STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	**174 HOOTS DRIVE WINSTON-SALEM, NC 27107**

(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 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 2 of 6 clients (#3 and #9) received a continuous active treatment program consisting of needed interventions relative to adaptive equipment. The findings are: A. The facility failed to provide mealtime adaptive equipment for client #3. For example: Observations in the group home on 12/12/22 at 5:55 PM revealed client #3 to participate independently in the dinner meal which consisted of Salisbury steak, mashed potatoes and gravy, green beans, milk and water. Continued observation revealed client #3 to utilize a high-sided divided dish to support him with consuming the dinner meal. Further observation revealed client #3 to utilize his spoon to cut the Salisbury steak. Observations in the group home on 12/13/22 at 8:05 AM revealed client #3 to participate independently in the breakfast meal which consisted of oatmeal with raisins, cereal, cheese	W 249		

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) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	**174 HOOTS DRIVE WINSTON-SALEM, NC 27107**

(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 249	Continued From page 1	W 249		

toast, milk, coffee and water. Continued observation revealed client #3 to utilize a high-sided divided dish to support him with consuming the breakfast meal.

Review of client #3's record on 12/13/22 revealed a person-centered plan (PCP) dated 1/27/22 which indicated client #3's adaptive equipment includes a high-sided divided dish and rocker T knife. Continued review of the record revealed an occupation therapy (OT) evaluation dated 2/22/19 which indicated client #3's adaptive equipment includes a high-sided divided dish and rocker T knife for mealtime.

Interview with Staff A on 12/13/22 revealed client #3's rocker T knife to be in a kitchen drawer. Continued interview with Staff A revealed client #3's is supposed to have the rocker T knife at dinner mainly to cut meats. Interview with qualified intellectual disabilities professional (QIDP) on 12/13/22 confirmed client #3's mealtime guidelines are current and further confirmed the rocker T knife should be provided at every meal.

B. The facility failed to provide mealtime adaptive equipment for client #9. For example:

Observations in the group home on 12/12/22 at 5:55 PM revealed client #9 to participate independently in the dinner meal which consisted of Salisbury steak, mashed potatoes and gravy, green beans, milk and water. Continued observation revealed client #9 to utilize regular utensils to support him with consuming the dinner meal. Further observation revealed client #9 to utilize his spoon to cut the Salisbury steak.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	174 HOOTS DRIVE WINSTON-SALEM, NC 27107

(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 249	Continued From page 2 Observations in the group home on 12/13/22 at 8:05 AM revealed client #9 to participate independently in the breakfast meal which consisted of oatmeal with raisins, cereal, cheese toast, milk, coffee and water. Continued observation revealed client #9 to utilize regular utensils to support him with consuming the breakfast meal. Review of client #9's record on 12/13/22 revealed a person-centered plan (PCP) dated 2/24/22 which indicated client #9's adaptive equipment includes a gait belt, bilateral knee pads, rocker T knife, and clothing protector. Continued review of the record revealed an OT evaluation dated 9/28/19. Review of the OT evaluation indicated client #9's adaptive equipment includes regular fork and spoon and rocker T knife. Add clothing protector or multiple cloth napkins for hygiene. He is independent with the use of rocker T knife. Interview with Staff A on 12/13/22 revealed client #9's rocker T knife to be in a kitchen drawer. Continued interview with Staff A revealed client #9's is supposed to have the rocker T knife at dinner mainly to cut meats. Interview with qualified intellectual disabilities professional (QIDP) on 12/13/22 confirmed client #9's mealtime guidelines are current and further confirmed the rocker T knife should be provided at every meal.	W 249		
W 287	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for the convenience of staff.	W 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	**174 HOOTS DRIVE WINSTON-SALEM, NC 27107**

(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 287	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure techniques to manage inappropriate client behavior were not implemented for the convenience of staff. The finding is: Observation in the group home on 12/12/22 and 12/13/22 revealed the pantry door in the kitchen to be locked. Continued observations throughout the survey revealed only staff to access the pantry with use of a key. Interview with Staff A on 12/12/22 revealed the pantry is locked due to client #5's food seeking behaviors. Review of client #5's record on 12/13/22 revealed a behavior support plan (BSP) dated 5/24/22. Review of client #5's BSP revealed one target behavior to include aggression. Continued review of client #5's record revealed no consent or other assessment to justify a restrictive intervention. Interview with the qualified intellectual disabilities professional (QIDP) on 12/13/22 revealed they are aware of client #5's food seeking behavior. Continued interview with the QIDP revealed they were not aware staff are locking the pantry to restrict client #5's access and further confirmed the pantry door should remain unlocked due to no client's having an approved restricted intervention relative to accessing the pantry.	W 287		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by:	W 455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	174 HOOTS DRIVE WINSTON-SALEM, NC 27107

(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 455	Continued From page 4	W 455		

Continued From page 4

Based on observations and interviews, the facility failed to implement an active program for the prevention and control of infection and communicable diseases in Rockcreek and Lakewood. The findings are:

A. The facility failed to ensure Rockcreek staff wore face masks while providing direct care services, which is a current requirement by the Centers for Medicare and Medicaid Services (CMS) to limit the potential spread of the COVID-19 virus. For example:

Observation upon entry of the group home on 12/13/22 at 6:45 AM revealed first shift staff to answer the door without a face mask on. Continued observation revealed first shift staff to put on a face mask immediately after survey observations began. Further observation at 7:00 AM revealed third shift staff to exit client #1's bedroom without wearing a face mask. Additional observations revealed third shift staff to continue working in the home without a face mask until their shift ended at approximately 7:30 AM.

Interview with the qualified intellectual disabilities professional (QIDP) on 12/13/22 confirmed all staff must wear a face mask while in the presence of or providing direct care services to clients.

B. The facility failed to ensure Lakewood staff wore face mask while providing direct care services, which is a current requirement by the Centers for Medicare and Medicaid Services (CMS) to limit the potential spread of the COVID-19 virus: For example:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	174 HOOTS DRIVE WINSTON-SALEM, NC 27107

(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 455	Continued From page 5 Observation in the group home on 12/12/22 at 4:00 PM to 6:00 PM revealed two second shift staff to be on duty providing direct care and supervision to six clients, one with the face covering worn below the nose and the other wearing no face covering throughout the rest of the visit. Continued observation in the group home on 12/13/22 revealed the second shift staff to cover third shift and to have no face mask on during observation from 5:45 AM to 8:30 AM. Subsequent observation in the group home 6:15 AM to 8:30 AM revealed the first shift staff to arrive and enter the home with no face mask and continue the shift with no face mask throughout the shift of observation while providing medication administration and the care and supervision of the clients. Additionally, the second shift staff from the prior day's observation arrived wearing the face mask again below the nose from 7:45 AM to 8:30 AM. Interview with the QIDP on 12/13/22 confirmed all staff must wear a face mask while in the presence of or providing direct care services to clients.	W 455		
W 476	MEAL SERVICES CFR(s): 483.480(b)(3) Food served to clients individually and uneaten must be discarded. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 3 sampled clients (#3) received food served that was not compromised. The finding is: Observation in the home on 12/13/22 at 8:15 AM revealed all clients to participate in a breakfast	W 476		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G027	A. BUILDING ______ B. WING ______	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTHURST I & II	**174 HOOTS DRIVE WINSTON-SALEM, NC 27107**

(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 476	Continued From page 6	W 476		

meal consisting of ¾ cups of oatmeal with 2 teaspoons of raisins, 2 teaspoons of cinnamon, 1 teaspoon of equal, 1 slice of cheese toast, 8 ounces of 1% milk and 4 ounces of juice and decaf coffee. Further observation at 8:20 AM revealed a non-sample client (#2) to serve themselves a second helping of oatmeal and to use the spoon that they ate their breakfast meal to scrape the remaining oatmeal from the serving spoon onto their plate leaving the spoon scrapped clean of all oatmeal. Subsequent observation revealed staff to pass the oatmeal dish and contaminated serving spoon onto client #6 who then used the contaminated spoon to serve one scoop of oatmeal onto their plate. Client #6 then proceeded to consume the oatmeal. Prior to the breakfast meal at 6:00 AM, the non-sample client #2 openly spoke of having a sore throat, not feeling well, and staying home to rest.

Interview on 12/13/22 with the homes Qualified Intellectual Disabilities Professional (QIDP) revealed that if a food item should become contaminated it should immediately be removed and replaced with a new serving and offered to the client. Staff witnessing and passing the contaminated oatmeal should have replaced the oatmeal with a newly cooked serving and not passed it onto another client to consume.