		AND HUMAN SERVICES				FORM	APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA							B NO. 0938-0391 X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING			COM	PLETED	
		34G027	B. WING			12/*	13/2022	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
SCOTTH	URST I & II				INSTON-SALEM, NC 27107			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	JLD BE COMPLETION		
W 249	PROGRAM IMPLE CFR(s): 483.440(d)		W 24	49				
	formulated a client's each client must re- treatment program interventions and se and frequency to su objectives identified plan. This STANDARD is Based on observat	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 s not met as evidenced by: tions, record review and						
	(#3 and #9) receive treatment program interventions relativ findings are:	y failed to ensure 2 of 6 clients ed a continuous active consisting of needed re to adaptive equipment. The I to provide mealtime adaptive						
	equipment for clien	t #3. For example:						
	5:55 PM revealed of independently in the of Salisbury steak, green beans, milk a observation reveale high-sided divided of consuming the dinn	e group home on 12/12/22 at client #3 to participate e dinner meal which consisted mashed potatoes and gravy, and water. Continued ed client #3 to utilize a dish to support him with her meal. Further observation o utilize his spoon to cut the						
	8:05 AM revealed c independently in the	e group home on 12/13/22 at client #3 to participate e breakfast meal which al with raisins, cereal, cheese						

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

TITLE

(X6) DATE

PRINTED: 12/16/2022

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	12/16/2022 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G027	B. WING_			12/ [,]	13/2022
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SCOTTH	IURST I & II				74 HOOTS DRIVE /INSTON-SALEM, NC 27107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	toast, milk, coffee a observation revealed high-sided divided of consuming the breat Review of client #3' a person-centered which indicated clied includes a high-sided knife. Continued revo occupation therapy which indicated clied includes a high-sided knife for mealtime. Interview with Staff #3's rocker T knife Continued interview #3's is supposed to dinner mainly to cut qualified intellectua (QIDP) on 12/13/22 mealtime guidelines confirmed the rocked at every meal. B. The facility failed equipment for client Observations in the 5:55 PM revealed of independently in the of Salisbury steak, for green beans, milk a observation revealed utensils to support for meal. Further observation	And water. Continued and water. Continued ad client #3 to utilize a dish to support him with akfast meal. 's record on 12/13/22 revealed plan (PCP) dated 1/27/22 ant #3's adaptive equipment ed divided dish and rocker T view of the record revealed an (OT) evaluation dated 2/22/19 ant #3's adaptive equipment ed divided dish and rocker T A on 12/13/22 revealed client to be in a kitchen drawer. with Staff A revealed client to be in a kitchen drawer. with Staff A revealed client to have the rocker T knife at t meats. Interview with I disabilities professional 2 confirmed client #3's s are current and further er T knife should be provided I to provide mealtime adaptive	W 24	49			

If continuation sheet Page 2 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING			AND HUMAN SERVICES			FORM	12/16/2022 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SCOTTHURST I & II STREET ADDRESS, CITY, STATE, ZIP CODE IMAGE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE IMAGE OF PROVIDERS TO TO EFFCENCES PREVEX IPACING EACH DEFICIENCIES IPACING EACH DEFICIENCIES IPACING PREVEX REGULATORY OR LSC IDENTIFYING INFORMATION) PREVEX 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 catmeal with raisins, cereal, cheese toast, milk, coffee and water. Continued observation revealed client #9 to utilize regular utensits 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 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 indicated client #9's in supposed to have the rocker T knife. Interview with Staff A nrule add dichting protector or multiple cloth napkitchen drawer. Continued interview with Staff A revealed client #9's is supposed to have the rocker T knife at dinner mainty to ut masts. 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 287			` '	E CONSTRUCTION	(X3) DATE SURVEY		
174 HOOTS DRIVE WINSTON-SALEM, NC 27107 OPAID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D D W 249 Continued From page 2 Observations in the group home on 12/13/22 at 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 utensits to support him with consuming the breakfast meal. W 249 W 249 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 alon T evaluation indicated client #9's adaptive equipment includes regular fork and spoon and rocker T knife. W 249 Interview with Staff A on 12/13/22 revealed client #9's rocker T knife Add clothing protector or multiple cloth napkins for hygiene. He is independent with the use of rocker T knife at dinner mainly to cut meats. Interview with qualified intelectual disabilities professional (OIDP) on 12/13/22 continued client #9's mealtime guidelines are current and further confirmed the rocker T knife should be provided at every meal. W 287 W 287 MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CPR(s): 483.450(b)(3) W 287			34G027	B. WING	 	12/ [,]	13/2022
SCOTTURENT 12 II (M) ID TAG Summary statement of DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATIONY OR LSC IDENTIFYING INFORMATION) ID TAG ID TAG PROVIDER'S PLAN OF CORRECTION BEDIC (CONSERVER TO SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (20) 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 natmeal with raisins, cereal, cheese toast, milk, coffee and water. Continued observation revealed dlient #9 to utilize regular utensits to support him with consuming the breakfast meal. W 249 W 249 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, bilatera these pads, nocker T knife, and clothing protector. Continued review of the record revealed an 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 soucher t knife to be in a kitchen drawer. Continued interview with Staff A revealed client #9's soucher t knife stould be provided at every meal. W 287 W 287 MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CPR(s): 483.450(b)(3) W 287	NAME OF F	ROVIDER OR SUPPLIER					
Pričenk TAG (EACH OFFICIENCY NUST BE PRECEDB OB YFULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÍČIN TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMŘÉČÍN DMTE 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 catmeal with raisins, cereal, cheese toast, milk, coffee and water. Continued observation revealed client #9 to revealed 2/24/22 which indicated client #9 second 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 287 W 287 MGM OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483 450(b)(3) W 287	SCOTTH	URST I & II					
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 to be provided at every meal. W 287 W 287 MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) W 287	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
behavior must never be used for the convenience of staff.		Observations in the 8:05 AM revealed of independently in the consisted of oatmest toast, milk, coffee a observation revealed utensils to support to breakfast meal. Review of client #9' a person-centered p which indicated clie includes a gait belt, knife, and clothing p the record revealed 9/28/19. Review of client #9's adaptive fork and spoon and protector or multiple is independent with Interview with Staff #9's rocker T knife to Continued interview #9's is supposed to dinner mainly to cut qualified intellectual (QIDP) on 12/13/22 mealtime guidelines confirmed the rocke at every meal. MGMT OF INAPPR BEHAVIOR CFR(s): 483.450(b)	a group home on 12/13/22 at client #9 to participate e breakfast meal which al with raisins, cereal, cheese and water. Continued ed client #9 to utilize regular him with consuming the 's record on 12/13/22 revealed plan (PCP) dated 2/24/22 ent #9's adaptive equipment bilateral knee pads, rocker T protector. Continued review of an OT evaluation dated the OT evaluation indicated equipment includes regular rocker T knife. Add clothing e cloth napkins for hygiene. He the use of rocker T knife. A on 12/13/22 revealed client to be in a kitchen drawer. with Staff A revealed client to be in a kitchen drawer. with Staff A revealed client to have the rocker T knife at t meats. Interview with I disabilities professional confirmed client #9's s are current and further er T knife should be provided ROPRIATE CLIENT (3) age inappropriate client				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		PRINTED: 12/16/2022 FORM APPROVED DMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (>	X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
34G027 В	3. 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 SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
 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 necord 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 455 INFECTION CONTROL CFR(s): 483.470(I)(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 287	

Facility ID: 922547

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		AND HUMAN SERVICES				FORM	12/16/2022 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (l` í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G027	B. WING	12/ [,]	13/2022		
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SCOTTH	IURST I & II				74 HOOTS DRIVE /INSTON-SALEM, NC 27107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 455	Based on observati failed to implement prevention and con communicable dise Lakewood. The find A. The facility failed wore face masks w services, which is a Centers for Medica (CMS) to limit the p COVID-19 virus. For Observation upon et 12/13/22 at 6:45 AM answer the door wit Continued observati put on a face mask observations began AM revealed third s bedroom without we observations reveal working in the home their shift ended at Interview with the q professional (QIDP staff must wear a fa presence of or prov clients. B. The facility failed wore face mask wh services, which is a Centers for Medica	tions and interviews, the facility an active program for the trol of infection and eases in Rockcreek and dings are: It to ensure Rockcreek staff thile providing direct care a current requirement by the re and Medicaid Services botential spread of the or example: entry of the group home on M revealed first shift staff to thout a face mask on. tion revealed first shift staff to immediately after survey n. Further observation at 7:00 shift staff to exit client #1's earing a face mask. Additional led third shift staff to continue e without a face mask until approximately 7:30 AM. ualified intellectual disabilities) on 12/13/22 confirmed all ace mask while in the riding direct care services to d to ensure Lakewood staff tile providing direct care a current requirement by the re and Medicaid Services potential spread of the	W 4	-55			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	12/16/2022 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	ì í	TIPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		34G027	B. WING _		12/	13/2022	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SCOTTH	URST I & II			174 HOOTS DRIVE WINSTON-SALEM, NC 27107			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 455 W 476	4:00 PM to 6:00 PM staff to be on duty p supervision to six cl covering worn below wearing no face cov the visit. Continued home on 12/13/22 r to cover third shift a during observation Subsequent observ AM to 8:30 AM reve arrive and enter the continue the shift w the shift of observat administration and t the clients. Addition from the prior day's the face mask again AM to 8:30 AM. Interview with the C staff must wear a fa presence of or prov clients. MEAL SERVICES CFR(s): 483.480(b) Food served to clien must be discarded. This STANDARD is Based on observat failed to ensure 1 of	group home on 12/12/22 at I revealed two second shift providing direct care and ients, one with the face w the nose and the other vering throughout the rest of observation in the group evealed the second shift staff and to have no face mask on from 5:45 AM to 8:30 AM. ation in the group home 6:15 ealed the first shift staff to home with no face mask and ith no face mask throughout tion while providing medication the care and supervision of hally, the second shift staff observation arrived wearing h below the nose from 7:45	W 45 W 47				
		nome on 12/13/22 at 8:15 AM to participate in a breakfast					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	12/16/2022 APPROVED 0938-0391
		. ,	PLE CONSTRUCTION G	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		34G027	B. WING		12/ [,]	13/2022
NAME OF PROVIDER C	OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SCOTTHURST I &	II			174 HOOTS DRIVE WINSTON-SALEM, NC 27107		
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
meal con teaspool ounces of decaf con revealed themselve use the set observat dish and #6 who t serve on Client #6 oatmeal the non- a sore th to rest.	ns of raisin n of equal, of 1% milk offee. Furth d a non-san ves a seco spoon that e the rema nto their pla d clean of a tion revealed contamina then used t he scoop of 6 then proc . Prior to the sample clien noat, not fee w on 12/13/ ual Disability d that if a for nated it sho aced with a ht. Staff wit nated oatm with a new	age 6 ³ / ₄ cups of oatmeal with 2 s, 2 teaspoons of cinnamon, 1 1 slice of cheese toast, 8 and 4 ounces of juice and her observation at 8:20 AM inple client (#2) to serve ind helping of oatmeal and to they ate their breakfast meal ining oatmeal from the serving ate leaving the spoon all oatmeal. Subsequent ed staff to pass the oatmeal ated serving spoon onto client the contaminated spoon to f oatmeal onto their plate. eeded to consume the he breakfast meal at 6:00 AM, ent #2 openly spoke of having eeling well, and staying home ² / ₂ with the homes Qualified ties Professional (QIDP) bod item should become build immediately be removed a new serving and offered to nessing and passing the heal should have replaced the <i>l</i> /y cooked serving and not ther client to consume.	W 47			

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