STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G241	A. BUILDING _____ B. WING _____	01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARCHES-HORIZONS RESIDENTIAL CARE CENTER	5900 BETHABARA PARK BOULEVARD WINSTON SALEM, NC 27106

(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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 8 of 10 audit clients (#1, #2, #3, #5, #7, #8, #9 and #10) had the right to be treated with dignity regarding the use of incontinence padding. The finding is: During observations in the facility throughout the survey on 1/23/23 - 1/24/23, clients #1, #2, #3, #5, #7, #8, #9 and #10 were observed sitting in wheelchairs and/or recliners with an incontinence pad positioned in the seats underneath them. The incontinence pad was visible to anyone in the area. Interview on 1/24/23 with the clinical director, qualified intellectual disabilities professional and director of operations confirmed that the incontinence padding placed under the clients does not provide the clients with dignity.	W 125		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to assure all medications and biologicals remained locked except when being prepared for medication administration for 10 of 10 clients (#1,	W 382		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 382	Continued From page 1 #2, #3, #4, #5, #6, #7, #8, #9, #10). The finding is: Morning observations in the group home on 1/24/23 at 6:50 AM revealed staff to step into client #4's room to provide medication administration and close the door. Continued observation revealed the medication cart and computer monitor to remain unlocked and unattended. Observations revealed the computer monitor was visible as others walked down the hallway. Observations at 7:00 AM revealed the staff to push the medication cart to the dayroom as the cart remained unlocked. Subsequent observations at 7:15 AM revealed the facility nurse to walk away from the medication cart, leaving the cart unlocked and unattended. Observations at 7:18 AM revealed the nurse to enter into the kitchen and return to the medication cart which remained unlocked. Observations also revealed the nurse to leave the medication cart unlocked and unattended for a total of three minutes. Continued observations at 7:20 AM revealed the nurse to prepare for medication administration and lock the cart as she continued medication administration. Interview with the Clinical Director on 1/24/23 revealed that staff should lock the medication administration cart before walking away to provide medication administration to clients. Continued interview with the Clinical Director revealed all staff have received medication administration training. Further interview with the Clinical Director and qualified intellectual disabilities professional (QIDP) verified that all staff have been trained to not leave the computer monitor and medication cart unlocked and	W 382		

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W 382	Continued From page 2 unattended when it is not is use.	W 382		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to furnish and maintain in good repair the use of adaptive equipment for 3 clients (#1, #4, #6). The finding is: Observations throughout the 1/23/23-1/24/23 survey revealed client #1 to ambulate in a wheelchair with staff assistance. Continued observation revealed the foot rest of client #1's wheelchair to be torn across the bottom of the footrest. Additional observations throughout the survey period revealed client #4 to ambulate in a wheelchair with staff assistance. Continued observation revealed the right arm rest to be torn with foam padding visible and uncovered. Subsequent observations throughout the survey period revealed client #6 to ambulate in a wheelchair with staff assistance. Continued observation revealed the lap tray attached to client #6's wheelchair to be torn on the left and right sides of the tray. Interview with the Director of Operations (DOO) on 1/24/23 revealed staff visit the facility biweekly	W 436		

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W 436	Continued From page 3 to inspect and repair wheelchairs for all clients. Continued interview with the DOO and Clinical Director revealed staff were not aware of clients' #1, #4, #6 repairs needed with their wheelchairs. Further interview with the DOO revealed the facility does not keep a list of what repairs are needed for the clients' wheelchairs.	W 436		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: The facility failed to assure fire drills were conducted quarterly for each shift of personnel as evidenced by interview and record verification. The finding is: Review on 1/23/23 of the facility's fire drill evacuation reports revealed for the time period of January 2022 through December 2022, fire drills were not conducted for March 2022, July 2022 and September 2022. Interview with the clinical director, qualified intellectual disabilities professional and director of operations revealed maintenance is responsible for conducting fire drills and stated that the fire drills that were reviewed were the only drills completed to their knowledge.	W 440		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on review of fire drill evacuation reports and interviews, the facility failed to ensure fire evacuation drills were conducted at varied times/conditions. The finding is:	W 441		

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W 441	Continued From page 4 Review on 1/23/23 of the facility's fire drill evacuation report for the time period of January 2022 through December 2022 revealed fire drills were conducted on 1st shift at 1:39pm, 1:31pm and 12:35pm; 2nd shift at 3:14pm, 3:45pm, and 3:16pm; and 3rd shift at 11:45pm, 6:38am, and 6:00am. Interview on 1/24/23 with the clinical director, qualified intellectual disabilities professional and director of operations confirmed the fire drills were not conducted at varied times.	W 441		
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: The facility failed to ensure an active program for the prevention and control of infection and communicable diseases was present in the group home as required as evidenced by observations and interviews. The finding is: During observations in the facility throughout the survey on 1/23/23 - 1/24/23, staff were observed to wear a face mask below their nose or below their chin. Interview with the clinical director, qualified intellectual disabilities professional and director of operations revealed staff are trained to wear face masks above their nose and covering the chin and should be wearing their masks appropriately.	W 455		