DEPARTMENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES				MB NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		E SURVEY IPLETED
	34G074	B. WING			01/	24/2023
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ASHLEY HEIGHTS HOME				990 RESERVATION ROAD BERDEEN, NC 28315		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 249 PROGRAM IMPLE CFR(s): 483.440(d		W 2	49			
formulated a client each client must re treatment program interventions and s and frequency to s	erdisciplinary team has 's individual program plan, eceive a continuous active consisting of needed services in sufficient number upport the achievement of the d in the individual program					
Based on observa interviews, the faci clients (#2) receive treatment program interventions and s Individual Program	is not met as evidenced by: tions, record review and lity failed to ensure 1 of 4 audit ed a continuous active consisting of needed services as identified in the Plan (IPP) in the areas of tation regarding the use of The finding is:					
survey on 1/23/23 not wear gloves. A	is in the home throughout the through 1/24/23, client #2 did at no time during the aff encourage the client to put					
revealed due to se wears protective sl transportation and	of client #2's IPP dated 1/3/23 If injurious behaviors client #2 eeves, hand mitts during gloves that are to be worn rs for 1 hour and 50 minutes 0 minutes.					
#2 is supposed to skin picking and se	3 with Staff B revealed client wear protective gloves due to If injurious behavior for 1 hour DER/SUPPLIER REPRESENTATIVE'S SIG			TITLE		(X6) DATE

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

(X6) DATE

PRINTED: 01/25/2023

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.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		TE SURVEY MPLETED
		34G074	B. WING		01	/24/2023
NAME OF I	PROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHLEY	HEIGHTS HOME			2990 RESERVATION ROAD ABERDEEN, NC 28315		
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W 249	and 50 minutes dur breaks.	age 1 ring the day with 10 minute 3 with the qualified intellectual	W 249)		
W 340	disabilities professi have been trained of sleeves, hand mitts confirmed client #2 gloves throughout t after every 1 hour a	onal (QIDP) confirmed staff on the use of the protective and gloves. The QIDP should have been wearing the the day with 10 minute breaks and 50 minutes. CES	W 340)		
	other members of t appropriate protect measures that inclu- training clients and health and hygiene This STANDARD i Based on observa- failed to ensure sta- implement appropri	s not met as evidenced by: tions and interviews, the facility ff were sufficiently trained to iate health and hygiene ected 3 of 4 audit clients (#2,				
	the medication adm put on gloves and of medication room. S punching his medic Client #4 took his n medication room. A the medication room with punching medic Client #2 took med medication room. A	ions in the home on 1/23/23 of hinistration at 4:05pm staff A client #4 came into the Staff A assisted client #4 in cations from the bubble pack. hedications and exited the At 4:10pm client #2 came into m and staff A assisted client #4 ications from the bubble pack. ication and exited the At 4:18pm client # 3 entered m and staff A assisted client #2				

If continuation sheet Page 2 of 6

		AND HUMAN SERVICES				FORM	01/25/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G074	B. WING	i		01/2	24/2023
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ASHLEY	HEIGHTS HOME				990 RESERVATION ROAD ABERDEEN, NC 28315		
(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 340	At no time did staff assisting client's du	age 2 ications from the bubble pack. A change gloves between iring medication pass nor have r hands before handling	W S	340			
	confirmed staff sho clients during medie	3 with the facility nurse ould change gloves in between cation administration and have ir hands prior to handling					
	home on 1/23/23 at the kitchen to assis 5:18pm client #4 ca with processing his	ions of meal preparation in the t 5:15pm, client #2 came into st with processing her food. At ame into the kitchen to assist food. At no time were client ed to wash or sanitize their					
W 369	disabilities profession	RATION	W 3	369			
	that all drugs, inclus self-administered, a This STANDARD is Based on observat interviews, the facili medications were a This affected 3 of 4	are administered without error. s not met as evidenced by: tions, record review and ity failed to ensure all administered without error. audit clients (#2, #3 and #4) medications. The findings are:					

If continuation sheet Page 3 of 6

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 34G074 B. WING 01/24/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 01/24/2023 ASHLEY HEIGHTS HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH ODRESPICAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 0 W 369 Continued From page 3 administration pass in the home on 1/23/23 at 4:05pm staff A administered the following medications to client #4' S physician's orders dated 1/11/23 reveal an order for Protein Powder 80% use 1 scoopful daily at 4pm. W 369 W 369 During observations of the medication administration pass in the home on 1/23/23 at 4:10pm staff A administered the following medication to client #2: Klonopin 1mg, Baclofen W 369 W 369			AND HUMAN SERVICES				FORM	01/25/2023 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ASHLEY HEIGHTS HOME STREET ADDRESS, CITY, STATE, ZIP CODE (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 OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMM2ETH DATE W 369 Continued From page 3 administration pass in the home on 1/23/23 at 4:05pm staff A administered the following medications to client #4: Oxybutynin 5mg and Boost supplement. W 369 Review on 1/24/23 of client #4's physician's orders dated 1/11/23 reveal an order for Protein Powder 80% use 1 scoopful daily at 4pm. W if the medication administration pass in the home on 1/23/23 at 4:10pm staff A administered the following medication to client #2: Klonopin 1mg, Baclofen	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DAT	E SURVEY
ASHLEY HEIGHTS HOME 2990 RESERVATION ROAD ABERDEEN, NC 28315 (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) COMPLETN DATE W 369 Continued From page 3 administration pass in the home on 1/23/23 at 4:05pm staff A administered the following medications to client #4: Oxybutynin 5mg and Boost supplement. W 369 W 369 Review on 1/24/23 of client #4's physician's orders dated 1/11/23 reveal an order for Protein Powder 80% use 1 scoopful daily at 4pm. W 369 W 369 During observations of the medication administration pass in the home on 1/23/23 at 4:10pm staff A administered the following medication to client #2: Klonopin 1mg, Baclofen H 369			34G074	B. WING	. <u></u>		01/:	24/2023
ASHLEY HEIGHTS HOME ABERDEEN, NC 28315 (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) COMPLETN DATE W 369 Continued From page 3 administration pass in the home on 1/23/23 at 4:05pm staff A administered the following medications to client #4: Oxybutynin 5mg and Boost supplement. W 369 W 369 Review on 1/24/23 of client #4's physician's orders dated 1/11/23 reveal an order for Protein Powder 80% use 1 scoopful daily at 4pm. During observations of the medication administration pass in the home on 1/23/23 at 4:10pm staff A administered the following medication to client #2: Klonopin 1mg, Baclofen During baservations of the medication	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
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) COMPLETM DATE W 369 Continued From page 3 administration pass in the home on 1/23/23 at 4:05pm staff A administered the following medications to client #4: Oxybutynin 5mg and Boost supplement. W 369 W 369 Review on 1/24/23 of client #4's physician's orders dated 1/11/23 reveal an order for Protein Powder 80% use 1 scoopful daily at 4pm. During observations of the medication administration pass in the home on 1/23/23 at 4:10pm staff A administered the following medication to client #2: Klonopin 1mg, Baclofen During Observations of the medication Image: Completent = 0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0	ASHLEY	HEIGHTS HOME						
administration pass in the home on 1/23/23 at 4:05pm staff A administered the following medications to client #4: Oxybutynin 5mg and Boost supplement. Review on 1/24/23 of client #4's physician's orders dated 1/11/23 reveal an order for Protein Powder 80% use 1 scoopful daily at 4pm. During observations of the medication administration pass in the home on 1/23/23 at 4:10pm staff A administered the following medication to client #2: Klonopin 1mg, Baclofen	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
10mg, Oxybutynin 5mg and a Boost supplement. Client #2 took medications whole with water and then consumed the Boost supplement. Review on 1/24/23 of client #2's physician's orders revealed an order dated 12/6/22 to change client #2's diet to ground and crush medications and administer with yogurt, applesauce or pudding. Further observations of the medication administration pass in the home on 1/23/23 at 4:18pm staff A administered the following medication to client #3: Metformin 500mg and Levothyroxin 25mcg. Review on 1/24/23 of client #3's physician's orders dated 10/7/22 revealed an order for Levothyroxin 25mcg 1 tablet by mouth at 8:00am. Interview on 1/24/23 with the facilty nurse confirmed client #4 should have received protein powder at 4pm and client #2 should have all medications crushed and mixed in applesauce,	W 369	administration pass 4:05pm staff A adm medications to clien Boost supplement. Review on 1/24/23 orders dated 1/11/2 Powder 80% use 1 During observations administration pass 4:10pm staff A adm medication to client 10mg, Oxybutynin S Client #2 took medi then consumed the Review on 1/24/23 orders revealed an client #2's diet to gr and administer with pudding. Further observation administration pass 4:18pm staff A adm medication to client Levothyroxin 25mc Review on 1/24/23 orders dated 10/7/2 Levothyroxin 25mc Interview on 1/24/2 confirmed client #4 powder at 4pm and	 a in the home on 1/23/23 at inistered the following in #4: Oxybutynin 5mg and of client #4's physician's 23 reveal an order for Protein scoopful daily at 4pm. s of the medication in the home on 1/23/23 at inistered the following the end of the following the end of the medication in the home on 1/23/23 at inistered the following the end of the medication is and a Boost supplement. of client #2's physician's order dated 12/6/22 to change round and crush medications in the home on 1/23/23 at inistered the following the end of the medication is in the home on 1/23/23 at inistered the following the end of the medication is in the home on 1/23/23 at inistered the following the end of the medication is in the home on 1/23/23 at inistered the following the end of the medication is in the home on 1/23/23 at inistered the following the end of the medication is in the home on 1/23/23 at inistered the following the end of the medication is in the home on 1/23/23 at inistered the following the end of the medication is in the home on 1/23/23 at inistered the following the end of the medication is in the home on 1/23/23 at inistered the following and g. of client #3's physician's 22 revealed an order for g 1 tablet by mouth at 8:00am. 3 with the facilty nurse should have received protein I client #2 should have all 	W	369			

If continuation sheet Page 4 of 6

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/25/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
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W 369	Continued From pa	ge 4	W 3	369		
W 382	8am. DRUG STORAGE / CFR(s): 483.460(l)(AND RECORDKEEPING 2)	W 3	382		
W 383	locked except when administration. This STANDARD is Based on observat failed to ensure all r except when being During observations 3:30pm, the keys to observed hanging f quality assurance s the door and remov Interview on 1/24/23 confirmed the medi remained locked at the room administe	3 with the facility nurse cation closet door should all times unless staff are in ring medications. AND RECORDKEEPING	W 3	383		
	Only authorized per keys to the drug sto This STANDARD is Based on observat failed to ensure only access to the keys finding is: During observations	rsons may have access to the orage area. Is not met as evidenced by: tions and interviews, the facility y authorized persons have to the drug storage area. The s in the home on 1/23/23 at				
	observed hanging f	o the medication closet were rom the lock. At 4:33pm the taff was observed to walk to re the keys.				

If continuation sheet Page 5 of 6

		AND HUMAN SERVICES				FORM	01/25/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		34G074	B. WING	<u>} </u>		01/:	24/2023
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ASHLEY	HEIGHTS HOME				990 RESERVATION ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 383	Continued From pa	ige 5	W	383			
	confirmed that staff	3 with the facility nurse fare to keep the keys to the on their person at all times.					