DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		34G149	B. WING _			12/ <sup>,</sup>	13/2022
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WILMING	GTON ROAD GROUP	НОМЕ			0 WILMINGTON ROAD		
			FAYETTEVILLE, NC 28304				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE
W 240	CFR(s): 483.440(c) The individual prog		W 24	40			
	toward independer This STANDARD is Based on observat interviews, the facil Individual Program interventions to sup	nce. s not met as evidenced by: ions, record review and ity failed to ensure client #3's Plan (IPP) included specific port the use of a one-on-one day. This affected 1 of 4					
	program throughou 12/13/22, various s aspects of her daily walking, toothbrush shift observed, no s	s in the home and at the day t the survey on 12/12 - taff assisted client #3 with routine including eating, ing and toileting. Across each single staff person was noted pport to client #3 with the lients in the home.					
	Staff I revealed clie assigned to her on indicated this perso schedule for the da posted in the medic Further interview no	2 - 12/13/22 with Staff D and nt #3 has a "one-to-one" staff each shift. Additional interview n would be identified on the y/shift (staff work schedule cation room and office). oted the one-to-one staff nt #3 with walking and toileting.					
	5/12/22 revealed du unsteady gait and v requires assistance home and on uneve of the plan noted a held on 4/12/22 to c	2 of client #3's IPP dated ue to her history of falls, an ision problems, the client with walking throughout the en surfaces. Additional review mini-team meeting had been discuss recent falls and safety #3. The report noted a request					

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

TITLE

(X6) DATE

PRINTED: 12/14/2022

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.

		AND HUMAN SERVICES				FORM	12/14/2022 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		34G149	B. WING			12/13/2022		
NAME OF F	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	:		
WILMING	GTON ROAD GROUP	НОМЕ			00 WILMINGTON ROAD AYETTEVILLE, NC 28304			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 240	Continued From pa	ge 1	W 2	240				
	awaiting approval. IPP did not include one-on-one staff per interventions neede staff person. Interview on 12/13/2 Intellectual Disabilit confirmed the intero April '22 regarding t staff person to assis had been submitted The QIDP indicated currently assigned t this person should I "responsible for her QIDP acknowledge	had been submitted and was Further review of the client's any information regarding a erson assigned to client #3 or ed from staff as a one-on-one 22 with the Qualified ies Professional (QIDP) disciplinary team had met in the need for a one-on-one st client #3 and this request d and approved as of May '22. d a one-on-one staff is to the client on each shift and be "with her at all times" and is r and no other individual." The ed client #3's IPP needs to						
W 249		-	W 2	249				
	formulated a client's each client must rea treatment program interventions and se and frequency to su	rdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program						
	Based on observat interviews, the facili	s not met as evidenced by: tions, record review and ity failed to ensure 1 of 4 audit d a continuous active						

If continuation sheet Page 2 of 11

		AND HUMAN SERVICES				FORM	12/14/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G149	B. WING _			12/ <sup>,</sup>	13/2022
NAME OF	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP C	ODE		
WILMIN	GTON ROAD GROUP	НОМЕ		800 WILMINGTON ROAD FAYETTEVILLE, NC 28304			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
W 249 W 255	treatment program interventions and s Individual Program adaptive equipmen During 3 of 3 mealt the survey on 12/12 provided and assist handle and a lid co was used while drin afternoon observat and at 4:42pm, the regular cup for drin Review on 12/12/22 5/12/22, the client's update dated 9/8/22 orders dated 10/3/2 blue mug with a str Interview on 12/13/ revealed client #3 of containing a lid with interview indicated the lid of the mug h would drink from th had been discontin Interview on 12/13/ Intellectual Disabilit indicated client #3 s drinking from her b The QIDP noted us discontinued. Furth cup should not be u	<ul> <li>consisting of needed ervices as identified in the Plan (IPP) in the area of t use. The finding is:</li> <li>ime observations throughout 2 - 12/13/22, client #3 was ted to use a blue mug with a ntaining a small hole. No straw oking from the mug. During ions in the home at 3:55pm client was assisted to use a king.</li> <li>2 of client #3's IPP dated o Occupational Therapy (OT)</li> <li>2 and her current physician's 22 revealed the client uses a aw.</li> <li>22 with the Home Manager drinks from a blue mug n a small hole. Additional a straw inserted in the hole in ad been tried but the client e straw too fast so the straw ued.</li> <li>22 with the Qualified tes Professional (QIDP) should be using a straw when lue mug as noted in her plan. te of the straw had not been er interview indicated a regular used with client #3 for drinking. TORING &amp; CHANGE</li> </ul>	W 24				

If continuation sheet Page 3 of 11

		AND HUMAN SERVICES				FORM	12/14/2022 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE SURVEY COMPLETED	
		34G149	B. WING	i		12/	13/2022
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WILMING	GTON ROAD GROUP	НОМЕ			800 WILMINGTON ROAD FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 255	The individual progleast by the qualifie professional and rebut not limited to sit successfully completidentified in the indi This STANDARD is Based on record refacility failed to ensure program Plan (IPP) successfully completis: Review on 12/13/22 Support Plan (BSP) objective to exhibit behaviors for 11 ou The plan included the disruption/verbal age behavior, threats to Additional review of client #3's interview with the B revealed from Janu 2022, the client exhibit with no other docum months. Interview on 12/13/27 #3 does not have b During an interview acknowledged clier behavior of plective; active part of her IP Interview on 12/13/27 #3 does not have b During an interview acknowledged clier behavior objective; active part of her IP Interview on 12/13/27 #3 for the part of her IP Inte	ram plan must be reviewed at di intellectual disability vised as necessary, including, tuations in which the client has eted an objective or objectives ividual program plan. s not met as evidenced by: eview and interviews, the ure client #3's Individual ) was revised after she had eted an objective. The finding 2 of client #3's Behavior ) dated 1/7/22 revealed an 0 incidents of challenging t of 12 consecutive months. arget behaviors of severe ggression, self-injurious o self and physical aggression. f the plan also incorporated the dress her behaviors. Further s behavior progress notes and behavior Specialist (BS) iary 1, 2021 - December 12, hibited one behavior a year ago mented behaviors for 23 22 with Staff C indicated client ehaviors. o on 12/13/22, the BS of #3 had completed her however, it remained an	W 2	255			

If continuation sheet Page 4 of 11

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		TE SURVEY MPLETED
	of correction	IDENTIFICATION NOWBER.	A. BUILDING	i		MFLETED
		34G149	B. WING			/13/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 800 WILMINGTON ROAD	DE	
WILMING	GTON ROAD GROUP	HOME		FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
W 255	confirmed client #3	's BSP had been completed	W 255			
W 312	with no changes to DRUG USAGE CFR(s): 483.450(e		W 312			
	individual program specifically towards elimination of the b are employed. This STANDARD i Based on record re facility failed to ens for a reduction and to control behaviors the behaviors was audit clients. The f	C C				
	Support Plan (BSP objective to exhibit behaviors for 11 ou The plan included t disruption/verbal ac behavior, threats to Additional review o use of Abilify to add client's physician's an order for Abilify daily for behaviors client #3's behavior with the Behavior S January 1, 2021 - D exhibited one behaved	2 of client #3's Behavior ) dated 1/7/22 revealed an 0 incidents of challenging it of 12 consecutive months. sarget behaviors for severe ggression, self-injurious o self and physical aggression. f the plan also incorporated the dress her behaviors. The orders dated 10/3/22 included 5mg, take 1 tablet by mouth at 8:00am. Further review of progress notes and interview Specialist (BS) revealed from December 12, 2022, the client vior a year ago with no other riors for 23 months. Review of icate client #3 had been				

If continuation sheet Page 5 of 11

		AND HUMAN SERVICES				FORM	APPROVED	
	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT		LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED	
		34G149	B. WING			10/	12/13/2022	
NAME OF F	PROVIDER OR SUPPLIER	0+01+0	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/1	13/2022	
					00 WILMINGTON ROAD			
	STON ROAD GROUP	НОМЕ	FAYETTEVILLE, NC 28304					
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETION DATE	
		· · · · · · · · · · · · · · · · · · ·	-		DEFICIENCY)			
W 312	Continued From pa	ge 5	W 3	12				
	Interview on 12/13/	22 with Staff C indicated client						
	#3 does not have be	_						
		on 12/13/22, the BS						
	even though no beh	continues to ingest Abilify						
	documented for alm							
		-						
		on 12/13/22, the Qualified						
		ties Professional (QIDP) Interdisciplinary Team needs						
		's continued need for Abilify						
	based on her lack c	of behaviors.						
W 350	DENTAL SERVICE		W 3	50				
	CFR(s): 483.460(e)	)(3)						
	The facility must pro	ovide education and training in						
	the maintenance of	oral health.						
		s not met as evidenced by:						
		eviews and interviews, the ure training was provided for						
		each client's oral health. This						
		t clients (#1 and #3). The						
	findings are:							
	A Review on 12/1:	2/22 of client #1's dental report						
		led his oral hygiene "Needs						
	improvement." The	e report noted the client's teeth						
		ed and flossed twice daily.						
		f the client's Individual ) dated 11/3/22 identified an						
		his teeth with 75% accuracy for						
	2 consecutive revie	w periods (implemented on						
	3/1/22).							
	Interview on 12/13/	22 with Qualified Intellectual						
		ional (QIDP) confirmed client						
		, , , , , , , , , , , , , , , , , , ,						

If continuation sheet Page 6 of 11

		AND HUMAN SERVICES				FORM	12/14/2022 APPROVED 0938-0391
STATEMENT OF DE AND PLAN OF COF	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G149	B. WING	i		12/13/2022	
NAME OF PROVI	DER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WILMINGTON	I ROAD GROUP I	НОМЕ			00 WILMINGTON ROAD AYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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 369 DRU CFF W 369 DRU CFF The that self- This Bas inten meco This Bas inten meco This Bas inten meco This Bas inten meco This Bas inten meco This Bas inten meco This Bas	eded improveme in made to his ex l no training had Review on 12/12 ed 8/24/22 revea que build up." The hygiene "Needs iew of the client's met criteria on a 85% accuracy ise a proxy brush continued on 9/- thbrushing object erview on 12/13/2 abilities Professi is last dental visit eded improveme ectives had been l been provided full UG ADMINISTR R(s): 483.460(k) e system for drug t all drugs, includ f-administered, a s STANDARD is sed on observat riview, the facility dications were a s affected 1 of 2 eiving medications ing observations	<ul> <li>indicated his oral hygiene ant; however, no changes had xisting toothbrushing objective been provided to staff.</li> <li>2/22 of client #3's dental report aled "heavy bleeding and he report also indicated her s improvement." Additional s IPP dated 5/12/22 noted she objectives to brush her teeth (discontinued on 7/1/21) and h with 85% accuracy 1/22). No current ctives were identified.</li> <li>22 with Qualified Intellectual ional (QIDP) confirmed client t indicated her oral hygiene ent; however, no toothbrushing h implemented and no training to staff. ATION</li> </ul>	W 3				

If continuation sheet Page 7 of 11

	-	AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		וחוד	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		242442					
		34G149	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	12/1	13/2022
NAME OF F	PROVIDER OR SUPPLIER				00 WILMINGTON ROAD		
WILMING	GTON ROAD GROUP	HOME			AYETTEVILLE, NC 28304		
(X4) ID		TEMENT OF DEFICIENCIES	ID			(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETION DATE
		·			DEFICIENCY)		
W 360	Or the second From no			~~~			
W 369	Continued From pa nostrils of client #1's	•	W 3	69			
	NOSTINS OF CHERTER IS	s nose.					
		2 of client #1's physician's					
		22 revealed an order for					
	Flonase 50mcg, use daily at 8:00am.	e one spray in each nostril					
	ually at 0.00am.						
		22 with the facility's nurse					
		's physician's orders were					
	Flonase.	uld have received one spray of					
W 460		TION SERVICES	W 4	60			
	CFR(s): 483.480(a)			•-			
	Each client must re	ceive a nourishing,					
		ncluding modified and					
	specially-prescribed	1 diets.					
		s not met as evidenced by:					
		tions, record reviews and ity failed to ensure each					
		et was followed as indicated.					
		audit clients (#1 and #2). The					
	findings are:						
	A. During lunch ob	servations at the day program					
		3am, client #1 consumed					
		salad. Closer observation of					
		was thick, lumpy and dry.					
	difficulty.	d the tuna pasta salad without					
	annoarty.						
		rvations in the home on					
		i, client #1 consumed pureed bles and noodles. Closer					
		food revealed it was thick,					
	lumpy and dry. Clie	nt #1 consumed the shrimp					

If continuation sheet Page 8 of 11

	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		СОМ	PLETED
		34G149	B. WING			12/ <sup>,</sup>	13/2022
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WILMING	GTON ROAD GROUP	НОМЕ			800 WILMINGTON ROAD FAYETTEVILLE, NC 28304		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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	Continued From pa and noodles entree	-	W 46	60			
		-					
	12/13/22 at 7:59am turkey sausage. Cl sausage revealed it bits of sausage. Aft crumbs to the saus	oservations in the home on a, client #1 consumed pureed loser observation of the t was loose, watery with visible er staff added moist bread age mixture, visible bits of Client #1 consumed only a					
	portion of the food v						
		22 with Staff G revealed client reed diet which would be ood."					
		2 of client #1's Individual ) dated 11/3/22 revealed he et.					
	Intellectual Disabilit	22 with the Qualified res Professional (QIDP) 's food should be pureed and oplesauce."					
	12/13/22 at 7:35am oatmeal and ground	t observations in the home on , client #2 consumed pureed d up turkey sausage. The e food without difficulty.					
	#2 is on a pureed d	22 with Staff G revealed client liet and his turkey sausage served pureed but it doesn't					
		2 of client #2's IPP dated consumes a regular pureed					
	Interview on 12/13/2	22 with the QIDP confirmed all					

If continuation sheet Page 9 of 11

		E & MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED	
		34G149	B. WING		12/	13/2022	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WILMING	TON ROAD GROUP	HOME		800 WILMINGTON ROAD FAYETTEVILLE, NC 28304			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
W 460	Continued From pa	age 9	W 460	)			
W 488	of client #2's food s DINING AREAS AN CFR(s): 483.480(d	ND SERVICE	W 488	3			
	manner consistent level. This STANDARD Based on observa interviews, the faci ate in a manner wh	ssure that each client eats in a with his or her developmental is not met as evidenced by: tion, record review and lity failed to ensure client #5 nich was not stigmatizing. This lit clients. The finding is:					
	12/13/22, client #3 portion of her cloth the table in front of secured around he food, client #3's bo top of the lower po During the observa- meal independent!	bservations in the home on consumed her food with lower ing protector spread across ther and the upper portion er neck. While consuming her wil and cup were positioned on rtion of her clothing protector. ations, the client consumed the y. A few bread crumbs fell on tor as the client consumed her					
		/22 with Staff A revealed she en she spread client #3's across the table.					
	Program Plan (IPP uses a clothing pro	2 of client #3's Individual 9) dated 5/12/22 revealed she otector at meals. The plan did othing protector should be used riously described.					
	Intellectual Disabili	v on 12/13/22, the Qualified ties Professional (QIDP) ng the clothing protector in this					

If continuation sheet Page 10 of 11

CENTERS FOR MEDICARE & MEDICALD SERVICES         OMB NO. 0838-0391           STATEMENT OF DEFICIENCIES         (X1) PROVIDER OR SUPPLY         (X2) DATE SUPPLY         (X3) DATE SUPPLY           AND PLAN OF CORRECTION         (X1) PROVIDER OR SUPPLY         (X2) DATE SUPPLY         (X3) DATE SUPPLY           NAME OF PROVIDER OR SUPPLIER         34G149         B. WING         B. WING         12/13/2022           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         800 WILMINGTON ROAD         FAYETTEVILLE, NC 28304           (X4) IDI         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER OR ROAD CORRECTION SHOLLD BE         000 WILMINGTON ROAD           PREEX         REGULATORY OR LSC DENTFYING INFORMATION)         ID         PREEX         CROSS REFERENCE ON SPECIAL OR WAS BEING ON TO PROVEMATE         0000 PROVEM			AND HUMAN SERVICES			FORM	APPROVED 0938-0391			
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         WILMINGTON ROAD GROUP HOME       STREET ADDRESS, CITY, STATE, ZIP CODE         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         W 488       Continued From page 10    STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, Z	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DATE	E SURVEY			
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         WILMINGTON ROAD GROUP HOME       800 WILMINGTON ROAD         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)         W 488       Continued From page 10			34G149	B. WING _		12/13/2022				
WILMINGTON ROAD GROUP HOME       FAYETTEVILLE, NC 28304         (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 488       Continued From page 10       W 488       W 488	NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>				
WILMINGTON ROAD GROUP HOME       FAYETTEVILLE, NC 28304         (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 488       Continued From page 10       W 488       W 488					800 WILMINGTON ROAD					
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETION DATE         W 488       Continued From page 10       W 488       W 488       W 488	WILMING	TON ROAD GROUP	номе							
	PREFIX	( EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI)			FIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTIC G CROSS-REFERENCED TO THE APPROPRIATE DATE					
	W 488		-	W 48						

Facility ID: 944891