granted, an exen COVID-19 vaccination (viii) A process for endocumentation, which clinical contraindication and which supports seexemptions from vacci and dated by a license the individual request is acting within their ras defined by, and in applicable State and ensuring that such do (A) All information spathorized COVID-19 contraindicated for the and the recognized of contraindications; 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 king and securely VID-19 vaccination status of obtained any booster doses the CDC; ch staff may request an taff 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 ing the exemption, and who espective scope of practice accordance with, all local laws, and for further ocumentation contains: ecifying which of the ovaccines are clinically e staff member to receive linical reasons for the die authenticating practitioner ne staff member be	W 5	08			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		34G177	B. WING		C 10/26/2022
	ROVIDER OR SUPPLIER	IAL HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 235 KINLAW RD FAYETTEVILLE, NC 28301	10/20/2022
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
W 508	recognized clinical of (ix) A process for ensecure documentation staff for whom COV temporarily delayed CDC, due to clinical considerations, incluindividuals with acut COVID-19, and indimonoclonal antibodifor COVID-19 treatm (x) Contingency plan vaccinated for COVID-19 treatm (x) Contingency plan vaccination requiren staff for whom COVID-19 treatm (x) CovID-19 treatm (x) Contingency plan vaccination requiren staff for whom COVID-19 treatm (x) CovID-19 treatm	nents for staff based on the contraindications; suring the tracking and on of the vaccination status of D-19 vaccination must be as recommended by the precautions and iding, but not limited to, e illness secondary to viduals who received es or convalescent plasma nent; and ins for staff who are not fully D-19. Iter Publication: suring that all staff specified in his section are fully D-19, except for those staff ited exemptions to the nents of this section, or those D-19 vaccination must be as recommended by the precautions and not met as evidenced by: on, record review and failed to follow policies and ID-19 relative to staff proved exemptions. The	W 50	8	

AND BLAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		34G177	B. WING _			C 10/26/2022
	ROVIDER OR SUPPLIER	AL HOME		STREET ADDRESS, CITY, STATE, ZIP CO 235 KINLAW RD FAYETTEVILLE, NC 28301	DE	10/20/2022
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W 508	Review on 10/26/22 of policy dated March 20 wear masks when wo expected to be vaccir resources to obtain a Further review of the management may as prevent further COVII 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 receive vaccination or exemp	of the facility's COVID-19 222 revealed staff are to rking 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 ag in the facility: staff A, staff 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		